Working Together for Health

Medicaid Annual Report
FY 2007

Government of the
District of Columbia
Adrian M. Fenty, Mayor

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

On the cover: Medicaid beneficiaries Doris Bernard and Nathaniel Roy. All beneficiaries named in this report are included with their permission or that of their parent or guardian. Some beneficiaries are identified by first name only.

This report is available on the web at www.doh.dc.gov, under "Medicaid" and then "Reports."

Working Together for Health

The Human Face of Medicaid 2
A message from Mayor Adrian M. Fenty

Putting the CARE Back in Health Care 3
A message from the Interim Director, Department of Health

Working Together for Health 4
A message from the Medicaid Director

Medicaid Nationwide and in D.C. 5
An essential public program

Coming Together for Kids 6
The Male Caregivers Advocacy Support Group

Oliver Roy and Family 7
Medicaid helps keep a family together

Providing Access to Health Insurance 8
Coverage for the D.C. population; expansions in access

Who Qualifies for Medicaid? 9
An explanation of Medicaid eligibility

Access to Care in the Managed Care Plans 10
Results from an evaluation of distance and travel time

Covering 60% of D.C. Children 11
A central role in health promotion, and a new web-based tool to improve care

Developing New Skills 12
The "New Vision" program serves Medicaid beneficiaries with intellectual disabilities

Our Beautiful City 13
Photos by Medicaid beneficiaries in the New Vision Photography Program

Funding Quality Services 14
HEDIS measures and other information on the quality of care

Meeting Beneficiary Needs 15
Results from satisfaction surveys of Medicaid beneficiaries

The Future of Medicaid 16
An interview with Medicaid Director Rob Maruca

Doris Bernard 17
Medicaid enables a grandmother to remain at home with her family

Value Purchasing and Improving Efficiency 18–19
Initiatives in pharmacy, coordination of benefits and transportation

Working for Beneficiaries 20–21
Profiles of the work done for beneficiaries by D.C. employees

Understanding Medicaid Spending 22–24
Insight into the Medicaid budget and Medicaid's role as a purchaser

For More Information .... Back cover

The Human Face of Medicaid

A Message from Mayor Adrian M. Fenty

EVERY DAY I MEET PEOPLE WHOSE LIVES are made better by our Medicaid program. In this report, you will have the same opportunity. You will meet Doris Bernard, who would be in a nursing home but for an innovative program that allows her to stay at home with her daughter and grandson. You will meet Oliver Roy, a single dad who is raising four boys—and who just agreed to adopt two other children in order to keep a family together. You will meet Philip Momchilovich, one of 60,000 adults who now has dental care thanks to a recent expansion in Medicaid coverage. And you will see our beautiful city through the eyes of photographers trained in a unique program for Medicaid beneficiaries with intellectual disabilities.

Mayor Fenty with Maurice and James, Medicaid beneficiaries who participate in the New Vision Photography Program

Our beneficiaries are served not by bureaucracies but by people. You will also meet Cecil Doggette, who saw a role for a support group of men who care for kids with special needs; Al Price, who started the photography program for people with intellectual disabilities; Dr. Milton Bernard, an oral surgeon who makes time for patients in need; and Gloria Watson, Seema Nazeer, Carolyn Rachel-Price and other public servants who devote their time and talents to running the Medicaid program.

All of these individuals immediately agreed when we asked to include them in this report, and I thank them for their willingness. They remind us that Medicaid, for all its complexity and expense, is in essence a very human program.

> *"Medicaid is a very* ***human*** *program"*

Medicaid brings benefits to 142,000 individuals, and these benefits are not small. As you will see, they include inpatient and outpatient care, care in the home, prescription drugs that control illness, treatment of serious dental problems, preventive care to keep children healthy, and many others. Medicaid also provides the peace of mind that comes from having financial protection against the devastating financial cost of illness. The D.C. Healthcare Alliance, a related program, provides many of these same benefits to an additional 46,000 people. Together, these programs serve almost one-third of D.C. residents.

Health care, like education and public safety, is the bedrock upon which our city is built. I thank everyone who has contributed to the Medicaid and Alliance programs. Let us work together toward continued success.

Adrian M. Fenty, Mayor

Putting the CARE Back in Health Care

A Message from the Interim Director, Department of Health

ALL OVER THE COUNTRY, STATES DISPLAY GROWING CONCERN over their Medicaid programs. Much of this trepidation centers on issues of cost; Medicaid comprises anywhere from an eighth to a quarter of some state's budgets. But here at the Department of Health, we wish to return the focus of Medicaid to the basic and fundamental purpose of the program: to protect and promote the health of vulnerable populations.

The FY 2007 Medicaid Annual Report highlights D.C.'s efforts in creating a high quality, cost-effective, and comprehensive program that increases access to care for underserved residents of the District. It provides an opportunity for the public to review our performance towards reaching this goal, and evaluate our progress over time.

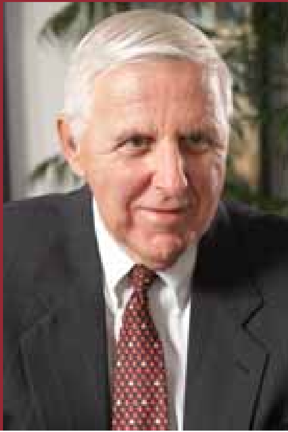
Because Medicaid covers one out of every four D.C. residents, it is key to ensuring that residents possess the tools to lead healthy and productive lives. Despite this extensive coverage, however, many residents still lack access to care. To address this, D.C. Government has continued to lead the nation in innovative expansion programs that extend Medicaid coverage to additional underserved populations, such as children in families up to three times the poverty level, adults who previously had no dental care, and seniors who struggle to pay for prescription drugs.

"Creating a high-quality, cost-effective, and comprehensive program"

While DOH is committed to the human aspect of the Medicaid program, we are also mindful of the need for financial responsibility. Over the years, Medicaid has grown to be the single largest program in the District of Columbia. Spending in FY 2007 was $1.4 billion, with 70% of those costs reimbursed by the federal government. We are proud of our ability to restrain growth in spending—D.C. Medicaid was comparable to the private sector national average of 6.1% —while simultaneously expanding benefits.[1] Based on our experience in FY 2007, we anticipate even further investments in effective strategies to reduce cost, while enhancing the quality and availability of services to our recipients.

As a physician, I have often witnessed how health care coverage can alleviate suffering during times of illness. However, health care is one part of the entire public health picture that must work in concert to improve the overall health and well-being of District residents. The Medicaid program has successfully collaborated with many other sectors, both inside government and out in the community, to leverage our health care investment into better health status. On some measures, we're doing well; on others, not as much. Moving forward, everyone who receives health care funding—our managed care plans, our contractors, our providers, and ourselves in the Department of Health—must be held accountable for translating health care dollars into better health. In the next year, we will remain committed to these fundamental goals, and we look forward to your continued partnership in this critical effort.

Carlos Cano, MD
Interim Director, Department of Health



Working Together for Health

A Message from the Medicaid Director

THE THEME FOR THIS REPORT WAS CHOSEN TO UNDERSCORE the importance of collaboration in achieving one of life's precious goals: good health. Many individuals and organizations have contributed to our efforts to build a world-class health insurance program for D.C. residents—the Mayor and his staff, members of Council, federal officials, our colleagues in the Department of Health and elsewhere in District government, beneficiaries and their advocates, managed care plans, and health care providers. I very much appreciate their efforts as well as those of the Medical Assistance Administration staff.

Mayor Fenty and Dr. Cano have touched on the significance of Medicaid and the Alliance to our beneficiaries and on our responsibility to beneficiaries and taxpayers. I would like to describe the high points of FY 2007, organized by the five themes that run through this report.

- **Increasing access.** Medicaid now provides essential health care coverage for one-quarter of D.C. residents, with the D.C. Healthcare Alliance covering another 8%. Due to low income or poor health, almost every one of these individuals would be unable to obtain coverage in the private sector. In FY 2007, we expanded Medicaid eligibility to cover another 1,600 children. See page 8.

"We are proud that many of our results exceed nationwide averages"

- **Expanding benefits.** We started providing dental coverage to 60,000 low-income adults who previously had to pay for care on their own, seek charity care or, all too often, forgo care entirely. See page 5.

- **Funding quality services.** We measured the quality of services provided by our Medicaid managed care plans and wrote stringent new criteria into the managed care contracts. We are proud that many of our results exceed nationwide averages. See page 14.

- **Meeting beneficiary needs.** We developed the EPSDT/HealthCheck Tracking System to improve coordination of care for the 69,000 children covered by Medicaid. See page 11.

- **Value purchasing and improving program efficiency.** In cooperation with physicians and pharmacists, we implemented a program to make sure Medicaid pays for the most cost-effective drugs. We also completely reorganized our non-emergency transportation program to reduce cost while improving service. See pages 18–19.

Thank you for your interest in the Medicaid and Alliance programs. I invite you to learn more about the programs in the following pages, and to work with us toward better health for D.C. residents.

