

Working Together for Health

MEDICAID ANNUAL REPORT FY 2005

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Government of the
District of Columbia
Anthony A. Williams, Mayor

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION



Working Together for Health

MEDICAID ANNUAL REPORT FY 2005

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Quality Health Care for Vulnerable Populations

A Message from the Director, Department of Health



I WANT TO EXPRESS MY CONGRATULATIONS TO THE MANAGEMENT AND STAFF of the Medical Assistance Administration for the progress they have made over the last year in ensuring the provision of a wide range of quality health services to the residents of the District of Columbia. The Department of Health is proud to be the agency to carry out the Mayor's vision of providing quality health services for the most vulnerable populations of the District of Columbia.

Medicaid services are essential for the over 140,000 residents (one in four District residents) who are served every month through the program. The breadth of services encompasses the entire spectrum of our population, from the newborns to our senior citizens. Through sound management and oversight, we continue to ensure that comprehensive health services are provided to our members.

"We are on our way to making D.C. one of the healthiest cities in the country."

This annual report on Medicaid services in the District is a testimony to all of you who work with the Department of Health and Medicaid to ensure we meet the health needs of our citizens. We are on our way to making D.C. one of the healthiest cities in the country.

Gregg A. Pane, MD
Director, Department of Health



Our Responsibility to Over 140,000 Residents

A Message from the Medicaid Director

OVER THE PAST TWO YEARS, THE DISTRICT OF COLUMBIA'S MEDICAID PROGRAM HAS FOCUSED on becoming a world-class health insurance program. New programs to provide care for those most in need have been developed, eligibility for Medicaid has been expanded, collaborative community, advocacy and provider relationships have been established, and fiscal integrity has been restored. I am proud of all of the Medicaid staff and their desire to ensure that our Medicaid recipients get the best possible health care.

The Medicaid budget will approach \$1.4 billion in FY 2006. We serve over 140,000 of the District's residents—one of every four residents—a number that continues to grow every month. We do not take this responsibility lightly. We are committed to working closely with the Mayor's office, with the Council, and with sister agencies to ensure that quality care is provided in a coordinated and effective manner.

“We are committed...to ensure that quality care is provided in a coordinated and effective manner.”

Our program provides a wide variety of benefits and services for our beneficiaries. Children, parents, childless adults and elders are all eligible to receive services from the Medicaid program. Over 90,000 of our beneficiaries are served through our managed care organizations

(MCOs). To ensure quality of care in these programs, we have worked closely with the National Committee for Quality Assurance (NCQA). To maintain NCQA accreditation, plans must meet high standards of quality that are measured for ongoing improvement. We are requiring our MCOs to become members of NCQA, a nationally recognized organization, to ensure better quality reporting and oversight. Additionally, we have instituted a process for them to report annually on 41 nationally recognized quality measures. As you can see, we view quality of health care as an extremely important part of our service to our beneficiaries.

We continue to increase our efforts to work closely with other District government health providers, establishing waivers and state plan amendments to increase access to Medicaid services in other settings. This provides our beneficiaries with a continuity of care that heretofore has not been available. We are also increasing the scope and breadth of home and community-based services that are available, so that institutionalization is not the only option, and individuals who choose to live at home can now do so.

As you read through this report you will see evidence that many new initiatives are making Medicaid a better program for our District residents. I would be remiss if I did not thank the Mayor, the District Council, and the Department of Health and our community partners for their support of our efforts. It has been my pleasure to oversee this program for the past two years and I look forward to even greater achievements in the year ahead.

Robert T. Maruca, Medicaid Director and
Senior Deputy Director, Medical Assistance Administration
Department of Health

Highlights of Fiscal Year 2005 and a Look to 2006

THE MEDICAID PROGRAM IN FY 2005

- **Enrollment.** In FY 2005, Medicaid enrollment averaged 141,941 people a month, or one quarter of the District's population. Enrollment increased over 2%. See page 5.
- **Spending.** For the fiscal year ended September 30, 2005, Medicaid spending for health care was \$1.26 billion, up 3.4% (preliminary data). Payment per enrollee per month was \$741, up 1.3%. See page 7.
- **Economic impact.** 92% of Medicaid payments are made to health care providers in the District. Medicaid also brings in about \$900 million a year in federal funding to D.C. See page 17.

HIGHLIGHTS OF FY 2005

- **New initiatives to help HIV-positive people stay healthy.** D.C. became the first Medicaid program to cover costly anti-retroviral drugs for HIV-positive people who are not yet sick enough to qualify for Medicaid under standard eligibility rules. The District also received a federal "Ticket to Work" grant so that HIV-positive people can keep Medicaid coverage while maintaining employment. See page 10.
- **More emphasis on managed care quality.** Medicaid began requiring its three managed care organizations to report results on 41 nationally accepted measures of quality. In FY 2006, all MCOs will be required to seek accreditation by the National Committee for Quality Assurance. See page 8.
- **Improved child immunization rates.** D.C. was one of two Medicaid programs nationwide that exceeded federally set goals for child immunization. See page 11.
- **Increased recoveries.** Medicaid efforts to reduce fraud and abuse, to ensure that Medicaid is the insurer of last resort, and to claim rebates from drug manufacturers all resulted in increased dollar recoveries. See page 18.
- **Eligibility simplified.** The Medicaid eligibility form was streamlined from 18 pages to 6 pages. See page 6.

MAJOR ISSUES AND INITIATIVES FOR FY 2006

- **Expansion in coverage and federal funding.** D.C. has requested federal approval to expand Medicaid coverage to include 1,700 people now covered by the D.C. Health Care Alliance. The expansion would generate \$19.0 million a year in new federal funding and free up District money that could be used to fund health care for other needy groups. See page 6.
- **Implementation of the Medicare drug benefit.** On January 1, 2006, Medicare will implement its new drug benefit. For 16,000 D.C. Medicaid beneficiaries, Medicare will pay for drugs now paid for by Medicaid. We are working with Medicare, beneficiary advocates and provider associations to ensure a smooth transition. See page 11.
- **Increased flexibility in home and community-based services (HCBS).** A new Medicaid initiative will give people receiving home and community-based services more autonomy in selecting the services they need and in choosing their caregivers. HCBS is a cost-effective program that helps people remain at home when their health conditions otherwise would require placement in an institution. See page 14.
- **Value purchasing for prescription drugs.** In FY 2006, Medicaid intends to become a more effective purchaser of prescription drugs by implementing a preferred drug list and changing drug payments to reflect maximum allowable cost (MAC) benchmarks. See page 19.

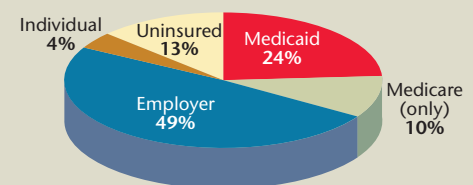
Essential Health Care for D.C. Residents

An overview of the residents that Medicaid serves and the services provided.

AN ESSENTIAL PROGRAM FOR D.C. RESIDENTS

- **2005 marks the 40th anniversary** of Medicaid and Medicare, two programs that have done enormous good for many millions of people who otherwise would have gone without health care coverage due to age, poverty or disability.
- **Serving more D.C. residents every year.** In the 2005 fiscal year that ended September 30, D.C. Medicaid served an average of 141,941 residents a month. Since many beneficiaries moved on and off Medicaid during the year, the number of people served at various points during FY 2005 was even higher.
- **How Medicaid fits in.** When it comes to health insurance, almost everyone in the U.S. comes under one of five categories.
 - *Employment-based coverage* is the foundation of the system. When employers offer health plans, they pay an average of 75% of the cost, which now exceeds \$10,000 a year for family coverage.¹ Unlike wage income, employees do not have to pay taxes on the health benefits they receive. But more and more employers do not offer health plans, especially to new hires, part-time workers or workers earning under \$15 an hour.²
 - *Medicare* is available for people age 65 and over, regardless of income, and for people with certain disabilities that prevent them from working.
 - *Individually purchased insurance* is bought by a few people, but is very expensive.
 - *Medicaid* primarily serves low-income children and their parents, people with disabilities, and low-income Medicare beneficiaries.
 - *The uninsured population* tends to include childless couples, single men and others who do not come under Medicaid eligibility categories, as well as people whose income exceeds Medicaid thresholds but who don't have access to employment-based coverage.
- **The second-largest source of insurance.** Medicaid covers about one-quarter of the D.C. population in an average month. About half the D.C. population has employment-based coverage.³ See the chart on this page.
- **Critical for kids.** Medicaid covers 44% of D.C. kids age 18 and under while employment-based plans cover 43%, according to the Kaiser Commission on Medicaid and the Uninsured.⁴

D.C. Health Insurance Coverage, 2003



Medicaid percentage includes 3% eligible for both Medicaid and Medicare.
Source: ACS Government Healthcare Solutions

Medicaid Population Demographics FY 2005

	Number	%
By Sex		
Male	57,185	40%
Female	84,756	60%
By Age		
17 and under	71,427	50%
18–21	9,019	6%
22–64	49,639	35%
65 and over	11,856	8%
By Race		
Black	124,181	87%
White	2,214	2%
Other	15,546	11%
By Ward		
1	15,218	11%
2	20,864	15%
3	1,649	1%
4	15,009	11%
5	18,969	13%
6	16,676	12%
7	24,199	17%
8	28,841	20%
Unknown	516	0%
TOTAL	141,941	100%

Note: Percentages may not sum to 100% due to rounding.

