

Working Together for Health

MEDICAID ANNUAL REPORT
FY 2005

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION



Working Together for Health

MEDICAID ANNUAL REPORT FY 2005

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

Highlights of FY 2005 and A Look to FY 2006	2
Quality Health Care for Vulnerable Populations.....	3
<i>A message from Department of Health Director Gregg Pane</i>	
Our Responsibility to Over 140,000 Residents	4
<i>A message from Medicaid Director Robert Maruca</i>	
Serving District Residents	5
<i>Growth in enrollment; overview of spending; changes in eligibility</i>	
Managing Care for Health and Cost Control.....	8
<i>Managed care enrollment; improvements in quality; new initiatives</i>	
Here for Health	10
<i>A dozen initiatives to improve health for Medicaid beneficiaries</i>	
Helping People with Long-Term Care	14
<i>Funding individualized care for some of our most vulnerable neighbors</i>	
The D.C. Resource Center	16
<i>Helping D.C. residents navigate the maze of options for long-term care</i>	
Partnerships with Providers.....	17
<i>How MAA serves the providers who serve Medicaid beneficiaries</i>	
Medicaid's Economic Impact on D.C.....	17
<i>Promoting a healthy workforce and providing revenue to D.C. employers</i>	
Spending Dollars Wisely	18
<i>Initiatives to bring in revenue, purchase carefully and protect against fraud</i>	
Working for Medicaid Beneficiaries.....	20
<i>Profiles of the work done for beneficiaries by D.C. employees</i>	
Understanding Medicaid Finances	22
<i>Overview and insight into the Medicaid budget</i>	
For More Information.....	<i>Back cover</i>

Highlights of Fiscal Year 2005 and a Look to 2006

THE MEDICAID PROGRAM IN FY 2005

- **Enrollment.** In FY 2005, Medicaid enrollment averaged 141,729 xx people a month, or one quarter of the District's population. Enrollment was up 1.9% from FY 2004. See page 6.
- **Spending.** For the fiscal year ended September 30, 2005, Medicaid spending for health care is projected at \$1.26 billion, up 3.3%. Payment per enrollee per month is projected to be \$742, up 1.4%. See page 7.
- **Economic impact.** 92% of Medicaid payments are made to health plans and providers located in D.C. Medicaid also brings in about \$900 million 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 their Medicaid coverage while maintaining their employment. See page 10.
- **More emphasis on managed care quality.** Medicaid began requiring its four managed care organizations to report results on 41 nationally accepted measures of quality. In FY 2006, all MCOs will be required to be accredited 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.

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 Alliance. The expansion would generate \$19 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 7.
- **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.

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 District residents (one in four) who are served through the program. The breadth of services encompass 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.

This annual report on Medicaid services in the District is a testimony to all of you that 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.

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

Gregg Pane, MD



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 approaches \$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 recipients. 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, MCOs must meet high standards of quality that are measured for ongoing improvement. We are requiring our MCOs to become a member of NCQA, a nationally recognized organization, to ensure better quality reporting and oversight. Additionally, we have instituted a reporting process for them, which will require 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 the 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
Senior Deputy Director
Medical Assistance Administration
Department of Health

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.

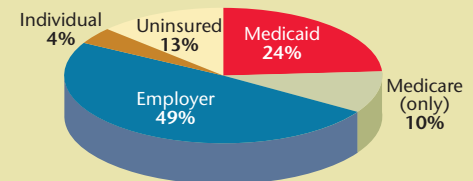
■ **Serving 142,000 residents a month.** In the 2005 fiscal year that ended September 30, D.C. Medicaid served an average of 141,729 residents a month, a 1.9% increase from FY 2004.¹ Since many beneficiaries move on and off Medicaid during a year, the number of people served at some point during FY 2005 was even higher.