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

Medicaid Nationwide and in D.C.

THE NATIONWIDE MEDICAID PROGRAM, RUN BY D.C. AND THE STATES with majority funding from the federal government, is often misunderstood. Congress created it in 1965 almost as an afterthought to the creation of the Medicare program, which provides universal coverage for people aged 65 and over. Over four decades, Medicaid has grown to become the "workhorse" of the health care system, in the phrase of Alan Weil, former Medicaid director in Colorado.[2] Medicaid fills many—but not all—of the gaps left by Medicare and employment-based insurance, covering 43 million Americans whose income or health problems make them otherwise uninsurable. For people needing long-term care, Medicaid is by far the largest source of financial support and an innovator in helping people continue living at home. One reason that legislators have turned to Medicaid is that its administration costs are half those of private insurance.[3]

The change has been seen in the District as well. "Once upon a time, Medicaid was understood as a small marginal program for people on public assistance," says Sara Rosenbaum, a long-time health policy analyst at George Washington University. "And now it's the city's largest insurer."

Medicaid's Economic Impact

- Providing health care to one-quarter of the population (one-third including the Alliance) is essential to maintaining a healthy, productive D.C. workforce.
- 92% of the $1.4 billion that Medicaid spent on health care in FY 2007 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 for the D.C. government, bringing in $1.1 billion in FY 2007. Every Medicaid dollar from District funds is matched by $2.33 from the federal government.

Philip Momchilovich and Dr. Milton Bernard

Dental Benefits Available for 60,000 Adults

Blood on his pillow and sharp pain in his jaw told Philip Momchilovich, 58 years old, that he needed a dentist. For someone of very modest income and disabled by a stroke, however, dental care can be hard to find. A Medicaid staffer put Mr. Momchilovich in touch with oral surgeon Milton Bernard. "He said, 'I don't want to extract it, but it's going to be life-threatening if I don't remove it,'" the patient recalls.

Dr. Bernard pulled a molar and cured the infection, which could have spread into the brain, bloodstream or lungs. "Dentistry is not just about a pretty smile," says Dr. Bernard. He notes that gum disease, for example, is common in adults and associated with heart disease and stroke.

Dental illnesses are particularly prevalent among people with low incomes, many of whom are among more than 100 million Americans without dental insurance.[4] Although all Medicaid programs cover dental care for children, coverage for adults is much more limited.[5]

In April 2007, D.C. became one of the few Medicaid programs to provide comprehensive dental coverage for adults, including two routine visits a year and periodontal, surgical and denture care as needed. The cost is estimated at $13 million a year. For Mr. Momchilovich, the new benefit meant he didn't have to choose between paying $1,600 out of pocket, begging for charity care, or taking the risk of leaving the problem untreated. "It's lifesaving—that's how I describe Medicaid," he says.

Coming Together for Kids

OVER A HUNDRED PARENTS IN THE ROOM, and just a couple of men. Cecil Doggette thought it wasn't right, and he decided to do something about it.

Two and a half years later, on a Wednesday evening in Anacostia, there's a spirited discussion on how to raise kids with special medical needs—serious behavioral problems, mental illness, cerebral palsy, paraplegia. One father reminds the others to expect report cards in the next week. Another asks for advice on getting his 17-year-old son to attend school. A third warns against buying jackets that are too nice. His own son was murdered over a jacket that wasn't even his. "I miss him dearly," the man says softly. His advice: "Don't buy a North Face. Give him a clown face coat if you have to. He'll complain but he'll be here."

Participants in the male caregivers' group at a Wednesday night meeting.

It's the weekly meeting of the Male Caregivers Advocacy Support Group. It was started in 2005 by Mr. Doggette, director of outreach services for Health Services for Children with Special Needs (HSCSN), a Medicaid care coordination plan. Although he appreciated the turnout at the regular parents' support group, he wondered where all the men were. He and his HSCSN colleagues then set up this group, which now attracts a loyal core of about 15 men, and more on some nights.

As their kids play in the next room, the men start by checking in with each other, introducing themselves and recounting the past week. Some concerns are universal among parents: school, talking back, siblings. Others are not: tonight the conversation also includes Supplemental Security Income, individualized education programs (IEPs), psychiatrist visits and psychotropic prescriptions. One girl is aging out of the care coordination plan; her grandfather gets advice on where she can continue receiving medications. Another man talks about the challenge of diagnosing severe behavioral issues. "If the meds don't work, they say the child doesn't have ADHD," he says, referring to attention deficit hyperactivity disorder, "but that's not true."

Along the way, the group has broken a few stereotypes. "People expect a group of African American men to get together and talk about football and women," says Oliver Roy, the chairman. "We talk about everything *except* football and women." He was shocked by the stereotyping at an academic conference he attended. Adds James Bridgers, a male caregiver with a Ph.D. in family science: "They always talk about what we don't do. Let's talk about what we do."

As the meeting draws to a close, a participant named Tim sums up his feelings. "Just being here with men who take care of their kids takes me to another level, gets me pumped up," he says. "I draw so much energy from this group. Everything I've heard tonight—I've had a piece of that."

Any man who takes care of a child with special needs is welcome to attend the group, regardless of whether the child has Medicaid coverage. For more information, contact Cecil Doggette at 202-835-2771 or cdoggette@hscsn.org.

Oliver Roy and Family

Five years ago, Oliver Roy, then 38 years old, was divorced, homeless, and the father of four boys. His 10-year-old son, Sean, had been in and out of shelters and foster care homes. “When I got him enrolled in school, he was always kicking people and acting out. You could tell something was really the matter,” recalls Mr. Roy. Time spent trying to keep Sean in school was one reason Mr. Roy lost his job as a computer tech. They lived at D.C. Village, an emergency shelter, for three months.

District staff helped Mr. Roy get Section 8 housing through a program to reunify families. Sean received Medicaid coverage, and then was diagnosed with attention deficit hyperactivity disorder and mild developmental delay. His dad learned a lot about managing Sean’s powerful medications and how to work with therapists, doctors and school officials.

Mr. Roy’s other three boys, all now living with him and Sean, also have Medicaid, as does Mr. Roy. “It’s hard to hold a regular job when you have four kids getting home around 4 p.m,” he says. Sean receives SSI payments for disability, but the family doesn’t receive public assistance (usually known by the acronym TANF). The District also asked Mr. Roy’s ex-wife to make modest child support payments.

Mr. Roy with his sons Oliver Jr., 18, Tayvon, 15, Nathaniel, 10, and Sean, 16.

The family lives in a tough neighborhood near Southern Avenue, and there are still arguments and clashes of will. “This isn’t the Cosbys,” says Mr. Roy. “It’s the Cosbys, R-rated.” Still, it’s working out. The family hopes to move to a bigger house in Northwest. Oliver Jr., 18, is off to college in January. Sean is an honor student at a school for children with special needs. “If it wasn’t for Medicaid, mental health-wise, I doubt he’d be in the shape he is now,” his dad says. “He’s fine now. It’s my hope that one day he’ll be OK without meds.”

Mr. Roy serves as an advocate for male caregivers, accepting invitations to speak to groups across the District and as far away as New York and Florida. He tells his story, including how he was in foster care as a child. “I never did drugs, never smoked, never been arrested,” he says. “I did end up with a rack of kids.” His cell phone rings 20–30 times a week with calls from parents seeking advice about navigating the health, education and social services systems. Last year, Parents Anonymous named him “D.C. Parent of the Year.” (His kids wanted to know why no one asked them.)

Even with Oliver Jr. moving out, the family is growing. Mr. Roy has decided to adopt Sean’s siblings, Mckeever, a 13-year-old girl, and Devante, a 14-year-old boy. They’ve lived in foster care most of their lives and been featured several times as “Wednesday’s Child” on Channel 4 without being adopted. Mr. Roy hesitated, but not for long. “What do you do when your son asks you, ‘Can you get my brother and sister out of foster care?’” he says. He’s scared it may not work out. “My focus is on getting Devante and Mckeever into a routine, getting them settled.” He adds: “The advantage I have now is that I’ve been through it before.”

Providing Access to Health Insurance

■ **Trends in Medicaid enrollment.** In FY 2007, D.C. Medicaid covered an average of 142,000 people per month, virtually unchanged from FY 2006. In FY 2007, total spending was $1.4 billion (preliminary data), of which the federal government paid 70%.

■ **The D.C. Healthcare Alliance**. The Alliance is a separate program that provides insurance to 46,000 D.C. residents who do not qualify for Medicaid. All Alliance members are enrolled in one of two managed care plans—the D.C. Chartered Health Plan or Health Right. In FY 2007, total spending was $130 million, all of which was funded by the D.C. government (preliminary data).