The Federal Poverty Line

Medicaid eligibility often depends on annual family income relative to the federal poverty line (FPL). This table shows the 2005 FPL.

Family Size	100% of FPL	150% of FPL	200% of FPL
1	\$9,570	\$14,355	\$19,140
2	\$12,830	\$19,245	\$25,660
3	\$16,090	\$24,135	\$32,180
4	\$19,350	\$29,025	\$38,700

CHANGES IN ELIGIBILITY

■ **Eligibility form simplified.** In FY 2005, the application for Medicaid benefits was reduced from 18 pages to 6 pages. The extra pages had been used to check for unusual sources of income and assets that rarely affected eligibility.

■ **Innovative waiver program will expand coverage.** In FY 2006, Medicaid intends to extend coverage to three groups of people:

- About 900 disabled people with incomes between 100% and 200% of the federal poverty line (FPL)
- About 300 19- and 20-year-olds
- About 500 unborn children of pregnant immigrant women

These groups are now covered by the D.C. Health Care Alliance, the program for the uninsured that is 100% funded by the District. Medicaid has requested federal approval to make these groups eligible for Medicaid, which is 70% funded by the federal government. The increase in Medicaid spending is expected to be about \$27 million a year, mostly for the people with disabilities who have chronic health care needs. The inflow of federal money will free up District funds that can be used to fund health care for other needy groups. The new beneficiaries will be eligible for a broader range of services than they are now. By extending coverage to unborn children, Medicaid can fund prenatal care for low-income immigrant women. Prenatal care is among the most cost-effective ways to improve the health of the D.C. population, especially since many of these children become eligible for Medicaid at birth.

■ **Plan to expand benefits for dual eligibles.** Medicaid has requested federal approval to simplify eligibility standards for people dually eligible for Medicaid and Medicare. Currently, some Medicare beneficiaries can obtain full Medicaid benefits if their incomes are under 100% of the FPL. For another group of Medicare beneficiaries, Medicaid will pay their Medicare Part B premiums if their income is between 100% and 120% of the FPL, though they do not receive full Medicaid benefits. The plan is to increase both thresholds to 150% of the FPL, benefiting about 150 people at a total cost of about \$200,000 a year.

Medicaid Spending by Fiscal Year Ending Sept. 30

	FY 2004 Actual	FY 2005 Preliminary	FY 2006 Budgeted
Spending for Care	\$1,221,035,000	\$1,262,424,000	\$1,337,198,000
Average Enrollees per Month	139,021	141,941	144,922
Average Spending per Enrollee per Month	\$732	\$741	\$769

Note: The FY 2006 enrollee count assumes the same growth rate as was seen between FY 2004 and FY 2005. It is not an official MAA projection.

MEDICAID SPENDING AND SERVICES

■ **Spending trends.** Medicaid spending for care was \$1.26 billion (preliminary data) in FY 2005, making Medicaid the largest item in the D.C. budget.⁵ The increase over FY 2004 was 3.4%, reflecting a 2.1% increase in average monthly enrollment and a 1.3% increase in spending per enrollee per month. The 1.3% figure compares very well with the nationwide 9.2% increase in the average cost of an employment-based health plan.⁶

■ **A foundation of managed care.** Of total average enrollment of almost 142,000 people, about 94,000 are enrolled in managed care in a typical month. These beneficiaries are typically children and working age adults without disabilities. About one-quarter of the Medicaid budget is spent purchasing care for this group.

■ **Care for the elderly and people with disabilities.** The 48,000 beneficiaries not enrolled in managed care plans are typically elderly and/or disabled, with heavy health care needs. About 45% of the budget is spent on their physician visits, hospital care, prescription drugs and other acute care services. In addition, they are more likely to need long-term care, which accounts for about 29% of the budget.

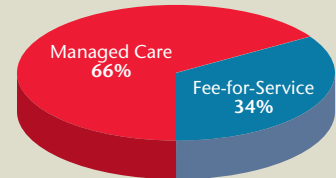
■ **The most important payer for long-term care.** Medicaid is by far the largest payer for long-term care, which includes nursing facility care, home health care, personal care attendants and other home and community-based services. Private-sector plans rarely cover these services, while Medicare's long-term care benefits are much more limited than those of Medicaid.

■ **A big help to poor and ill Medicare beneficiaries.** About 16,000 D.C. residents are eligible for both Medicare and Medicaid. Medicaid is the major payer for their long-term care and prescription drug needs and also pays much of their Medicare cost-sharing obligations. About 2% of the budget is spent on Medicare premiums and cost-sharing amounts on "crossover" claims.

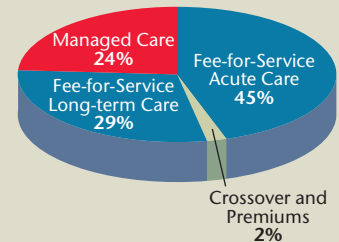
■ **Spending outlook.** Medicaid spending in FY 2006 is budgeted at \$1.34 billion, a 5.9% increase from FY 2005.

■ **Continued budget pressure.** Over the longer term, federal actuaries predict that Medicaid spending nationwide will outpace growth in national health spending. One factor—expected to account for about one-fifth of Medicaid spending growth—is the double-digit growth in home and community-based services, which allow elderly people and those with disabilities to remain at home instead of living in institutions.⁷

**Medicaid Enrollment FY 2005
141,941 Monthly Average**



**Medicaid Spending FY 2005
\$1.26 Billion (Preliminary)**



Managing Care for Health and Cost Control

Two-thirds of D.C. Medicaid beneficiaries receive health care from one of four managed care plans. Medicaid is taking strong steps to ensure the quality of care for plan beneficiaries.

■ **Medicaid managed care.** In 1994 the District began a major effort to promote managed care. In 1997, the District moved to mandatory enrollment for certain eligibility groups. Today, two-thirds of Medicaid enrollees belong to one of four managed care plans: AMERIGROUP, D.C. Chartered Health Plan, Health Right, and Health Services for Children with Special Needs (HSCSN).

■ **Managed care organizations.** AMERIGROUP, D.C. Chartered Health Plan and Health Right are managed care organizations (MCOs) that accept clinical and financial responsibility for almost all Medicaid services provided to their members, who are typically children and their non-disabled family members in the 21-64 age group.

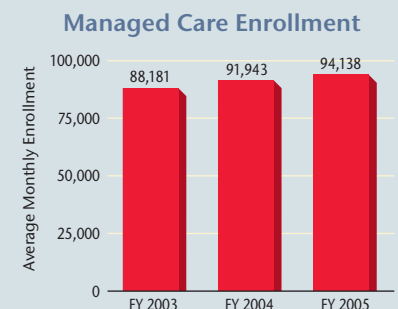
■ **Special plan.** HSCSN manages care for children with disabilities. Medicaid beneficiaries enroll voluntarily in HSCSN; enrollment averaged 3,375 children a month in FY 2005. HSCSN is not at financial risk for the care its members receive. The plan is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

■ **Improving coordination of substance abuse care.** Outpatient care for substance abuse is one of the few services that the MCOs do not provide. Instead, this care is 100% funded by the D.C. government. In FY 2005, MAA requested federal approval to make outpatient care for substance abuse a Medicaid service, which would bring \$3.0 million a year in new federal funding to the District. In addition to improved integration with other care received by MCO members, the change is expected to increase access to services, including residential substance abuse treatment for pregnant women.