■ **How Medicaid fits in.** The U.S. health insurance system was built on employment-based coverage. When employers offer health plans, they pay an average of 75% of the cost, which now exceeds \$10,000 a year for family coverage.² Workers get a break: taxes aren't payable on the employer's contribution. But more and more employers don't offer health plans, especially to new hires, part-time workers or workers earning under \$15 an hour.³ Medicare is available for people age 65 and over, regardless of income, and for people whose disabilities prevent them from working. Individually purchased insurance is prohibitively expensive for almost everyone. Medicaid fills in some large gaps, especially for low-income children and their parents, people with disabilities, and some Medicare beneficiaries. The uninsured population tends to include childless couples, single men and others who don't 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 No. 2 source of insurance.** Medicaid covers about one-quarter of the D.C. population in an average month. About half the population has employment-based coverage.⁴

■ **Critical for kids.** Medicaid covers 44% of D.C. kids under age 18 while employment-based plans cover 43% of children, according to the Kaiser Commission on Medicaid and the Uninsured.

D.C. Health Insurance Coverage, 2003



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

Medicaid Spending by Fiscal Year Ending Sept. 30

	FY 2004 Actual	FY 2005 Projected	FY 2006 Budgeted
Spending for Care	\$1,221,035,000	\$1,262,424,000	\$1,337,197,753
Average Enrollees per Month	139,021	\$141,729	\$xx
Average Spending per Enrollee per Month	\$732	\$742	\$xx

MEDICAID SPENDING AND SERVICES

■ **Spending trends.** Medicaid payments for care are projected to be \$1.26 billion in FY 2005, making Medicaid the largest item in the D.C. budget (check). The year-over-year increase is projected to be 3.3%, reflecting a 1.9% increase in average monthly enrollment and a 1.4% increase in spending per enrollee per month. The 1.4% figure compares very well with the nationwide 9.2% increase in the average cost of an employment-based health plan.⁵

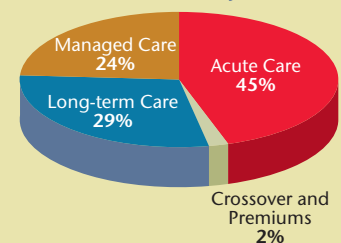
■ **A foundation of managed care.** About 94,000 beneficiaries are enrolled in managed care in an average month. These beneficiaries are typically children and working age adults without disabilities. About one-quarter of the Medicaid budget is spent purchasing care for these people.

■ **Care for the elderly and people with disabilities.** The 48,000 beneficiaries not enrolled in managed care plans are typically either elderly 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. Employment-based plans and individually purchased 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.

**Medicaid Payments FY 2005
\$1.26 Billion (Projected)**



CHANGES IN ELIGIBILITY

■ **Eligibility form cut by 12 pages.** In FY 2005, the application for Medicaid benefits was simplified and cut from 18 pages to xx 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, and about 500 unborn children of pregnant immigrant women. These groups are now covered by the D.C. Healthcare 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 heavy 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. Including unborn children means that 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 120% of the FPL. For another group of Medicare beneficiaries, Medicaid will pay their Medicare Part B premiums if their income is under 100% 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 Population Demographics FY 2004

	Number	%
By Sex		
Male		40%
Female		60%
By Age		
Under 17		46%
18–21		6%
22–64		35%
65 and over		13%
By Race		
Black		85%
White		2%
Other		13%
By Ward		
1		11%
2		14%
3		2%
4		11%
5		13%
6		12%
7		16%
8		19%
Unknown		2%
TOTAL		100%

The Federal Poverty Line

Medicaid eligibility often depends on family income relative to the federal poverty line (FPL). For example, one eligibility category may be limited to people with income below 100% of the FPL while another may be limited to people with income below 150% of the FPL. This table shows the FPL by family size that is applicable to D.C. in calendar year 2005.

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

Managing Care for Health and Cost Control

Two-thirds of D.C. Medicaid beneficiaries receive health care from one of four managed care organizations. Medicaid is expanding the scope of coordinated care to include more people with disabilities and is moving to increase the quality of care.