■ **Providing essential insurance**. Medicaid covers 24% of the D.C. population, with the Alliance covering another 8%. Covering almost one-third of the population puts D.C. in a group with only a few states in terms of ensuring access to health insurance. Medicaid is the second-largest source of insurance in D.C., ahead of Medicare and behind employment-based insurance. When people have employment-based insurance, they benefit from a tax break estimated (nationwide) at $1,573 for single coverage and $3,825 for family coverage.[6] However, very few people with Medicaid or Alliance coverage have access to employment-based insurance, either because they are not in a working family, their jobs do not offer them insurance, or they find the premiums unaffordable.[7]

■ **1,600 children newly eligible for Medicaid**. In June 2007, D.C. raised the income ceiling for Medicaid eligibility from 200% to 300% of the federal poverty line. To be eligible, children must be uninsured and under age 19. The District has embarked on a city-wide outreach strategy to communicate this change to parents, teachers, school nurses and community-based organizations.

■ **More help to people with Medicare coverage**. In 2007, about 300 Medicare beneficiaries with modest incomes became newly eligible for Medicaid assistance with their Medicare cost-sharing obligations. Although these individuals are not eligible for full Medicaid benefits, the assistance will help them afford their Medicare premiums, deductibles and coinsurance. The change was to increase the income ceiling for this type of Medicaid benefit from about 225% of the poverty line to 300%.

Medicaid Population Demographics
Average Month, FY 2007

By Gender and Age		
Female under 18	33,905	24%
Female 18–21	6,019	4%
Female 22–64	35,153	25%
Female 65 and over	8,544	6%
All Females	**83,621**	**59%**
Male under 18	34,768	24%
Male 18–21	4,363	3%
Male 22–64	15,404	11%
Male 65 and over	3,890	3%
All Males	**58,425**	**41%**
By Race/Ethnicity		
African-American	122,081	86%
Hispanic	13,068	9%
White/Other	3,409	2%
Unknown	3,546	3%
By Ward		
Ward 1	14,794	10%
Ward 2	19,891	14%
Ward 3	1,460	1%
Ward 4	16,116	11%
Ward 5	19,246	14%
Ward 6	16,068	11%
Ward 7	24,988	18%
Ward 8	28,724	20%
Unknown	759	1%
TOTAL	**142,046**	**100%**

Who Qualifies for Medicaid?

MEDICAID ELIGIBILITY, UNFORTUNATELY, RANKS AMONG the most complex topics in government. Here is a simplified explanation.[8]

Federal rules govern eligibility for Medicaid and a related program, the State Children's Health Insurance Program (SCHIP). Within these rules, D.C. and the states set their own policies. In D.C., SCHIP is integrated into Medicaid. Beneficiaries therefore do not have to change health plans and doctors when their incomes go above or below the various thresholds used in determining eligibility (see table).

Medicaid eligibility is categorical, which means that an individual must fall into a covered category *and* have family income below specified thresholds. Although there are dozens of categories, they are often combined into three broad groups:

■ **Low-income families with children**. In D.C., this is the largest category—about 101,000 people in 2007. Adults in this category are usually, but not always, pregnant women or single mothers. About 90,000 people in this category are enrolled in one of three managed care plans funded by D.C. Medicaid.

■ **People with disabilities**. About 28,000 people qualify for Medicaid because of disabilities, such as paraplegia, intellectual disability, or serious mental illness. Some do not meet the disability standards that would qualify them for Medicare while others are in the two-year waiting period for disability-related Medicare. Medicaid is typically their only coverage, covering both acute care needs like hospital and physician care as well as long-term care in the home or an institution. About 3,200 children in this group are enrolled in the Health Care for Children with Special Needs plan; everyone else receives care paid for by fee-for-service Medicaid.

■ **Low-income Medicare recipients**. Regardless of income, the federal Medicare program covers almost every senior (age 65 and over) as well as people of any age who meet Social Security disability standards. In D.C., about 13,000 people have dual Medicare/Medicaid coverage. Those with incomes under 100% of the poverty line receive full Medicaid coverage, which includes long-term care services not covered by Medicare. The others do not receive full Medicaid, but Medicaid pays all or some of their Medicare premiums, deductibles and coinsurance.

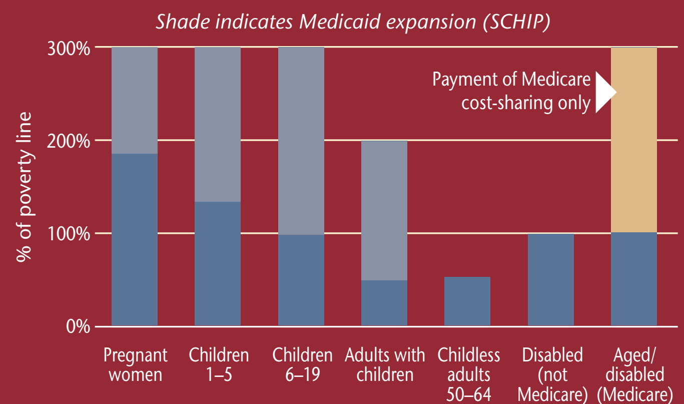
Nationwide, people who do not fall into one of the above categories—such as childless couples, single men and people whose health problems do not meet strict standards of disability—cannot get Medicaid, regardless of income. In D.C., about 1,500 childless adults aged 50–64 with incomes under 50% of the poverty line are an exception. They receive Medicaid under a waiver of federal rules.

The Federal Poverty Line

Medicaid eligibility often depends on annual family income relative to the federal poverty line (FPL). This table shows the 2007 FPL.

Family Size	50% of FPL	100% of FPL	200% of FPL	300% of FPL
1	$5,105	$10,210	$20,420	$30,630
2	$6,845	$13,690	$27,380	$41,070
3	$8,585	$17,170	$34,340	$51,510
4	$10,325	$20,650	$41,300	$61,950

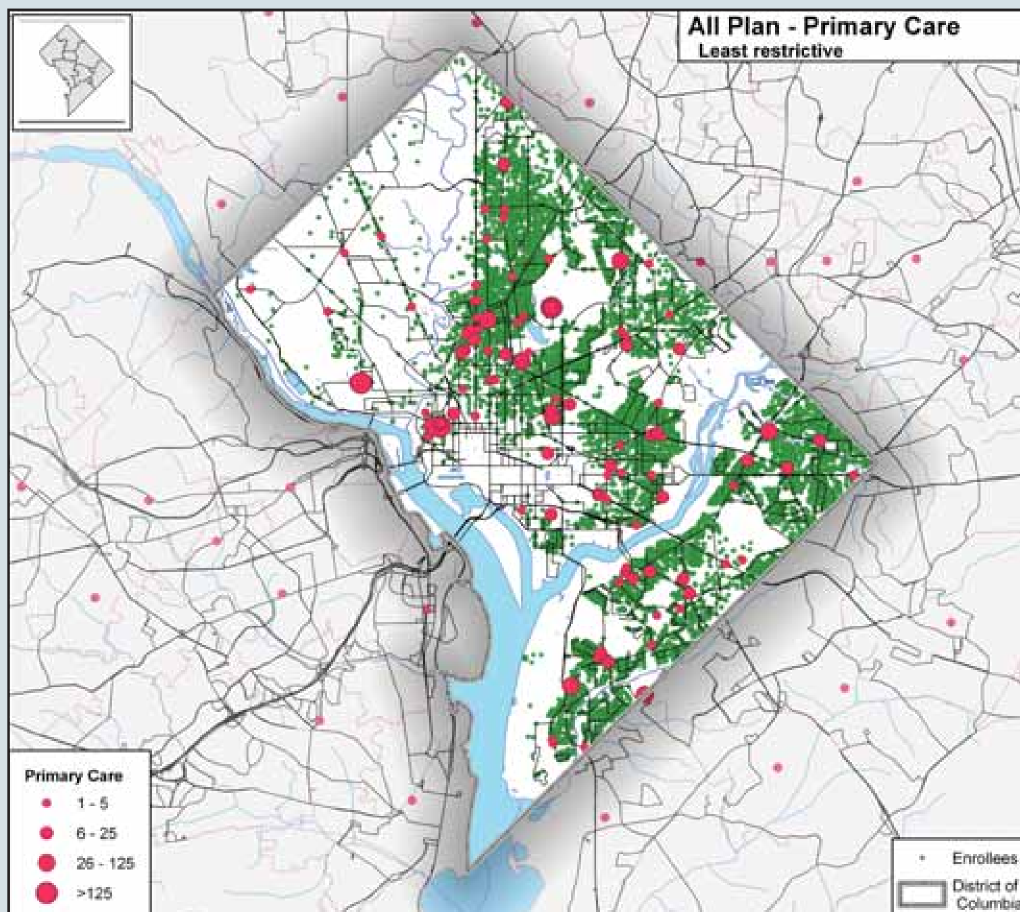
D.C. Medicaid Eligibility Standards, September 2007



Access to Managed Care

GEOGRAPHIC DISTANCE BETWEEN BENEFICIARIES AND PROVIDERS is an important factor in ensuring access to care. Almost every enrollee (99%) in the three District's Medicaid managed care plans lives within a two-kilometer radius of a primary care provider, according to a November 2006 study by Abt Associates Inc.[9] The study also found that all enrollees were able to choose between at least two primary care providers within 30 minutes of their home by public transportation. The District's small geographic size is a factor but it is also true that many providers are in the Southeast quadrant of D.C., where nearly half of enrollees live.