■ **Expansion of MCO membership.** Several years ago, the District began enrolling childless adults 50 to 64 years old in Medicaid, so long as their incomes were below 50% of the federal poverty line. (This required a waiver of federal eligibility rules.) In FY 2005, this group of 1,362 people became MCO members. These beneficiaries will benefit from improved coordination of care.

■ **MCO quality to be evaluated using 41 measures.** In FY 2005, D.C. began requiring MCOs to collect and report standardized quality measures, such as child immunization rates, breast cancer screening rates and customer satisfaction scores. "This is a huge step towards expanding our quality improvement efforts by measuring performance on a richer set of standards," said Dr. Gregg Pane, Director of the Department of Health, in announcing the initiative. The measures are from the nationally recognized Health Plan Employer Data and Information Set (HEDIS), thereby enabling Medicaid and the MCOs to track quality of care over time and in comparison with national benchmarks.

■ **NCQA accreditation.** In FY 2006, Medicaid will require all MCOs to seek accreditation by the National Committee for Quality Assurance (NCQA). The NCQA, a national, not-for-profit organization, is often described as the watchdog of managed care. Teams of NCQA experts will visit each MCO to evaluate it on patient safety, service, confidentiality and other quality standards.⁸



Carole Colbert and Family

“I thank God for Medicaid,” says Carole Colbert, whose six children have all benefited from Medicaid coverage. Today, Ms. Colbert is raising her daughters Jewel, 2, and Aniya, 5, her son, Randy, 7, and her grandson Demetrius, 11.

Growing up was not easy for Ms. Colbert and her two siblings, who were raised by a single mother addicted to alcohol. As Ms. Colbert explains, “Mom didn’t teach us about the ‘birds and the bees,’ so when I was coming up, I was always the one in trouble.”

Pregnant at the tender age of 14, Ms. Colbert’s children are as old as 27 and as young as 2. As Ms. Colbert explains, “Medicaid was always there to help.”

Reflecting on an early experience with her oldest daughter, Ora, now 22 years old, Ms. Colbert recalls: “One day, Ora was just walking on the grass, and she twisted her leg on a piece of metal that was stuck in the grass.” Ora had to be rushed to the hospital for knee surgery. “If it wasn’t for Medicaid,” she says, “I’d still be paying for it today.”

She also recalls a brief instance when she and her children experienced an interruption in coverage when she had to get recertified by Medicaid. During the recertification process, one of her kids needed medical attention. “After I spoke to the representative and explained my family situation,” says Ms. Colbert, “Medicaid got me back on the program quickly. Medicaid is always on time.”

Ms. Colbert also remembers what Medicaid was like before the District began working with managed care organizations to provide better access to quality health care. Ms. Colbert’s family is enrolled in D.C. Chartered Health Plan and she sees the benefits for herself and her children today. “Before Chartered,” she explains, “my children and I would miss doctors’ appointments because I couldn’t afford to get to the doctor, or I was too sick to get there. Once Chartered came along, they provided transportation for me and my kids so that I can take them to get their shots. Just think, if my kids didn’t get shots, they would not be in school,” Ms. Colbert says.

As a stay-at-home single parent with young children, Ms. Colbert needs to maintain her health. Medicaid has covered two surgical procedures for Ms. Colbert, including emergency surgery for a hernia. More recently, though, Ms. Colbert’s primary care physician referred her to a specialist to manage other health problems. “When I think about the surgery I’ve needed and that I need to see a specialist, I would have been pulling my hair out to pay for this because no one is going to take me without Medicaid.” Ms. Colbert concludes: “Just imagine if I didn’t have Medicaid.”



Carole Colbert with daughters Jewel and Aniya, son Randy, and grandson Demetrius.

“Just think, if my kids didn’t get shots, they would not be in school.”

Here for Health

When Congress enacted Medicaid 40 years ago, the program looked more like a welfare program than a health program. Today, Medicaid provides insurance for over 41 million Americans, giving it a central place in the health care system. D.C. Medicaid sees its role as improving the health of District residents, often in collaboration with other agencies. In this section we describe a dozen such initiatives.

■ **Medicaid beneficiaries gain from Medicare disease management program.** In FY 2005, D.C. was selected to participate in Medicare Health Support, a demonstration program designed to improve health outcomes and reduce costs for people with multiple chronic diseases. About 1,600 D.C. residents dually eligible for Medicare and Medicaid can choose to participate in Medicare Health Support, which was previously called the Chronic Care Improvement Program. Participation is free. In D.C., the program is managed by American Healthways, a national disease management company selected by Medicare. Depending on their needs, participants may receive nurse counseling, home monitoring equipment, home visits and intensive case management. MAA's role in the demonstration is to help with outreach to beneficiaries and providers and to assist with data analysis.

■ **Standardized child health screening form will improve care.** In FY 2005, Medicaid piloted a standardized form for HealthCheck, the District's program to make sure every child gets early screening and treatment for health problems. (HealthCheck is the D.C. version of the national Medicaid program called EPSDT.) Medicaid collaborated with physicians and managed care plans to develop a new standardized medical record form for HealthCheck. The form, which is completed by the primary care provider, is designed to capture all aspects of a well-child visit, including the need for additional services such as dental or specialty care. The form will be fully implemented early in FY 2006. The District will become the only Medicaid program to have a centralized child health registry accessible to providers and managed care plans. The registry will enable MAA to make sure HealthCheck services take place. As well, authorized providers will be able to view a child's history of immunizations and preventive health care visits. This picture of a child's health status will enhance MAA's ability to perform quality of care analysis with providers. MAA also plans to incorporate lead-poisoning data in the registry in the near future.

Innovative Programs Help Keep HIV-Positive People Healthy

On January 14, 2005, D.C. became the nation's first Medicaid program to cover critical yet costly anti-retroviral drugs for HIV-positive patients with incomes below 100 percent of the federal poverty line (FPL). The result: 267 people get needed coverage and preventive services before they become disabled. Another program provides some HIV-positive people with high-quality home water filters, which screen out bacteria that can be fatal to immune-compromised patients. Both initiatives required waivers of federal Medicaid rules.

A third program, called "HIV Ticket to Work Independence," allows an average of 420 HIV-positive people a month to keep their Medicaid coverage even if employment raises their incomes up to 300% of the FPL. Ticket to Work, which is 95% funded by the federal government, started in April 2005.

These programs help HIV-positive people stay healthy and remain in the workforce as long as possible, thereby contributing to the District's economic development.

■ **Drug utilization review (DUR) board works for appropriate medication use.** The DUR board, comprising D.C. physicians and pharmacists, works to improve quality of care, which is especially an issue for beneficiaries with complex conditions who may receive several drugs prescribed by different physicians. Since Medicaid claim files provide an overview that no individual physician has, the board draws on these records to create and review 400 patient profiles a month. The focus is on potential issues related to drug-drug interactions, drug-disease interactions, and over- and under-utilization of medications. If a potential issue is deemed significant then the prescribing physician is alerted. The board also undertakes four educational campaigns a year targeted at physicians. In FY 2005, these campaigns focused on resistance to antibiotics, coronary artery disease, diabetes and congestive heart failure.

■ **Interagency collaboration to improve health of D.C. residents.** Better delivery of health care services sometimes requires better coordination of services. That was the conclusion of MAA and several other D.C. agencies that signed a July 2005 Memorandum of Understanding. Parties to the memorandum included the Department of Health, Department of Mental Health, Department of Child and Family Services, Department of Youth Rehabilitation Services, Maternal and Child Health Administration, Addiction Prevention and Recovery Administration, and the D.C. Public Schools. The intended results are increased efficiency, increased interagency data sharing, and better coordination of services.

■ **D.C. exceeds child immunization goal.** In June 2005, D.C. was recognized as one of two Medicaid programs nationwide that exceeded its child immunization goal under the federal Government Performance and Results Act of 1993. Working in collaboration with managed care plans, Medicaid providers, community-based organizations, and the Office of Immunization's Vaccines for Children Program, MAA increased the Medicaid immunization rate from 63% in October 2000 to 73% in October 2004, exceeding the original goal of 72% for children under two years old. The D.C. Medicaid immunization rate for school-age children is 95%.

■ **Focusing on childhood obesity.** Recognizing the increasing need to prevent obesity from an early age, participating managed care plans conducted a study to establish baseline data on obese and overweight children and youth. As a result of the study, MAA developed guidelines for the identification of care for obese/overweight children, adopted mandatory screening of two-year-olds to assess obesity/overweight symptoms based on height, weight and body mass index, developed an appropriate model for treatment, and trained managed care practitioners on the treatment model in June 2005. To ensure continued refinement of these efforts, MAA established the Obesity Prevention Advisory Committee, comprising D.C. agencies, the public schools, and community stakeholders.