■ **Medicaid managed care.** In 1994 the District began a major effort to promote managed care for children and for adults without disabilities between ages 21 and 64. In 1997, the District moved to mandatory enrollment for certain eligibility groups. Today, two-thirds of D.C. Medicaid enrollees belong to one of four MCOs: America Group, xx D.C. Chartered Health Plan, Health Right, Inc., or HSCSN. Check enrollment totals in chart.

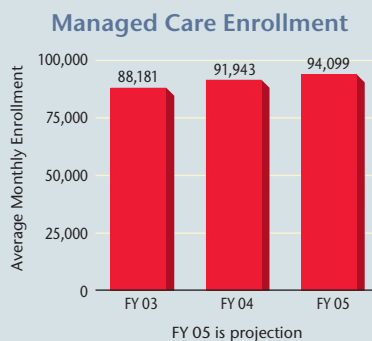
■ **Scope of services.** MCOs are responsible, both financially and clinically, for almost all Medicaid services provided to MCO members.

■ **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, Medicaid requested federal approval to make outpatient care for substance abuse a Medicaid service, which would bring \$3.0 million a year xx in new federal funding to the District. MAA is negotiating agreements with the MCOs so that this care can be integrated with the other care they provide to their members.

■ **MCO membership.** Traditionally, Medicaid MCOs have served children and non-disabled adults age 21-64 (often, the mothers of the children). Their health care needs are similar to those of people with employment-based insurance, which the first MCOs served. D.C. Medicaid has expanded this traditional focus to bring the benefits of coordinated and cost-effective care to people with disabilities. One MCO, Health Services for Children with Special Needs Inc. serves about 3,300 Medicaid children a month. And in FY 2005, Medicaid expanded MCO membership to include 643 adults with disabilities who are in the 50-64 age group. The goal is that these beneficiaries receive improved coordination of care and better management of complex medical conditions. They will also become eligible for limited dental benefits, which adults in regular Medicaid do not receive.

■ **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.⁶ 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 that all MCOs serving Medicaid beneficiaries be accredited by the National Committee for Quality Assurance (NCQA). The NCQA, a national, not-for-profit organization, is often described as the watchdog of the managed care industry. Teams of NCQA physicians and other experts will visit each MCO to rate it on patient safety, service, confidentiality and other standards.⁷



Carole Colbert and Family

"I thank God for Medicaid," says Carole Colbert, a 43-year-old mother of six and grandmother of four, who has spent most of her life with the program. Today, Ms. Colbert's two daughters Jewel, 2, and Aniya, 5, her son, Randy, 7, and her grandson Demetrius, 11, live with her.

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."