Location of Managed Care Members and Primary Care Providers



In the map to the left, each green dot shows the home of a Medicaid managed care enrollee. The red dots show the locations of primary care providers, with larger dots showing larger concentrations.

The Abt study also found that 74% of enrollees live within two kilometers of a psychiatrist and 86% of females age 11 to 50 live within two kilometers of an obstetrician/gynecologist. In each case, providers were included in the calculation only if they treated Medicaid managed care enrollees.

Access can also be measured by surveying managed care members; see page 15.

Covering 60% of D.C. Children

The welcome screen of the new web-based child health registry.

MEDICAID PLAYS A SPECIAL ROLE IN PROMOTING children's health. The benefits start before birth, since uninsured pregnant women with annual incomes under $30,630 can receive prenatal care even before being enrolled in Medicaid. (This policy is known as presumptive eligibility.) In D.C., Medicaid pays for 64 percent of births, including screening exams at birth, well-baby exams, and neonatal intensive care, if necessary.

Medicaid's child health program is often known as EPSDT, for Early and Periodic Screening, Diagnosis, and Treatment. The program emphasizes prevention, identifying and treating health problems before they worsen, and bringing health care to beneficiaries. (Medicaid conducts health screenings in schools, for example.)

Medicaid provides health insurance for 69,000 kids under age 18. These include (from top), Taniya, 9 years old, Tania, 8, and Lesinae, 3.

In FY 2007, D.C. Medicaid developed the web-based EPSDT/HealthCheck Tracking System. The agency collaborated with physicians and managed care plans to develop seven standardized medical record forms, with data on 40,000 children loaded into the tracking system so far. Starting in early 2008, physicians, hospital staff and other health professionals with the appropriate security permissions can obtain real-time access to EPSDT records that include immunization history, hearing and metabolic screenings, specialty referrals, well-child visits and more.

Dr. Mark Weissman, Interim Chief Director of General Pediatrics at Children's National Medical Center, is a strong proponent. "Kids in D.C. getting services through EPSDT are receiving some of the most comprehensive care in the United States. There's still work to do but there has been tremendous improvement in the past five years," he says. Web-based access to EPSDT records will help caregivers understand their patients' needs, see what EPSDT services have already been provided, and reduce costly duplication of immunizations and other services.

Developing New Skills

"Each and every one has a talent that they're very good at. You just have to bring it out of them." Lynwood Flowers is speaking about people with intellectual and developmental disabilities, often referred to as mental retardation. He is an employment specialist at the New Vision Photography Program, an innovative organization funded by Medicaid.

Each weekday, New Vision teaches photography and vocational skills to about 38 adults with intellectual disabilities. For many, it's the first time they have had the opportunity—and been expected—to learn workplace skills.

In the program's photo studio on Rhode Island Avenue, students learn the artistic and technical sides of basic photography. "That's right," says instructor Basil Hinds. "Set up the subject at a 45-degree angle." As the shutter clicks, another half-dozen students wait their turn. Later, they will critique their work in a computer slide show.

The instructors both counsel patience—"Take your time; a picture lasts a lifetime"—and practice it. Breaking tasks down into steps, minimal distraction and repetition are the keys to success. Since the program started three years ago, 28 students have been placed into jobs. CVS, the pharmacy chain, promises a job at regular wages to every student who completes the program. The students also put on public exhibitions in 2004 and 2006, complete with opening night receptions.

Al Price, a long-time professional photographer and advocate for people with disabilities, founded New Vision. Here, he instructs Saquella, a 20-year-old student, in the program's new videography studio.

Salih, a CVS employee since 2005, with his job coach, Wanda Fenwick.

In a nearby classroom, students work on counting change, using a keyboard and operating a shredder. Mr. Flowers speaks to a woman in her 30s, who can hear but not speak. She responds in sign language, which he has taught her. Previously, she had no real way of communicating.

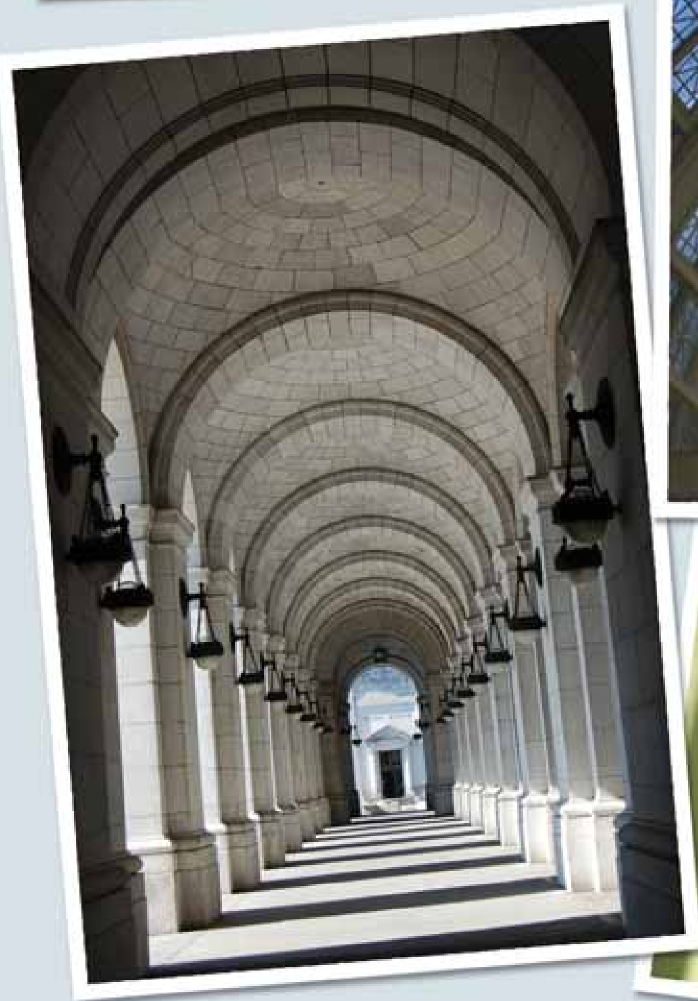
Students choose to be in the program, often at the suggestion of their case manager from the Department of Disability Services. Medicaid funds the program on a per student basis—$100 a day for prevocational training and $140 for supportive employment, which includes the cost of a job coach.

Nationwide, Medicaid serves over a half-million people with intellectual disabilities, at an average cost of $52,000 per person per year.[10] It is a very vulnerable population, often poor and sometimes coming from difficult family situations. The disability is defined as significantly below-average intellectual ability (IQ under 70) that limits a person's ability to live independently.

Some New Vision students also have other significant diagnoses, such as cerebral palsy, a seizure disorder or Down syndrome. Functional ability varies widely from person to person, so programs such as New Vision tailor their services to individuals. Given the opportunity, says Mr. Flowers, "They love to learn."

Our Beautiful City

Photos by Medicaid Beneficiaries in the New Vision Photography Program



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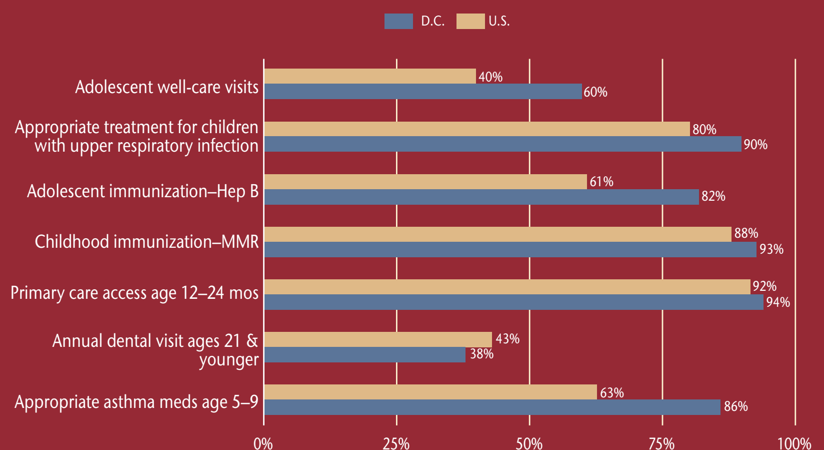
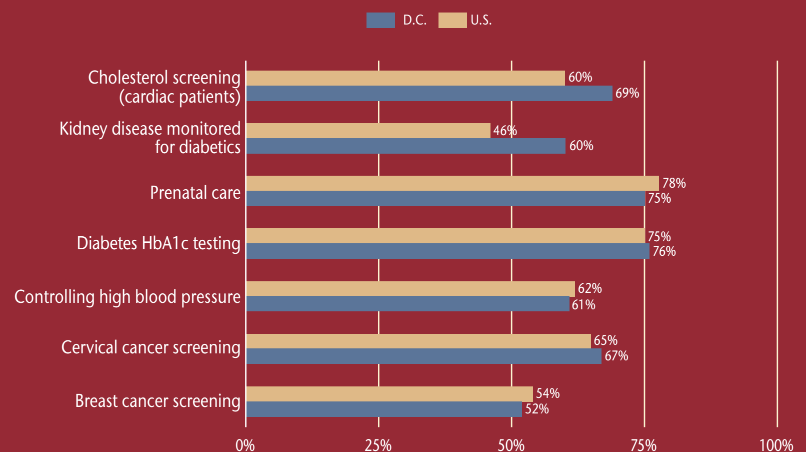
Funding Quality Services