Impact of the New Medicare Drug Benefit on Medicaid Beneficiaries

On January 1, 2006, about 77,000 Medicare beneficiaries in D.C. will become eligible for Medicare's new Part D prescription drug benefit. For residents who are dually eligible for Medicare and Medicaid, Medicare will start paying for the prescription drugs that Medicaid has paid for in the past. About 16,000 dually eligible beneficiaries will be affected.

Our top priority is that Medicaid beneficiaries have no interruptions in the supply of essential medications. MAA is partnering with an extensive network of providers, pharmacists and advocacy groups to assist beneficiaries in making the transition. We are participating in educational forums for health care professionals, advocates and the public about this new and important benefit. We are also sharing information with beneficiaries through direct mail updates.

The new Medicare Part D benefit applies only to prescription drugs provided through pharmacies. Drugs provided to Medicaid beneficiaries in hospitals, physician offices, dialysis clinics and other settings are unaffected.

Beneficiaries and providers with questions about the new Medicare benefit can find information at www.cms.hhs.gov, www.medicare.gov and 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

**Hello. I Speak Amharic
I don't speak English well. I need a professional
interpreter.**

**ጤና ይስጥልኝ። አማርኛ ነው የምናገረው።
እንግሊዝኛ በደንብ አልናገርም። አስተርጓሚ
ያስፈልገኛል።**

ይህንን ካርድ ለጸሐፊዎ ያሳዩ።

Wallet cards like this one will be available in Amharic, Chinese, Korean, Spanish, and Vietnamese.

■ **Reaching out to non-English speaking communities.**

Overcoming language barriers and improving communication is critical to increasing access to health care for the District's diverse population. Medicaid collaborated with community groups to develop a culturally sensitive brochure about beneficiaries' rights to interpreter services for health care. The brochure was field-tested to ensure wide acceptance among non-English speakers. In FY 2006, the brochure will be made available in Amharic, Chinese, Korean, Spanish, and Vietnamese, which, other than English, are the most prevalent languages spoken in the D.C. schools. In the past, no similar information had been provided to non-English speakers.

■ **Getting kids to the dentist.** Access to dental care for low-income children is a problem across the U.S., with fewer than 20% of Medicaid children having an

annual dental visit.⁹ Using a combination of focus groups, health fair participation, and increased outreach efforts in partnership with managed care plans, D.C. Medicaid boosted its rate from 20% in FY 2003 to 32% in FY 2004. (The FY 2005 rate is not yet available.) To maintain the momentum, MAA implemented a dental helpline in FY 2005 to help beneficiaries locate providers and intends to improve access by increasing fees paid to dentists in FY 2006.

■ **Preventing deaths from the flu.** The District of Columbia reported only one flu-related death in FY 2005, thanks in part to Medicaid's successful efforts to make flu shots available using the house call system despite limited supplies. Not one Medicaid beneficiary died of flu-related causes.

■ **Ensuring the confidentiality of beneficiaries' health information.** MAA was one of 10 District agencies involved in a citywide effort to upgrade policies, procedures and business processes to improve the security of beneficiaries' confidential health information. In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), all MAA staff members now receive training in how to properly handle protected health information. In FY 2006 and FY 2007, MAA and other agencies will be working to implement additional HIPAA regulations designed to protect confidential health information.

Vincent Massey

Vincent Massey, then 35 years old, was washing his car when he was shot once in the leg and twice in the lungs. One bullet ricocheted inside his chest and lodged in his spine, where it remains today, seven years later. At that instant, his lower abdomen and legs became paralyzed. The drive-by gunman was never identified.

At D.C. General Hospital, a staff member had Mr. Massey fill out the forms that would qualify him for federal Supplemental Security Income and D.C. Medicaid benefits. He was transferred to the National Rehabilitation Hospital on Irving St. NW, which treated both the physical and mental after-effects. “When you get a jolt like that—losing your legs—you go through a depressive period,” he says now. A hospital psychiatrist helped him get through it. Rehabilitation “built my morale up.”

At first, he used an ordinary wheelchair. It made a big difference when a doctor said he needed a motorized chair. “It allowed me to just be normal. I don’t have to stay in the house,” he says. Rather than “watching TV, my mind going nowhere,” Mr. Massey gets out every day, riding the Metro, going to appointments and visiting friends and family. He goes out so much that his wheelchair needs regular repairs. He also benefits from a stander, a device that helps him stand up, exercise his muscles, and avoid serious problems such as pressure sores.

With therapy, he has regained some use of his lower abdomen and legs. Before, he couldn’t move so much as a toe and he needed incontinence garments. Now, he can lift his feet off the footrests, reposition himself from the chair to a bed, and take himself to the bathroom. “I can move—things I couldn’t do before,” he says.

Last year the rehabilitation hospital asked Mr. Massey to participate in a study on investigational drugs to decrease involuntary muscle tightness. He undergoes four hours of tests each week. “I’m giving back for what’s been given to me,” he says.

“I’ll put it this way... It (Medicaid) takes a broken person and makes him feel whole.”

someone less fortunate,” he says. “That’s my goal.” For now, he tells people how lucky he is. “I like to talk to people, to tell people how good God has been to me. Every day I feel grateful.”

Except for the research study, which is paid for under a grant, Medicaid has paid for all of Mr. Massey’s care. “I’ll put it this way,” he says of Medicaid. “It takes a broken person and makes him feel whole.” Without Medicaid, “people like me wouldn’t have a chance.”



Vincent Massey with his doctor, Sandeep Simlote, at the National Rehabilitation Hospital.

From here, Mr. Massey’s goal is to move from his room in a group home into his own apartment, get a job, and continue improving his ability to move. “Hopefully, some day in the near future I’ll be able to donate this chair to

Helping People Who Need Long-Term Care

Medicaid is the leading funding source for long-term care across the U.S., covering services such as nursing facility care for the elderly, residential care for people with developmental disabilities, and home-based assistance with the activities of daily living. To the greatest extent possible, the goal is to tailor care to fit each person's medical, social and physical situations.

■ **Flexible, cost-effective programs allowed 815 people to live at home instead of in institutions.** D.C. Medicaid operates two programs that fund home and community-based services (HCBS) for people who otherwise would have to live in institutions. Since this care costs less than institutional care, the federal government has waived otherwise-applicable rules so that beneficiaries can receive services designed for their specific needs. The HCBS program may pay for assistance with daily activities like eating and dressing, wheelchair ramps, a supportive living environment such as a group home, or occasional institutional care to give family caregivers a respite.

In FY 2005, the HCBS program for elderly people and people with physical disabilities served an average of 408 beneficiaries a month, up from 197 in FY 2004. These beneficiaries otherwise would typically be living in a nursing facility. The HCBS program for people with mental retardation and developmental disabilities served an average of 407 beneficiaries per month, an increase from 397 in FY 2004. These beneficiaries otherwise would be living in an intermediate care facility.

■ **Robert Wood Johnson grant will evaluate innovative D.C. program.** The prestigious Robert Wood Johnson Foundation awarded a grant to compare the Medical House Call Program (MHCP) with other ways of serving recipients of home and community-based services. The Medical House Call Program coordinates all home, hospital and community-based care through home visits to beneficiaries with chronic illnesses and limited mobility. (One participant is Mimi D. Atkins; see page 15.) The goal is to avoid unnecessary emergency room visits, hospitalizations, and nursing home placements. Results from the evaluation will help improve the program and potentially expand it. The evaluation grant will be managed by MAA and administered through a partnership that includes the Washington Hospital Center MHCP, Unity Health Care (a new house call program based on the Washington Hospital Center model), and the Delmarva Foundation, the quality improvement organization for D.C. Medicaid.

■ **New nursing facility payment method designed to boost access.** A new way of paying nursing facilities is intended to improve access to care and keep D.C. residents closer to home. Contingent upon federal approval, nursing facilities will be paid more for patients with greater care needs and less for patients with fewer care needs. Patient care needs will be measured using Resource Utilization Groups (RUGs), a clinical algorithm also used by Medicare and several other Medicaid programs. MAA's previous payment method was based on each facility's costs per day of patient care. These cost-based rates were capped and they didn't vary by patient, so patients with more expensive needs often had to be placed in facilities outside the District to get the care they needed.

■ **Consumer-directed care in home and community-based services.** A new initiative will give about 100 beneficiaries more flexibility in the home and community-based services they receive. Called "consumer-directed care," the initiative will give beneficiaries flexibility within a defined budget to decide which services they need to live as independently as possible. They will also have more involvement in selecting their personal care attendants and other caregivers. In FY 2006, consumer-directed care will become available to beneficiaries in the HCBS program for elderly people and people with physical disabilities.

■ **Improved access to services under the MR/DD waiver.** To improve access to home and community-based services for beneficiaries with mental retardation and developmental disabilities, MAA changed the rules to allow individual occupational therapists and speech/language pathologists to provide services. Previously, therapists had to be employees of an agency, which reduced the availability of providers.

Mimi D. Atkins

At first, Mimi D. Atkins didn't pay much attention to occasional back pain. It was the 1970s, and she was working at St. Elizabeth's Hospital as a nursing assistant, taking care of people with mental illness. But the pain got worse, and then her doctor said she had rheumatoid arthritis. It was a bad case. By 1979, she had to quit after 10 years at St. E's. As the illness progressed through the 1980s, she had both knees replaced, and she relied more and more on a wheelchair. By about 1990, the inflammation, deformity and pain in her joints meant she was bedridden.

Since the 1970s, BlueCross BlueShield insurance has continued to pay for her physician care, drugs, and occasional hospitalizations. But BlueCross, like virtually all commercial insurance plans, doesn't cover the costs of long-term care. Ms. Atkins's mother was her primary caregiver, turning her in bed, preparing her meals, bathing her and keeping her company.

In 2001, Ms. Atkins was hospitalized with blood clots, which typically form in leg veins and can be fatal if they break away and travel to the lungs. Hospital staff "talked to me about going to a nursing home until I got better. I said I didn't want to do it."

It was obvious that Ms. Atkins's mother, herself approaching 80, couldn't continue to care for her. Medicaid would pay for nursing facility care after Ms. Atkins exhausted her life savings, which, because of the cost of nursing facility care, usually doesn't take long. Instead, a doctor suggested Medicaid's program of home and community-based services (HCBS), which is designed to allow patients like her to stay at home as long as possible. Ms. Atkins applied for Medicaid and was accepted, but she wasn't yet old enough to qualify for the HCBS program. She was on a waiting list for over a year.

Today Ms. Atkins, now 60, and her mother still share one of D.C.'s classic brick row houses. Ms. Atkins's electrically controlled bed is in the former dining room. Family photos are on the living room mantle, and her mother sits on the porch to greet visitors and neighbors. Medicaid pays for a personal care aide 16 hours a day. The aide fixes her meals, bathes her, and turns her every two hours.

"I read, I have friends that call me every day, I have television of course, I talk to my aides and they talk to me, which is a godsend," she says. "I do a lot of things." Her lap is her desk, where she reads her mail and pays her bills. At night, she can press an alarm button to summon help or an ambulance if needed. She says she's doing well. "Life is what you make of it. I choose to be happy, the way I am right now."

Ms. Atkins also participates in an innovative program funded by Medicaid. Called the Medical House Call Program, its goal is to prevent unnecessary emergency room visits, hospitalizations and nursing facility placements. When a person can't walk, pressure sores, infections, blood clots and depression are constant threats to life, health and the ability to stay at home. Individual circumstances—how their home is arranged, how well they're eating, their activities— affect their physical and mental health. Under the Medical House Call Program, a nurse practitioner and a social worker, both specially trained, visit Ms. Atkins each month. A physician visits at least quarterly. They take 45 to 60 minutes to check her head to toe. Thankfully, and amazingly, she has had no problems with pressure sores. They also monitor her congestive heart failure, a serious illness that has been very well controlled.

"I wouldn't be able to stay at home if it wasn't for Medicaid," Ms. Atkins says. "They really help a lot, and I'm grateful for that. It's a blessing, really."



"I wouldn't be able to stay at home if it wasn't for Medicaid."

The D.C. Resource Center

Navigating the Maze of Long-Term Care Options



Resource center supervisor Angelique Calhoun assigns care managers to do individualized assessments of what's best for each individual.

When you can no longer live at home on your own, the options are baffling. Home health care, assisted living, nursing facility? Pay as you go, Medicare, Medicaid, private insurance? What's the difference? What's best for your situation?

Now, there's a one-stop answer. In January 2005, the D.C. Resource Center for Aging and Persons with Disabilities opened at 2311 Martin Luther King Avenue, near the Anacostia Metro stop. The public can drop in to the pleasant renovated home, call the center at 202-204-3540, or email inquiries to acalhoun@dcresourcecenter.com. A website is planned for the coming year.

About 100 people ask for help each month, and that number will grow as the word spreads. Sometimes the resident makes an inquiry; sometimes it is a family member or friend. They might learn about the resource center from its booth at a health fair or have been referred by a seniors' group or a health care provider. For some residents, life has changed suddenly because of a stroke or a fall; for others, they're just finding it harder and harder to live at home on their own.

A receptionist asks for basic information, then a professional staff member calls back within four hours. When appropriate, one of the center's three care managers will visit the home for a complete assessment, at no charge. "What medical conditions do you have? Can you walk on your own? Are loose rugs a hazard? Does a neighbor check in?" are typical questions.

Though placement in a nursing facility may be the best option for the resident, it's often possible for people to continue living in the community so long as they get a bit of help. Options include personal care attendants, skilled nursing care at home, modifications such as wheelchair ramps, or moving to an assisted living facility. Many of these services are covered by Medicaid's home and community-based services (HCBS) program.

To cut red tape, an eligibility worker from the D.C. Income Maintenance Administration is on site at the resource center. A resident can apply right there for Medicaid and the HCBS program. The eligibility worker even helps people apply for other D.C. programs such as food stamps and cash assistance for people with disabilities or families with children. When residents aren't eligible for Medicaid, care managers can advise them on other options such as Social Security, Medicare, subsidized housing and grant programs. At all times, the goal is to help residents navigate the maze of programs that might help them live as independently and as happily as possible.

Partnerships with Providers

In a typical month, 4,300 providers provide services to Medicaid beneficiaries—everything from a wheelchair van for a doctor’s appointment to heart surgery at one of D.C.’s top hospitals. MAA and its contractors work to do a good job serving the providers who serve our beneficiaries.

■ **Managed care and fee-for-service.** For about 94,000 beneficiaries, Medicaid pays managed care plans, and then the plans pay physicians, hospitals, pharmacies and other providers. The other 48,000 beneficiaries are in “fee for service,” where Medicaid is responsible for enrolling providers, setting payment rates, and processing claims.

■ **Rising participation rates.** A key measure of beneficiary access to care is the number of providers that serve Medicaid fee-for-service beneficiaries in a typical month. The table shows the provider types for which the participation rate is a good measure of access. (This rate is not as useful for hospitals, nursing facilities and other large providers that almost always serve some Medicaid beneficiaries each month.) MAA is pleased to report that participation rates have been rising for almost all provider types in the table.

■ **Increased electronic billing.** In FY 2005, MAA processed 7.0 million claims. The proportion of claims submitted electronically rose to 89% in FY 2005 from 77% the year before. The District’s claims processing contractor turns around electronic claims within two days of receipt. Paper claims are keyed within an average of four days of receipt (a 19% improvement over FY 2004) and processed within two days after that. Providers are paid twice a month, in contrast to other Medicaid programs in this region that pay monthly. About 75% of payments are made by electronic funds transfer (EFT), up from 62% in FY 2004. EFT is significantly less costly for Medicaid than cutting paper checks.

■ **Increased communication with providers.** In FY 2005, MAA’s claims processing contractor, ACS Government Healthcare Solutions, handled 84,899 phone calls from providers with an average answer time under 30 seconds. In addition, MAA and ACS increased their provider education efforts, which include quarterly newsletters, brochures on reducing billing errors and other topics, and over 300 face-to-face meetings with providers, in either individual or group sessions.

Monthly Averages of Participating Providers

	FY 2003	FY 2004	FY 2005
Physicians	1,693	1,742	1,768
Pharmacies	181	181	191
Nurse practitioners	26	34	44
Dentists	19	20	23
Medical equipment & supplies	51	53	62
Transportation (excluding amb.)	146	152	182
Lab & X-ray providers	439	400	380

Note: “Participating” providers have billed Medicaid at least once during a one-month period.

Medicaid’s Economic Impact on the District of Columbia

Though Medicaid exists to improve the health of District residents, it’s also important to the health of the D.C. economy.