FOR TWO-THIRDS OF MEDICAID BENEFICIARIES, almost all services in FY 2007 were provided through one of three managed care organizations (MCOs): AMERIGROUP (average monthly enrollment of 38,606), D.C. Chartered Health Plan (37,371) and Health Right (13,586). In the last several years, MAA has taken several steps to ensure quality of care. These include:

- **HEDIS performance indicators**. The standardized Healthcare Effectiveness Data and Information Set indicators were developed by the National Committee for Quality Assurance (NCQA), a not-for-profit private-sector organization. Data are collected from each MCO using strict definitional criteria. The charts on this page show weighted averages for the three MCOs in comparison with nationwide Medicaid averages.[11]

- **NCQA accreditation**. In 2007, all three MCOs achieved NCQA accreditation, which is widely recognized by employers, consumers, and governments as the gold standard in health plan accreditation. Accreditation depends on clinical performance, customer satisfaction, and a review of each plan's processes. Only 17 states have Medicaid managed care plans with NCQA accreditation.





- **New contractual language**. In FY 2008, MAA will sign new MCO contracts based on a request for proposals (RFP) that contains innovative pay-for-performance incentives, for example in achieving strong HEDIS and customer satisfaction scores. The RFP also greatly expands MAA's ability to oversee MCO performance, for example through on-site audits, staff and enrollee interviews, and medical record reviews.

- **Customer satisfaction surveys.** As shown on the facing page, D.C. Medicaid also commissioned an independent evaluation of beneficiary satisfaction with each plan and with fee-for-service Medicaid.

In addition to the three MCOs, another 3,222 Medicaid beneficiaries chose to enroll in Health Services for Children with Special Needs (HSCSN), a specialized plan that serves children with disabilities. Although HSCSN is not eligible for full NCQA accreditation, it received three years of NCQA certification in both utilization management and credentialing in FY 2007.

Meeting Beneficiary Needs

D.C. MEDICAID RECENTLY COMMISSIONED A BENEFICIARY SATISFACTION SURVEY across the managed care and fee-for-service populations.[12] A national research firm, Abt Associates Inc., contacted a random sample of 3,200 beneficiaries using a multimodal (mail and telephone) questionnaire based on the federal government's Consumer Assessment of Healthcare Providers and Systems. Use of the CAHPS template enables comparison of D.C.'s results with national Medicaid averages.

The survey comprised several dozen questions. Results were calculated for each MCO, for HSCSN, and for fee-for-service Medicaid. The table on this page shows the highlights of the results. Numerical results have been shaded to indicate at a glance how the D.C. results compare with national Medicaid averages. The differences have not been tested for statistical significance, however.

Beneficiary Satisfaction in D.C. Medicaid

- Higher than the national result (more than 5 points higher)
- Somewhat higher than the national result (3 to 5 points higher)
- About the same as the national result (within 2 points)
- Somewhat lower than the national result (3 to 5 points lower)
- Lower than the national result (more than 5 points lower)

Question	Response	Adult			Child	
		National	D.C. Medicaid Mgd Care	D.C. Medicaid Fee for Service	National	D.C. Medicaid Mgd Care
Since you joined your health plan, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?	% Not a problem	71%	77%	73%	80%	85%
In the last six months, how much of a problem, if any, was it to see a specialist that you needed to see?	% Not a problem	65%	75%	81%	68%	84%
In the last six months, how much of a problem, if any, was it to get the care, tests, or treatment you or a doctor believed necessary?	% Not a problem	75%	69%	68%	82%	71%
In the last six months, when you needed care right away for an illness, injury, or condition, how often did you get care as soon as you wanted?	% Always	56%	52%	55%	70%	64%
In the last six months, how often did your doctors or other health providers explain things in a way you could understand?	% Always	63%	68%	63%	76%	77%
In the last six months, how often did your doctors or other health providers show respect for what you had to say?	% Always	66%	71%	68%	77%	79%
In the last six months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?	% Not a problem	65%	71%	46%	69%	74%
Use any number on a scale from 0 to 10... where 10 is the best care possible. How would you rate all your health care?	% giving score of 9 or 10	55%	50%	58%	66%	65%

Notes 1. *Results for children in fee-for-service Medicaid are not shown because the sample was too small for statistical validity.*
2. *Wording for questions about children's care was similar to that shown here, except that references were to "your child."*

The Future of Medicaid

Rob Maruca, D.C. Medicaid director since 2003, previously served as the Medicaid director for New Mexico, chief executive officer of the 126-bed Children's Hospital of New Mexico, and chief operating officer of a 300-bed military hospital. In an interview, he shared his perceptions of Medicaid's direction nationwide and in the District.

Over the years, how have you seen the role of Medicaid, and the perception of Medicaid, change?
The program is much better known, now that it covers more and more individuals. In places like D.C., Medicaid covers 25% of the population. Because of the size of the District—what I would call a city-state—and because of the close involvement with so many advocates and the health community in general, there's much more emphasis on Medicaid here than in most states. Because we cover such a large percentage of the population, we can make a big impact on the health of the District.

What would be the situation if Medicaid did not exist?
One quarter of the population would not have health care and would be using emergency rooms more often, would be using specialty services without access to a primary care physician, and would not have managed care organizations helping manage their care. Instead of a program focusing on keeping people well, you would have people using services only as a last resort. People would get very ill before they would see a doctor, they wouldn't get an annual checkup, their kids wouldn't get vaccinations. Medicaid really contributes to a healthy population for the District.

Looking out five years, what major changes do you see for Medicaid?
From a national perspective, and clearly from a District perspective, we are looking at how we can tie Medicaid into a universal program of some sort. We will focus on how to cover more individuals, how to cover the childless adults who have no coverage now, and how to help employers—small businesses in particular—provide services for their employees.

What changes do you see in the role of Medicaid as a purchaser?
Spending more money doesn't necessarily make it better. Spending less can make it better, too. When you become efficient and you have quality measures, then you have a balance between cost effectiveness and the quality of service. Our HEDIS measures [see page 14] are a great indicator of what we are doing, and in the District our HEDIS measures have been very good.

"We can make a big impact on the health of the District"

Because managed care is such a large part of our budget, we have to make sure we get a good return on our investment. In the last couple of years we have reduced the capitation payments that we pay the managed care organizations, because we felt there were excess profits. We are emphasizing encounter data and reporting to make sure that we get reports [on quality] that we were not previously getting from our MCOs. In the majority of areas we are doing very well, but we have areas where we want to do even better.

As you think about the future of Medicaid, let me ask a favorite question of emergency room doctors—that is, are you feeling better than you were before, worse, or about the same?
I feel a lot better. We are making significant changes in our managed care program, which covers two-thirds of our population. In our fee-for-service population, our elderly and physically disabled waiver was only serving a few hundred individuals a few years ago. Now it's serving 1,600 individuals and growing. We have a waiver to cover the 50–64 year old childless population who wouldn't otherwise be eligible for Medicaid. These individuals were very heavy emergency room users before. Now they are in a managed care program where they are getting proactive care. We have a close working relationship with the Department of Disability Services and that waiver [for people with developmental disabilities] is growing. In our nursing home program, we put a prior authorization program in effect so that when someone comes out of a hospital and needs a nursing home, they don't just get moved to Maryland or Virginia because that may be easier for the hospital. Our first goal is always to provide services within the District wherever possible.

Doris Bernard

Three years ago, Doris Bernard, now 78 years old, came to a crossroads reached by many senior citizens. "As time passed, Mother was getting more and more frail," recalls her daughter, Renee Thornton. "She was becoming a danger, actually." Ms. Bernard has diabetes, hypertension, spinal stenosis and spinal arthritis, requiring the use of a wheelchair or walker to get around.

For many years, someone like Ms. Bernard would have had only two choices—moving into a nursing facility or relying on care from family members. But in recent years, a third way has become one of the most popular Medicaid programs nationwide. Called "home and community-based services," the program funds individualized care in the home for people who otherwise would have to live in a nursing facility.[13] For Ms. Bernard, a personal care assistant comes in 16 hours a day to help with bathing, dressing, traveling to medical appointments, and taking medications.

Doris Bernard at her home in the Eastland Gardens neighborhood, with Beauty.