- First and foremost, providing health care to one-quarter of the D.C. population is essential to maintaining a healthy, productive D.C. workforce.
- 92% of the \$1.22 billion that Medicaid spent on health care in FY 2004 was paid to D.C. providers. Of the remainder, 6% went to Maryland, 1% to Virginia and 0.5% to other states.
- Medicaid is the single largest source of federal funding to the D.C. government, bringing in about \$900 million a year. Medicaid is cost-shared 30/70 between the two levels of government, so every D.C. Medicaid dollar is matched by \$2.33 from the federal government.

Spending Dollars Wisely

Medicaid is the single largest spender in the D.C. government, with annual expenditures exceeding those of the K-12 public schools. Like all prudent purchasers, Medicaid seeks value for money—in this case, maximum health for the health care dollar. As a \$1.26 billion program, Medicaid also inevitably attracts some providers intent on defrauding or abusing the program. This section describes initiatives related to value purchasing and program integrity.

■ **Fraud, waste and abuse recoveries rise 74%.** In FY 2005 MAA recovered \$15.0 million as a result of efforts to protect against waste, fraud and abuse. Recoveries increased 74% over FY 2004. The surveillance and utilization unit and the investigations and compliance unit investigate possible overpayments to providers. These can reflect unintentional billing errors or conscious efforts to abuse or defraud the program. In FY 2005, for example, a physician, a dentist and a transportation provider were convicted of fraud. Five other cases are pending.

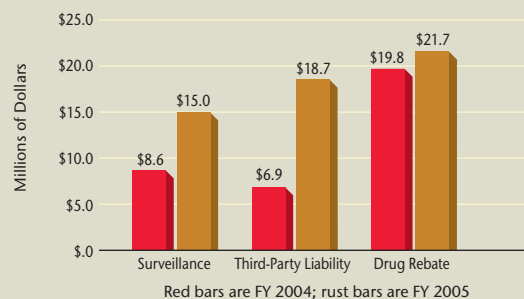
■ **Third-party liability recoveries.** TPL recoveries were \$18.7 million in FY 2005, more than double the previous year. Medicaid is the insurer of last resort, and the TPL unit recovers funds from other parties when they are liable for payments originally made by Medicaid. Third-party liability may exist when a beneficiary also has coverage from a commercial insurer, when a court holds a negligent driver financially responsible for injuring a Medicaid beneficiary, or when a deceased beneficiary's estate can pay for some of the care funded by Medicaid. In FY 2005, the TPL unit increased its efforts to recover money from third parties that were liable for care provided by Medicaid managed care plans. This effort paid off with a big increase in recoveries.

■ **Focus on cost avoidance.** Although TPL and fraud protection efforts bring in easily quantifiable recovery dollars, it is better practice to avoid the expenditures in the first place. In FY 2005, Medicaid tightened computer edits on the 250 most expensive physician services and on durable medical equipment, prosthetics, orthotics and supplies. Similar "cost avoidance" efforts in the future may well result in less need to recover dollars after the fact.

■ **Medicaid enrollees identification initiative.** In FY 2005, MAA implemented a new cost avoidance strategy to identify more Medicaid-eligible residents that are currently receiving public assistance paid by the District instead of through federal matching funds in the Medicaid program. MAA began conducting data matches to identify Medicaid-eligible students enrolled in the District's public schools, eligible recipients being assisted by the Department of Mental Health, and other eligibility shown on provider records.

■ **\$21.7 million in revenue from drug rebates.** Drug rebate revenue rose 9.6% between FY 2004 and FY 2005. Rebates come from drug manufacturers under a federal law that requires that manufacturers always give Medicaid their best prices. To receive the rebates, Medicaid must meticulously track dosages on 1.2 million prescriptions a year and then defend the data to drug manufacturers. In a comparison of eight Medicaid programs, D.C. had the highest success ratio of rebates received to rebates invoiced.

Across-the-Board Increases in Recoveries



■ **Plan to hire transportation broker.** In FY 2006, Medicaid will improve the organization of non-emergency transportation services, such as the wheelchair vans that take beneficiaries to medical appointments. Instead of dealing individually with each transportation provider, we will contract with a transportation broker to coordinate requests for service, supervise the service provided by individual transportation providers, and monitor providers for fraud. About 3,700 beneficiaries a month currently use these services.

■ **Plan to improve drug purchasing.** In FY 2006, we will take two steps to control drug expenditures while maintaining access to cost-effective drugs. First, we will follow the successful efforts of other Medicaid programs in using Maximum Allowable Cost (MAC) pricing for certain generic drugs. MAC prices more closely reflect actual marketplace prices than do the widely published Average Wholesale Prices or Federal Upper Limit prices. Second, we will implement a Preferred Drug List, which will increase competition among drug manufacturers for Medicaid's business.

■ **Plan to assess payment levels for health care.** In FY 2006, Medicaid will undertake a review of its payment levels for a wide range of services. Changes to payment levels are possible if such changes would make Medicaid a more effective purchaser of care.

■ **Payment Error Rate Measurement (PERM).** The District was awarded a federal grant to pilot test the PERM process that will be implemented nationwide in FY 2006. The pilot, which began in October 2004 and ended in September 2005, was designed to measure the accuracy of Medicaid payments using a sophisticated sampling methodology. It covered both the fee-for-service and managed care components and was designed to identify both payments that were too high and those that were too low. The pilot will yield important information to the District and will help the federal government develop final PERM regulations that are fair and accurate to Medicaid programs and providers.

■ **Partnerships with the private sector.** MAA uses a stringent competitive bidding process to hire experienced contractors to help it run the complex Medicaid program. In FY 2006, MAA expects to issue requests for proposals for four major contracts: the fiscal agent, which processes claims through the Medicaid Management Information System (MMIS); the pharmacy benefit manager, which administers the pharmacy claims payment system; the transportation broker described earlier in this section; and a decision support system (DSS). The DSS will be a new contract that will give Medicaid policy managers greatly increased access to the data necessary to manage the program.

How One Fraud Scheme Was Stopped

One individual probably thought he could make some easy money presenting fabricated prescriptions to pharmacies. He posed as a "runner" for a personal care home and said the prescriptions were for Medicaid beneficiaries. At one pharmacy, for example, he submitted 1,695 prescriptions in just three months. He used the name of a real physician (who was not involved) but a fictitious physician identification number. He was arrested for narcotics violations, pled guilty to a \$1.4 million fraud scheme and was jailed.

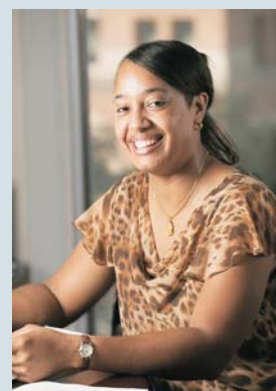
And there the matter would have ended, except that federal and District investigators turned to the pharmacies that filled the fraudulent prescriptions. On July 28, the government announced that Chronimed Inc. had agreed to pay \$475,000 to settle allegations that it submitted false claims. Investigations of other pharmacies are under way.¹⁰

Working for Medicaid Beneficiaries

A total of 121 people work for the Medical Assistance Administration, the lead agency for administering the D.C. Medicaid program. In this section we describe some of the work they do.

■ **Suprenia Robinson**, a program analyst in the Program Operations area, has worked with the Medicaid program for 15 years, first as a staff member for the claims processing contractor and then, since 2001, for MAA. “One of the reasons I’ve stayed with Medicaid so long,” explains Suprenia, “is because I can help people. It’s rewarding to know that during the course of my day, I’ve been able to help someone.”

On average, Suprenia fields 60 to 80 calls each day from providers or social workers seeking authorizations for non-emergency transportation for disabled Medicaid beneficiaries. She also trains providers on how to submit claims accurately, resolves billing discrepancies, and processes provider appeals.



■ **Jeff Anderson** is a former U.S. Navy Search and Rescue aircrewman who joined MAA earlier this year as a public health analyst. “I wanted to continue to work in an environment where I could help people,” says Jeff. “I certainly enjoy working with people who want help, but it makes me feel better working with those who need help.”

Jeff largely focuses on implementing the District’s home and community-based services (HCBS) program in support of the Real Choice Systems Change (RCSC) grant that MAA received from the federal government in September 2002. Jeff coordinates consensus-building meetings and works with a diverse group of stakeholders, including representatives of MAA’s Office on Disabilities and Aging, the RCSC advisory committee, various subcommittees, beneficiaries, and providers to determine how best to serve the community.

■ **Elisa Fauntleroy** joined the Office of Managed Care as a program analyst and is one of seven staff members who works to ensure that the 93,000 Medicaid managed care beneficiaries have access to quality health care. Part of her job is to monitor MAA’s contract with the District’s four managed care plans.

Elisa also serves as the “go to” person when eligibility questions arise for managed care beneficiaries. She serves as a liaison with the D.C. Income Maintenance Administration (IMA), which determines Medicaid eligibility, and with the contractor that coordinates managed care enrollment. “When people have questions, I’m the person they can always reach,” Elisa explains. “Nine times out of 9½ times, I can get it done. Resolving most recipient eligibility issues usually means a quick call to IMA, and we’re able to resolve the issue usually within 24 hours. All you have to do is get on the phone and talk to the right person.”



■ **Gwendolyn Bell**, a physician assistant, plays a key role in spearheading MAA’s quality management and in managing the prior authorization review process. Daily, Gwen fields more than 60 calls from providers requesting authorization for unusual, expensive or medically complex services. She monitors the integrity of the medical records review process and helps to develop state plan amendments, among her many efforts to promote better quality and access to health care. After Hurricane Katrina, Gwen was one of several MAA employees who provided care to evacuees housed at the D.C. Armory. She cancelled her vacation days to do it.



While the pace of Gwen’s job is fast, ultimately it’s the satisfaction of helping someone that makes it worthwhile. As she explains, “They’re so appreciative once you’ve helped them resolve the issue, and that makes all the difference. Hearing a ‘thank you’ for solving their problems is what keeps me going.”



■ **Diallo “Abe” Bennett** joined MAA in 2001 as chief of investigations to reduce fraud and protect the integrity of public funds administered by Medicaid. With 20 years as a detective in the New York Police Department, as the former chief of the fraud unit in the Georgia Medicaid program, and with a wealth of experience in security management at private firms, Abe came very well prepared.

“I love my job and I feel I can help people—people who are probably in the least fortunate position,” explains Abe. His unit’s main goal is to “pay the right amount to a legitimate provider for covered, reasonable, and necessary services provided to eligible recipients.”

Though Abe’s job involves knowing about criminals, it also requires him to understand the intricacies of health care coding and billing, since this is how fraud gets perpetrated. He also believes in the importance of prevention, educating providers on how to avoid errors.

In August 2005, the U.S. Attorney for D.C. commended Abe for his contribution to the successful resolution of a case that recovered \$475,000. (See page 19.) The federal Centers for Disease Control and Prevention has also asked Abe to help write a policy manual on combating fraud in the Vaccines for Children Program.

■ **Milka Shephard**, a program specialist, joined Medicaid 16 years ago, and now reports to the Medicaid director. Her job is to make sure that requests for information from beneficiaries, other D.C. agencies, the federal government, providers and community-based organizations are handled promptly through either the director or one of his staff. As Milka puts it, “I want things done to the best of my abilities in a timely manner.”

Milka often uses her bilingual skills to field inquiries from Spanish-speaking beneficiaries. “While we can refer non-English speaking beneficiaries to Language Line services for assistance when they call, if they speak Spanish, it’s easier for me to find out what they need and help them,” she says. “I always put myself in their shoes. What if it was me? I’ll do whatever it takes to help someone because I love what I do.”



Understanding Medicaid Finances

Medicaid is a highly complex program that funds a very wide range of health care services in accordance with numerous federal and District statutory, regulatory and policy provisions. In this section we explain the D.C. Medicaid budget and some of the factors that drive it.

MEDICAID SPENDING IN CONTEXT

In FY 2005, spending for care was \$1.26 billion (preliminary data), a 3.4% increase from FY 2004. The increase reflects a 2.1% increase in average monthly enrollment and a 1.3% increase in average monthly spending per enrollee. By contrast, the average cost of an employment-based family insurance plan rose 9.2% from 2004 to 2005, according to the September/October 2005 issue of *Health Affairs*.

The federal government pays 70% of the total and District taxpayers pay 30%.

The table on this page presents an overview of spending by responsibility center for FY 2004 through FY 2006, while the table on page 23 offers insight into detailed spending patterns in FY 2004. In a typical month, for example, there were 7,609 beneficiaries who received at least one physician service during the month. For these 7,609 recipients, Medicaid spent \$187 per person per month, on average.

In reviewing the detailed spending data, three points should be kept in mind. With very minor exceptions, all Medicaid spending for managed care enrollees is shown in the “insurance premiums” category. Second, care provided under waiver programs (for example, most personal care) is shown under the “waiver” category. Third, spending totals under other categories (especially physician and hospital) include spending both on beneficiaries for whom Medicaid is the primary payer, and on beneficiaries for whom Medicaid is the secondary payer behind Medicare.

The D.C. Medicaid Budget

Responsibility Center	Actual FY 2004	Preliminary FY 2005	Budgeted FY 2006
Disproportionate Share Hospital Payments (6020)	\$ 40,566,000	\$ 40,188,012	\$ 41,086,606
Day Treatment (6030)	27,291,000	26,530,713	27,326,634
Inpatient Hospital (6050)	249,270,000	272,787,923	280,971,561
Outpatient Hospital (6060)	25,007,000	19,276,729	20,047,798
Insurance Premiums (6070)	289,754,000	305,689,430	317,917,007
Nursing Facilities (6140, 6080)	182,048,000	176,977,991	186,769,173
Intermediate Care Facilities for the Mentally Retarded (6110)	77,317,000	78,405,445	81,613,033
Physician Services (6120)	17,053,000	18,389,101	19,124,665
Residential Treatment (6130)	13,089,000	14,033,602	14,594,946
Vendor Payments (6150)	162,754,000	169,731,140	183,512,970
Cost Settlement (6160)	11,300,000	22,977,417	22,977,417
St. Elizabeth's Hospital (6170)	34,559,000	25,956,923	42,381,548
D.C. Public Schools (6180)	19,636,000	19,375,879	22,258,552
D.C. Child & Family Services (6190)	48,736,000	41,960,556	38,322,831
Waivers	22,655,000	30,143,548	38,293,010
Subtotal Payments for Care	\$ 1,221,035,000	\$ 1,262,424,409	\$ 1,337,197,753
MAA Administration (6010)	30,704,000	36,737,155	38,904,904
TOTAL	\$ 1,251,739,000	\$ 1,299,161,564	\$ 1,376,102,657
Average Enrollees per Month	139,021	141,941	144,922
Average Spending per Enrollee per Month	\$ 732	\$ 741	\$ 769

Notes

1. The fiscal year runs from October 1 through September 30. Expenses are tallied on an accrual basis.

2. FY 2005 numbers are preliminary data as of September 2005.

3. FY 2006 enrollment figure assumes a continuation of the growth rate seen between FY 2004 and FY 2005. It is not an official MAA projection.

4. “MAA administration” excludes other costs of administering Medicaid, such as the cost of eligibility determination borne by the Income Maintenance Administration.