"I probably wouldn't be able to keep Mother at home," says her daughter. "I'd have to stay home to take care of her but I couldn't afford to do that. Plus, she gets better care and she's healthier and happier." Ms. Bernard also helps raise her grandson, Benjamin, 15 years old. "It's nice to have the two generations communicate—the experiences he'll never have, and family history. And they love their animals," Ms. Thornton says, referring to the cats, Beauty and Sneakers. Life without her assistant would be very difficult, says Ms. Bernard. For example, "I like to cook, but I shouldn't be in the kitchen by myself."

Medicaid "keeps families together"

Ms. Bernard is one of 1,600 people in D.C.'s elderly and physically disabled (EPD) waiver program. Because Congress didn't include home and community-based services as a specific Medicaid benefit, D.C. and every state offer these services under a waiver of federal law. To receive the waiver, D.C. Medicaid must demonstrate that its cost ($33 million in FY 2007) is less than the cost of what nursing facility care would have been. Individuals must be assessed by a doctor as needing help with at least two of the five activities of daily living (eating, bathing, toileting, transferring and dressing) and at least three instrumental activities of daily living (such as medication management and housekeeping). Their income also must be less than about $23,000 a year. Although Ms. Bernard has Medicare coverage, Medicare doesn't cover long-term care.

Dr. Robert Cosby, the Chief of the Medicaid Office of Disabilities and Aging, has a doctorate in gerontology and remembers when a nursing facility was "the only option." He and his staff are working to expand the number of people eligible for the waiver and to give beneficiaries more control over the care they receive. For Ms. Bernard and her family, the program is working well now. "It keeps families together," says Ms. Thornton. Adds her mother: "I don't believe I'd still be alive if I was still living by myself."

Spending Dollars Wisely

As the purchaser of $1.4 billion a year in health care services in a very complex program, D.C. Medicaid has an obligation to ensure that funds are spent wisely to attain as many health benefits as possible for beneficiaries. On these pages we describe three initiatives for value purchasing.

Value Purchasing in Pharmacy

A new Medicaid initiative will save at least $5 million a year in drug costs while maintaining beneficiary access to medications.

Like Medicaid programs nationwide, D.C. Medicaid has experienced high and rising spending on prescription drugs. In 2006, the trend line shifted downward when Medicare took over drug costs for dually eligible beneficiaries. However, Medicaid drug costs are still projected to grow strongly in coming years.[14] In part, the growth reflects important new therapies that benefit patients. But it can also reflect extensive marketing campaigns and aggressive pricing by drug manufacturers.

Consumer advocate and former D.C. Council member Sandy Allen, speaking at the Sept. 27, 2007, P&T meeting. The 15-member committee also includes physicians, pharmacists and other clinicians from MAA and the health care community.

In February 2007, the District took three, related steps to bring more sense of balance to purchasing decisions: D.C. joined the National Medicaid Pooling Initiative, set up a preferred drug list, and inaugurated a Pharmacy and Therapeutics (P&T) Committee. The national pool combines the purchasing power of 15 Medicaid programs, giving D.C. access to price rebates from 82 manufacturers. If a drug is put on the preferred list, then Medicaid will pay for the drug without prior authorization (PA). Although other controls still exist to ensure therapeutic appropriateness, the lack of a PA requirement is popular with manufacturers. The P&T Committee recommends which drugs will be preferred. In its deliberations, the committee considers both the clinical benefits of specific drugs in comparison with each other as well as prices paid by Medicaid after rebate. A manufacturer rebate is not required for a drug to be put on the preferred list, but pricing definitely matters when different drugs have similar clinical benefits.

In the first eight months of the initiative, D.C. Medicaid became eligible for $4 million in rebates. Because the rebates come directly from manufacturers, Medicaid payments to D.C. pharmacies are unaffected. As well, Medicaid still will pay for a very wide range of drugs. “Non-preferred” status means only that the physician must discuss the prescription with Medicaid clinical staff before Medicaid will pay for it. The preferred drug list is available on the D.C. Department of Health website.

Untangling Complexity to Reduce Costs and Improve Coverage

A Medicaid team is at work on an initiative that, so far, has identified as much as $20 million in savings while actually improving insurance coverage for Medicaid beneficiaries. To pull it off, the team had to delve deep into the intricacies of Medicaid and Medicare eligibility and payment rules.

The team did extensive analysis of three and a half years of Medicaid paid claims data, using a two-pronged approach. First, they searched for beneficiaries who were age 65 or older but who did not appear to have Medicare coverage. Second, they searched for services and diagnoses that suggest that the patient may have had end-stage renal disease (ESRD). From an insurance standpoint, ESRD is very unusual—it's the only disease that makes someone of any age eligible for Medicare, provided that certain other eligibility requirements are also met.

On services covered by both Medicare and Medicaid, Medicare is the primary payer while Medicaid covers the beneficiary's cost-sharing obligations. Patients with ESRD in particular often have annual health care expenses in six figures. When Medicare eligibility is appropriately established, Medicaid saves dollars that can be redeployed to other priorities. As well, the beneficiaries gain the financial protection of having both Medicare and Medicaid coverage.

So far, 1,877 people have been identified who may have had Medicare eligibility during the time period. Potential savings from establishing Medicare eligibility, which can be done retroactively, could be as much as $20 million, plus costs avoided for future services. Medicare eligibility has actually been established for 52 people, with other cases in process. Medicaid has recouped $4.9 million on claims that will now be billed to Medicare.

Anomalies in eligibility can arise for several reasons, including people not understanding the benefits of having both Medicaid and Medicare coverage. That's why a big part of this project involves beneficiary and provider outreach initiatives. MAA has received assistance from the federal Department of Health and Human Services as well as the Social Security Administration and the Greater Washington Urban League in educating providers and beneficiaries about dual eligibility.

Prosecuting Fraud and Tightening Controls in Transportation

Medicaid plans nationwide pay for non-emergency transportation so that low-income beneficiaries can receive needed medical services. Examples include transport by wheelchair van, public transit, and taxi.

Becoming a transportation provider typically does not require medical licensure or significant capital investment, so it can be an easy area for criminals to infiltrate. In recent years the Office of Inspector General and the Federal Bureau of Investigation have investigated Medicaid transportation fraud in many states. In D.C., federal agencies have been aided by MAA's Investigation and Compliance Unit.

Three D.C. Medicaid cases resulted in convictions in FY 2007. Together these cases involved over $2 million in services that were billed to Medicaid but not actually provided. Two defendants are in prison and a third is scheduled to be sentenced. In the largest case, federal officials seized $1.2 million and two cars from the perpetrator.[15]

MAA has strengthened controls to shut down this avenue of fraud. Prior authorization requirements and tracking of Medical Necessity Certification forms have been tightened. Most significantly, in October 2007 MAA began outsourcing management of non-emergency transportation services to a single experienced broker. Under the contract, the broker will have strong incentives to control fraud and to ensure that the most efficient mode of transportation is used. The quality of service is also expected to improve for all beneficiaries, especially the elderly and people with disabilities.

Working for Beneficiaries

The Medical Assistance Administration (MAA) serves as the State Medicaid Agency for D.C. It also administers the D.C. Healthcare Alliance. MAA comprises 163 public servants organized into nine divisions: Disabilities and Aging, Managed Care, Program Operations, Quality Management, Program Integrity, Finance and Audit, Children and Families, the Healthcare Alliance, and Office of the Senior Deputy Director. In this section, we describe some of the work they do.

■ **Seema Nazeer**, a program analyst for the Office of Children and Families, joined MAA in 2003. As a certified Project Management Professional (PMP), Seema serves as the project manager for the new EPSDT/Healthcheck Tracking System (see page 11). She works closely with the contractor building the system and the physician offices and hospitals that will use it. Seema also helps manage the program through which Medicaid covers low-income childless adults aged 50 to 64. Because the program operates under a waiver of federal rules, MAA must regularly report the enrollment to the federal government and ensure that spending caps have not been exceeded.

Seema has a long-standing interest in public health issues that affect children and wrote her master's thesis on childhood immunization rates in Chicago. She says, "I enjoy my job because it allows me to apply my background in health care administration, information technology and statistics to help people in the District get the care they need."

■ **Alex Peralta**, the interim Chief of the Office of Program Operations, has been with MAA since 2005. Alex is certified in project management and has a strong background in information technology, both at a New York hospital and at a D.C. Medicaid managed care plan. For MAA, Alex manages the complex contractual relationships between MAA and various outside vendors. The largest contract is for "fiscal agent" services such as claims processing and provider relations. In September 2007, the District and ACS Government Healthcare Solutions signed a seven-year renewal. Alex will oversee the contractor's work in building a brand new claims processing system that will go live in October 2009. (See page 24.)

Alex often has more work on his hands than time but says he loves solving problems. "You always have to keep the beneficiaries in mind with everything that you do," he says. "We can't take our day-to-day decisions too lightly because they can have a big impact on people who are already having a hard time."