Behind the Numbers: Detail of Medicaid Spending, FY 2004

Responsibility Center	Actual FY 2004	Average Spending per Month	Average Recipients per Month	Average Spending per Recipient per Month
Disproportionate Share Hospital Payments (6020) <i>Supplementary payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients</i>	\$ 40,566,000	\$ 3,380,500	N/A	\$ N/A
Day Treatment (6030) <i>Day treatment programs for people with mental illness</i>	\$ 27,291,000	\$ 2,274,250	1,241	\$ 1,833
Inpatient Hospital (6050) <i>Payments to acute-care hospitals for inpatient care</i>	\$ 249,270,000	\$ 20,772,500	1,953	\$ 10,636
Outpatient Hospital (6060) <i>Payments to acute-care hospitals for outpatient care</i>	\$ 25,007,000	\$ 2,083,917	6,763	\$ 308
Insurance Premiums (6070) <i>Mostly payments to managed care organizations. Also includes some payments by Medicaid of Medicare premiums.</i>	\$ 289,754,000	\$ 24,146,167	100,718	\$ 240
Nursing Facilities (6140, 6080)	\$ 182,048,000	\$ 15,170,667	2,900	\$ 5,232
Intermediate Care Facilities for the Mentally Retarded (6110)	\$ 77,317,000	\$ 6,443,083	656	\$ 9,828
Physician Services (6120)	\$ 17,053,000	\$ 1,421,083	7,609	\$ 187
Residential Treatment (6130) <i>Non-hospital inpatient care for people with mental illness.</i>	\$ 13,089,000	\$ 1,090,750	124	\$ 8,779
Vendor Payments (6150)	\$ 162,754,000	\$ 13,562,833		
<i>Pharmacy (retail)</i>	101,071,000	8,422,622	19,058	442
<i>Home health care</i>	22,357,580	1,863,132	1,153	1,616
<i>Medical transportation (e.g., wheelchair vans)</i>	18,769,674	1,564,140	4,016	389
<i>Federally qualified health centers</i>	2,395,628	199,636	1,020	196
<i>Durable medical equipment</i>	9,680,493	806,708	2,469	327
<i>Personal care (assistance with activities of daily living)</i>	597,000	49,750	63	786
<i>Mental health clinics</i>	4,801,000	400,083	N/A	N/A
<i>Lab & x-ray (facilities separate from hospitals and clinics)</i>	3,853,000	321,083	3,967	81
<i>Private clinics</i>	10,223,341	851,945	855	996
<i>Hospice</i>	1,427,154	118,929	29	4,073
<i>Dental</i>	766,000	63,833	335	190
<i>Other vendor payments (e.g., optometrist, rehabilitation)</i>	6,591,664	549,305	N/A	N/A
<i>Drug rebates</i>	(19,780,000)	(1,648,333)	19,058	(86)
Cost Settlement (6160) <i>Net impact of retroactive payment adjustments due to cost report settlements for providers paid based on their costs.</i>	\$ 11,300,000	\$ 941,667	N/A	N/A
D.C. Mental Health & St. Elizabeth's Hospital	\$ 34,559,000	\$ 2,879,917	3,257	\$ 884
D.C. Public Schools (6180) <i>Payment to DCPS for health services provided to students enrolled in Medicaid, typically for students with disabilities.</i>	\$ 19,636,000	\$ 1,636,333	2,301	\$ 711
D.C. Child & Family Services (6190) <i>Payment to CFS for health services provided to clients enrolled in Medicaid, typically for managing care for people with disabilities.</i>	\$ 48,736,000	\$ 4,061,333	2,676	\$ 1,518
Waivers <i>Innovative programs operated under waivers from the federal government.</i>	\$ 22,655,000	\$ 1,887,917	1,473	\$ 1,282
TOTAL SPENDING FOR CARE	\$1,221,035,000			

MEDICAID ADMINISTRATION

The Medical Assistance Administration (MAA) is the lead agency for administering the Medicaid program. MAA spending on Medicaid administration in FY 2005 is projected to be \$36.7 million. This figure includes both the salaries of Medicaid staff and payments to contractors, such as those that process Medicaid claims, respond to provider inquiries and perform related functions. The number excludes the costs of other D.C. agencies that help administer Medicaid, such as the Income Maintenance Administration, which determines eligibility. Even when all administration costs are totaled, however, Medicaid is still much less expensive to administer than commercial insurance, where the cost of administration averages 13.6% of spending, according to CMS.¹¹

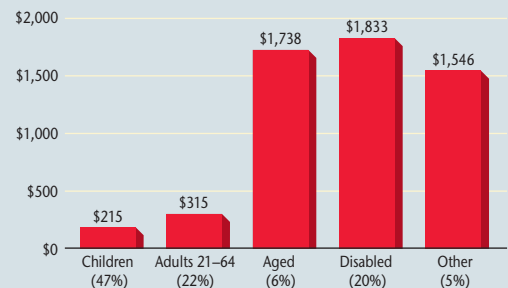
PATTERNS OF SPENDING

Medicaid spending is highly correlated with the type of eligibility a beneficiary has. On average, spending is relatively low for children and for non-disabled adults aged 21-64 (most often, the child's mother). Their health needs are similar to those of a commercially insured population, except with more emphasis on obstetrics and pediatrics. The 96,000 people in these two categories account for 69% of Medicaid enrollment but just 24% of Medicaid spending. They are primarily enrolled in Medicaid managed care plans.

On the other hand, spending is relatively high for people aged 65 or more and for people with disabilities. For some of these beneficiaries, Medicare covers their acute care costs, such as physician care and hospital stays. For dual eligibles, Medicaid usually pays their Medicare cost-sharing obligations (deductible, coinsurance, premiums) and these costs may be significant. And for some people in these groups, Medicaid is their only source of acute care coverage.

Most important, beneficiaries in these groups rely on Medicaid to cover the cost of long-term care, such as long stays in nursing facilities and home and community-based services that enable the beneficiary to avoid institutionalization. Overall, the aged, disabled and "other" categories (which mostly include people in waiver programs) represent 31% of Medicaid enrollment but 76% of Medicaid spending.

Spending per Month by Eligibility Category



For example, children represent 47% of total enrollment.

Notes

- 1 Jon Gabel, Gary Claxton, Isadora Gil and others, “Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode,” *Health Affairs* 24:5 (September/October 2005), pp. 1273-80.
- 2 Sara R. Collins, Karen Davis, Michelle M. Doty, and Alice Ho, *Wages, Health Benefits, and Workers’ Health*, Issue Brief No. 788 (New York: The Commonwealth Fund, October 2004).
- 3 Estimates were made by ACS Government Healthcare Solutions based on Medicare and Medicaid administrative data and the 2002–03 Current Population Survey as analyzed by the Kaiser Family Foundation. (See www.statehealthfacts.org.)
- 4 Kaiser Commission on Medicaid and the Uninsured, www.statehealthfacts.org. The figures are for 2002–03.
- 5 FY 2005 spending totals are projections as of September 2005. Spending is accounted for on accrual basis, so final numbers may differ from the projections shown here.
- 6 Jon Gabel, Gary Claxton, Isadora Gil and others, “Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode,” *Health Affairs* 24:5 (September/October 2005), pp. 1273-80.
- 7 Stephen Heffler, Sheila Smith, Sean Keehan and others, “U.S. Health Spending Projections for 2004–2014,” *Health Affairs*, Web Exclusives (February 23, 2005), p. W4-78; Stephen Heffler, Sheila Smith, Sean Keehan and others, “Health Spending Projections Through 2013,” *Health Affairs*, Web Exclusives (February 11, 2004), p. W5-85.
- 8 For further information on HEDIS measures and NCQA accreditation, see www.ncqa.org.
- 9 U.S. General Accounting Office, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149 (Washington, DC: GAO, 2000), p. 10.
- 10 U.S. Attorney for the District of Columbia, “United States Reaches \$475,000 Settlement with a National Pharmacy Corporation to Settle Allegations that False Claims Were Submitted to Medicaid for Illegally Diverted Prescription Medications,” news release, August 4, 2005.
- 11 Cynthia Smith, Cathy Cowan, Art Sensenig and others, “Health Spending Growth Slows in 2003,” *Health Affairs* 24:1 (January/February 2005), p. 192.

For More Information

Information Need	Resource	Contact Information
Am I eligible for Medicaid? What do I do if my Medicaid card expires?	D.C. Department of Human Services, Income Maintenance Administration	202-727-5355 www.dhs.dc.gov
I can no longer live at home by myself. What are my options?	D.C. Resource Center for Aging and Persons with Disabilities	202-204-3540 info@dcresourcecenter.com 2311 Martin Luther King Ave. SE Washington, D.C. 20020
I have a question about my Medicaid benefits.	Managed care: Call your health plan. Fee-for-service: D.C. Medical Assistance Administration	AMERIGROUP: 800-600-4441 D.C. Chartered Health Plan: 800-408-7511 Health Right: 877-284-0282 HSCSN: 866-937-4549 Fee-for-service: 202-442-5988
I have a complaint about my Medicaid managed care plan.	Managed care complaint hotline	800-788-0342
How do I change from one managed care plan to another?	Managed care enrollment broker	202-639-4030
I want to report possible waste, fraud or abuse in Medicaid.	D.C. Medicaid Fraud Hotline	877-632-2873
I'm a health care provider. How do I enroll in Medicaid? How do I check whether my patient is eligible for Medicaid? What if I have a question about a claim I submitted?	ACS Government Healthcare Solutions (fiscal agent for D.C. Medicaid)	Provider enrollment: 202-906-8318 Eligibility verification: 202-610-1847 Other inquiries: 202-906-8319
I'm a health care provider. How do I obtain prior authorization for services?	Pharmacy: First Health Services Other: D.C. Medical Assistance Administration	Pharmacy: 804-527-5757 Other: 202-442-9115
How do I get a job at MAA?	D.C. Office of Personnel	202-671-1300
I'm a policy analyst or journalist with questions about Medicaid policy or budget.	Office of the Medicaid Director	202-442-5988
All other inquiries.	D.C. Medical Assistance Administration	202-442-5988 Room 5135 825 North Capitol St., NE Washington, D.C. 20002 www.doh.dc.gov