■ **Lawrence Williams** is a program analyst with the Office of Managed Care. Although Lawrence has been with the agency for less than a year, he knows a lot about Medicaid because he spent five years working for the District's fiscal agent, ACS Government Healthcare Solutions. Lawrence serves as the point person for many of the vendors that work with the Office of Managed Care. He is also heavily involved in the project to build a new claims processing system. "I am a translator," says Lawrence, "I translate geek into English." He also analyzes data from the managed care organizations to identify trends and resolve issues. Lawrence says that he likes interacting with people and enjoys the challenge of figuring out solutions to problems.

■ **Carolyn Rachel-Price**, **R.Ph.**, has worked for the D.C. government for 20 years, including service as a supervisory pharmacist at D.C. General Hospital and, since 2005, as a senior pharmacist in Medicaid. Her first project at MAA was helping dually eligible Medicare/Medicaid beneficiaries transition to the new Medicare Part D pharmacy benefit. During implementation, Carolyn spoke in churches, senior citizen homes and other settings to encourage enrollment in Part D.

She has also been instrumental in forming the Pharmacy and Therapeutics Committee and in developing the preferred drug list (see page 18). These initiatives will save millions of dollars for Medicaid. Her purpose, Carolyn says, is to work collaboratively with providers and recipients to improve medical outcomes in a cost-effective way. "When someone calls me to say thank you, that what we did made a difference for them, that just makes my day," she says.

■ **Gloria Watson**, **RN**, leads the Surveillance and Utilization Review team of two other nurses and two public health analysts within the Office of Program Integrity. The team performs scheduled and unscheduled audits of providers and beneficiaries to monitor compliance and to control improper or illegal utilization of the Medicaid program. Gloria came to Medicaid in 2002 after working in a hospital for 20 years, much of that in utilization review. Gloria says that those who defraud the Medicaid program hurt beneficiaries and take money away from people who need care. Although her duties often involve a lot of data collection and report preparation, she says she really enjoys conducting audits and working with providers. The audits do not always reveal intentional wrongdoing; often, they lead to opportunities for provider education.

■ **Linda Brock** has worked in the Office of Program Integrity since 2002, first as an investigator in the Investigations and Compliance unit and now as an analyst in Surveillance and Utilization Review. In both roles, she pursues fraud and abuse by providers and beneficiaries. For example, Linda played a key role in the conviction of several transportation providers that were inappropriately billing for services.

Last year, the Federal Bureau of Investigation presented Linda with an award for her "exceptional service in the public interest." This year, she won an Integrity Award from the federal Office of Inspector General. "Getting the bad guys out of the program means not only recovering lost dollars but avoiding future losses," says Linda. "That leaves more money for poor people to receive the benefits they need."

■ **Kathleen Jansen** is an investigator in Investigations and Compliance unit within the Office of Program Integrity. She started with MAA as a temp in 2001 and was hired in 2002. Kathy cross-references claims reports and other information to detect potentially fraudulent billing patterns. It's a big job—in FY 2007, D.C. Medicaid served 142,000 beneficiaries, had 5,600 enrolled providers, and processed two million claims.

Kathy and her colleagues have helped collect millions of dollars related to fraudulent billing practices and other system abuses. Her research often involves calling Medicaid beneficiaries to confirm the receipt of services that providers have billed. She says, "I like being able to talk directly with recipients and knowing that they are going to get help when they need it."

Understanding Medicaid Spending

TO UNDERSTAND MEDICAID FINANCES, IT HELPS TO ANALYZE spending by broad groupings of beneficiary eligibility and type of service. The table on this page shows such an analysis for FY 2006. Several dozen eligibility categories are collapsed into the three groups discussed on page 9. Spending is grouped into fee-for-service acute care, fee-for-service long-term care, payment of premiums to health plans, and Medicaid payment of a beneficiary's Medicare cost-sharing obligations. Although the groupings are simplifications of a very complex program, the following discussion should illuminate the drivers behind Medicaid spending.

People with "family-related" eligibility account for 72% of enrollment but just 30% of spending. This is a relatively healthy population similar to a commercially insured population but with more emphasis on obstetrics and pediatrics. About 90,000 of 102,600 beneficiaries were enrolled in one of three managed care plans. Fee-for-service payments for people with "family-related" eligibility are for people ineligible for managed care or for managed care enrollees who need certain services not covered by the plans. Overall, average spending per enrollee per month was around $325.

The most expensive eligibility group—both in total and per person—comprises people with disabilities whose only coverage is Medicaid. These 28,400 people represented 20% of enrollment but 48% of spending, or about $1,900 per person per month. Many live in nursing facilities or homes for people with developmental disabilities. Others are enrolled in "waiver" programs that provide long-term care in the community. This group also shows high spending for acute care services such as prescription drugs, hospital care and physician care. About 3,200 children are enrolled in the Health Services for Children with Special Needs plan.

The third group—the dual eligibles—are the smallest group but also often the most misunderstood. Although Medicare is their primary coverage, they often need expensive long-term care not covered by the federal program. This group represented 9% of enrollment and 15% of spending.

Of Medicaid's total budget, about 23% was spent on insurance premiums to health plans, about 45% for acute care (including disproportionate-share payments) and about 30% for long-term care.

Summary of Medicaid Payments, FY 2006

	Broad Eligibility Category			
Total Spending	**Family**	**Disabled**	**Dual**	**Total**
Enrollees	*102,600*	*28,400*	*12,400*	*142,500*
Acute care	$117,364,953	$369,195,939	$25,606,276	**$512,167,169**
Long-term care	$35,166,791	$209,582,946	$160,096,473	**$404,846,210**
Medicare cost-sharing	$ –	$ –	$19,947,574	**$19,947,574**
Insurance premiums	$246,071,534	$63,183,253	$48,806	**$309,303,594**
Subtotal	**$398,603,278**	**$641,962,139**	**$205,699,129**	**$1,246,264,546**
Not specific to individuals				$94,106,346
Total Spending				**$1,340,370,892**

	Broad Eligibility Category			
Percentage Split of Spending	**Family**	**Disabled**	**Dual**	**Total**
Enrollees	*72%*	*20%*	*9%*	*100%*
Acute care	9%	28%	2%	**38%**
Long-term care	3%	16%	12%	**30%**
Medicare cost-sharing	0%	0%	1%	**1%**
Insurance premiums	18%	5%	0%	**23%**
Subtotal	**30%**	**48%**	**15%**	**93%**
Not specific to individuals				7%
Total Spending				**100%**

	Broad Eligibility Category			
Spending per Enrollee per Mo.	**Family**	**Disabled**	**Dual**	**Total**
Acute care	$95	$1,083	$172	**$300**
Long-term	$29	$615	$1,076	**$237**
Medicare cost-sharing	$0	$0	$134	**$12**
Insurance premiums	$200	$185	$0	**$181**
Subtotal	**$324**	**$1,884**	**$1,382**	**$729**
Not specific to individuals				$55
Total Spending				**$784**

Notes:
1. *Totals are by date of payment and therefore differ from the table on p. 23, which is by date of service.*
2. *This table excludes some payments of Medicare premiums.*
3. *"Payments not specific to individuals" include supplementary payments to disproportionate share hospitals, final settlements to providers paid according to cost, and accruals for future payments.*

Medicaid Spending in FY 2007

Responsibility Center	FY 2006	FY 2007 (Preliminary)
Disproportionate Share Hospital Payments (6020) *Supplementary payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients*	$40,741,719	$68,342,856
Day Treatment (6030) *Day treatment programs for people with mental illness*	$25,737,746	$17,133,449
Inpatient Hospital (6050) *Payments to acute-care hospitals for inpatient care*	$272,000,292	$283,558,521
Outpatient Hospital (6060) *Payments to acute-care hospitals for outpatient care*	$29,424,103	$27,505,845
Insurance Premiums (6070) *Mostly payments to managed care organizations. Also includes some payments by Medicaid of Medicare premiums.*	$329,875,665	$316,797,900
Intermediate Care Facilities for the Mentally Retarded (6110) *Residential care for beneficiaries with intellectual disabilities*	$76,113,435	$84,704,487
Physician Services (6120)	$20,922,164	$22,190,916
Residential Treatment (6130) *Non-hospital inpatient care for people with mental illness*	$13,603,718	$10,028,574
Nursing Facilities (6140, 6080)	$174,054,515	$171,891,906
Vendor Payments (6150)		
Pharmacy	$63,332,613	$65,844,463
Home health and personal care	$41,388,847	$62,147,390
Medical transportation	$20,760,716	$10,409,230
Durable medical equipment	$11,403,960	$12,142,172
Private clinic	$9,340,754	$9,009,331
Federally qualified health centers	$6,640,749	$9,302,403
Lab & x-ray	$4,056,040	$4,065,014
Hospice	$1,723,560	$2,515,706
Mental health clinic	$1,173,900	$934,037
Dental	$905,774	$2,103,901
Other (podiatrist, optician, etc.)	$1,561,201	$1,563,174
Cost Settlements/Medicaid Accrual (6160) *Net impact of retroactive payment adjustments due to cost settlements for providers paid based on their costs*	$10,616,090	$36,625,231
D.C. Mental Health & St. Elizabeth's Hospital (6170)	469,605	$28,197,766
D.C. Fire & EMS *Emergency ambulance service*	$3,661,416	$3,399,246
Addiction, Prevention and Recovery Administration *Services to Medicaid beneficiaries*	$1,375	$8,176
D.C. Public Schools (6180) *Payment for health services provided to students enrolled in Medicaid, typically for students with disabilities*	$18,942,952	$17,349,760
D.C. Child & Family Services (6190) *Payment for health services provided to clients enrolled in Medicaid, typically for managing care for people with disabilities*	$70,601,246	$32,257,168
Waivers (Innovative programs operated under waivers from the federal government)		
Elderly & Physically Disabled Waiver *For people at risk of nursing home placement*	$19,411,997	$32,856,736
Developmental Disability Waiver *Services for people with intellectual disabilities*	$17,532,533	$31,190,925
Childless Adult Waiver *Childless adults age 50-64 enrolled in managed care*	$13,289,618	$12,857,143
HIV 1115 Waiver *Initiatives to prevent or delay serious illness for HIV+ individuals*	$3,530,368	$1,898,348
Subtotal Payments for Care	**$1,302,818,672**	**$1,378,831,774**
MAA Administration (6010)	$31,737,275	$34,056,283
TOTAL	**$1,334,555,947**	**$1,412,888,067**
Average Enrollees per Month	142,539	142,046
Average Spending per Enrollee per Month	$762	$809

Notes

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

2. FY 2007 numbers are preliminary data as of November 2007.

3. Prescription drug spending includes the net effect of rebates (credit) and "clawback" payments to the federal government (debit).

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

Medicaid's Role as a Purchaser

THE MEDICAID AGENCY PROVIDES no services directly. Instead, MAA acts a purchaser—almost certainly the biggest single health care purchaser in the District. In some markets, such as hospital and physician care and prescription drugs, Medicaid is one player along with Medicare and the commercial plans. In other markets, however, Medicaid is typically the largest or even the only purchaser.[16] These markets include residential and other services for people with intellectual disabilities, personal care, case management, community mental health care, and adult day care.

In setting payment rates, Medicaid's goals are enabling access to care; rewarding efficiency; encouraging quality; minimizing administrative burden; simplicity; and fairness (i.e., similar payment for similar services). How best to strike this balance varies for the 39 provider categories used in calculating payment (see table).

Medicaid Payment Methods as of October 2007

Method	Provider Categories
Fee schedule	Prescription drugs, home health and personal care, physician, dental, durable medical equipment, emergency ambulance, podiatry and other professional services
Payment per visit	Hospital outpatient (each hospital is paid a single rate for all visits)
Payment per day	Nursing facility, intermediate care facilities for the mentally retarded, day treatment, psychiatric residential treatment, hospice
Payment per episode	Hospital inpatient
Payment per person (capitation)	Managed care, non-emergency transportation
Cost reimbursement	Case management and other Medicaid services provided by other D.C. agencies such as the public schools and the Department of Mental Health

Notes: *The table omits lump-sum Medicaid "DSH" payments to hospitals and nursing facilities that serve a disproportionate share of Medicaid and uninsured patients, as well as Medicaid payments of Medicare cost-sharing amounts for dually eligible beneficiaries.*

In October 2007, Medicaid began making capitation payments to a broker contractor for non-emergency transportation; previously, payment was made by fee schedule to numerous individual providers (see page 19). In FY 2008, MAA will incorporate significant quality incentives in its payment method for managed care services (see page 14). The agency will also begin revising its inpatient hospital payment method by updating the Diagnosis Related Groups casemix measure.

Managing Payment *and* Information

In September 2007, MAA signed a contract for a completely new Medicaid Management Information System (MMIS), the claims processing computer system that is at the heart of every Medicaid program. In addition to processing two million claims a year, the new system will include a secure web portal that will allow providers to submit claims and perform many other functions; a clinical case management system; a new data mart that will give MAA staff desktop access to the detailed data needed for excellent program administration; and major improvements to the subsystems for surveillance and utilization review, management and administration reporting, and third party liability.

While the current system is 25-year-old Cobol technology, the new system will be a DB2 relational database system.

After an extensive procurement process, MAA chose ACS Government Healthcare Solutions to build the new system, with a go-live date of October 2009. The company has served as the District's claims processing contractor since 2001 and will continue in this role through 2014. The total value of the contract is $111 million. Nationwide, ACS processes almost 550 million Medicaid claims a year with payments to providers approaching $50 billion.

Notes

1 Gary Claxton, Jon Gabel, Bianca DiJulio and others, "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs* 26:5 (September/October 2007), pp. 1409, 1411.

2 Alan Weil, "There's Something about Medicaid," *Health Affairs* 22:1 (January/February 2003), pp. 21-30.

3 In 2005, the percentages of total spending represented by administration and the net cost of insurance were 7.0% for Medicaid and 14.1% for private insurance. Aaron Catlin, Cathy Cowan, Stephen Heffler et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs* 26:1 (January/February 2007), p. 150.

4 U.S. Department of Health and Human Services, *National Call to Action to Promote Oral Health*, NIH Publication No. 03-5303 (Rockville, MD: U.S. DHHS, 2003).

5 Medicaid/SCHIP Dental Association, *Adult Dental Benefits in Medicaid*, available at www.medicaiddental.org.

6 Thomas M. Selden and Bradley M. Gray, "Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs* 25:6 (November/December 2006), p. 1571.

7 Jennifer King and the State Planning Grant Team, *Insurance and Uninsurance in the District of Columbia: Starting with the Numbers* (Washington, D.C.: D.C. Department of Health and the Urban Institute, 2005), pp. 13-20; Catherine Hoffman, Karyn Schwartz and Jennifer Tolbert, *The Uninsured: A Primer*, Publication No. 7451-03 (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2007). Each report contains analysis of the characteristics of people who are or are not covered by employment-based insurance.

8 For a more complete explanation at the national level, see Andy Schneider et al., *The Medicaid Resource Book*, Publication No. 2236 (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2002), pp. 3-48. For more specific information, see D.C. Department of Human Services, *IMA Policy Manual,* available at www.dhs.dc.gov.

9 Chanza Baytop, Lorraine Bell, Brian Blankespoor and others, *Evaluation of the District of Columbia's Medicaid Managed Care Program: 2005-2006* (Washington, D.C.: Abt Associates, November 2006), pp. 80-84.

10 Tarren Bragdon, *A Case for Inclusion: An Analysis of Medicaid and Americans with Mental Retardation and Developmental Disabilities* (Washington, D.C.: United Cerebral Palsy, 2006).

11 Delmarva Foundation, *Medicaid Managed Care Organizations External Quality Review Annual Report* (Washington, D.C.: Delmarva Foundation, 2006): Appendix 2, Performance Measure Results.

12 In 2006, a random sample of 2,400 beneficiaries in Medicaid managed care plans was surveyed, with a response rate of 51%. In 2007, a random sample of 800 Medicaid fee-for-service beneficiaries was surveyed, with a response rate of 36%. See Chanza Baytop, Autumn Wiley, Allison Ackerman and others, *District of Columbia Consumer Assessment of Medicaid Health Plans* (Washington, D.C.: Abt Associates, October 2006) and Chanza Baytop, Sara Collins, Allison Goldberg and others, *District of Columbia Consumer Assessment of Medicaid Health Plans: FFS Population* (Washington, D.C.: Abt Associates, August 2007).

13 For an overview, see Gary Smith, Janet O'Keeffe, Letty Carpenter, and others, *Understanding Medicaid Home and Community Services: A Primer, Report to the Department of Health and Human Services* (Washington D.C.: George Washington University, Center for Health Policy Research: 2000).

14 The federal Office of the Actuary projects annual growth in nationwide Medicaid drug spending between 2007 and 2016 at 7.4% a year, slightly less than Medicaid overall (8.0%) but significantly higher than economic growth (GDP) at 4.7%. Centers for Medicare and Medicaid Services, Office of the Actuary, *National Health Expenditure Projections 2006-2016* (Baltimore: CMS, 2007), Tables 1, 3 and 11.

15 U.S. Attorney for the District of Columbia, "President of Transportation Company Found Guilty of Falsely Billing D.C. Medicaid over $1.8 Million (news release, April 22, 2007).

16 Kevin Quinn and Martin Kitchener, "Medicaid's Role in the Many Markets for Health Care," *Health Care Financing Review* 28:4 (Summer 2007), pp. 69-82.

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?	Office of Disabilities and Aging or Aging and Disability Resources website	202-442-5939 http://www.adrcdc.org
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, 202-408-4720 **Health Right:** 877-284-0282, 202-218-0380 **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 arrange transportation to my doctor?	Non-Emergency Transportation Program	866-796-0601
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
How do I find a dentist who accepts Medicaid?	Medicaid dental helpline	202-698-2000, 202-639-4030
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:** 800-273-4962 **Other:** 202-442-5988
How do I get a job at MAA?	D.C. Department of Human Resources	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

Government of the
District of Columbia
Adrian M. Fenty, Mayor