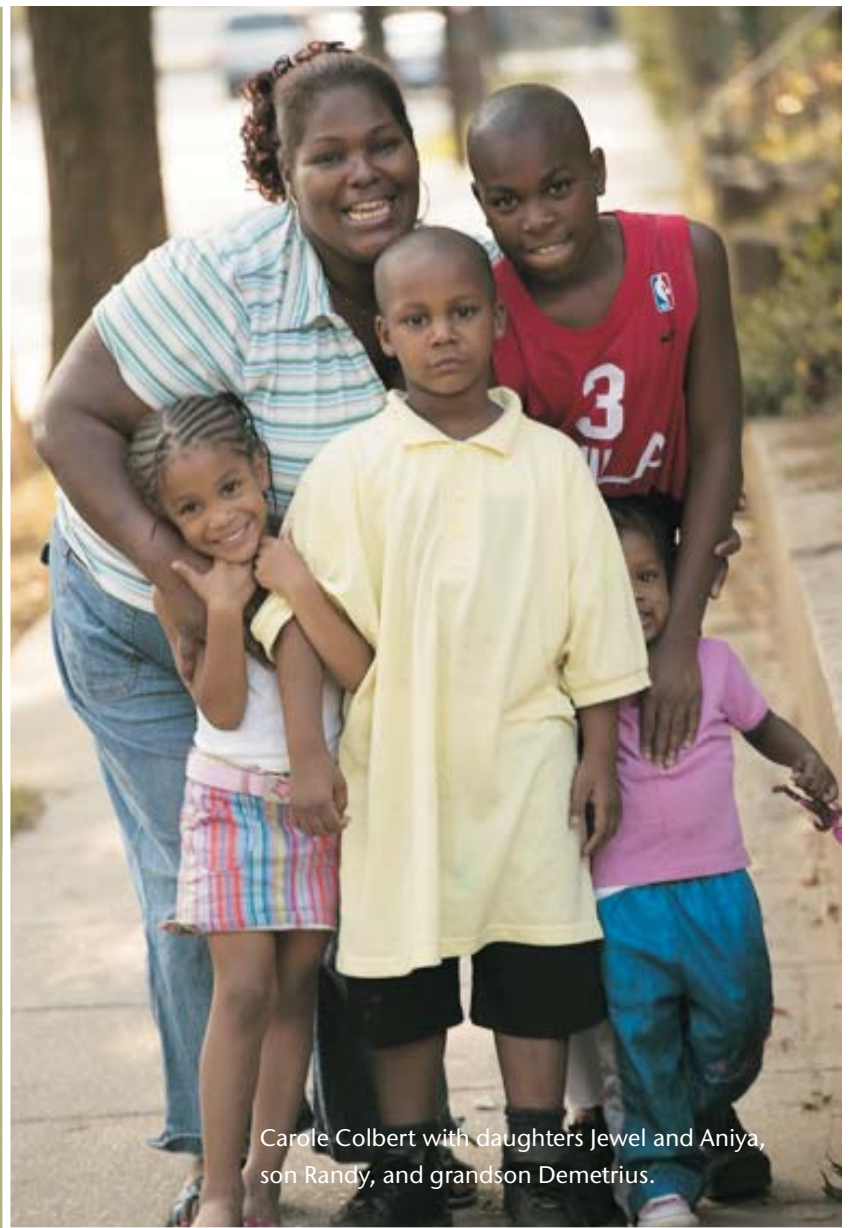
Reflecting on an early experience with her oldest daughter, Ora, now 22 years old, Ms. Colbert recalls: "One day, Ora was just walking on the grass, and she twisted her whole leg on a piece of metal that was stuck in the grass." Ora had to be rushed to the hospital for knee surgery. "If it wasn't for 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 for beneficiaries.

Ms. Colbert's family is enrolled in Chartered Health Plan and she sees the benefits for herself and her children today. "Before Chartered," she explains, "my children and I would miss doctor's 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's role providing insurance for over 41 million Americans gives 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 benefit 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 chronic diseases. About xxx D.C. residents dually eligible for Medicare and Medicaid are participating in Medicare Health Support, which was previously called the Chronic Care Improvement Program. Participation is free and voluntary. 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 assist with data analysis.

■ **Reaching out to the non-English speaking community.** 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. For example, brochure colors were 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. Previously, no information concerning such rights was provided to the non-English speakers.

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. 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.

■ **Standardized child health screening form will improve care.** In FY 2005, Medicaid piloted a standardized form for Health Check, the District's program to make sure every child gets early screening and treatment for health problems. (Health Check is the D.C. version of the national Medicaid program called EPSDT.) Medicaid collaborated with physicians and managed care organizations to develop a new Standard Medical Record Form for Health Check. 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 MCOs. The registry will enable MAA to make sure Health Check services take place. As well, authorized providers and MCO staff will be able to view a child's immunization history, preventive health care visit history and blood lead testing history. This almost-complete 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 to the registry.

■ **Drug utilization review (DUR) 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 claims files provide an overview that no individual physician has, the board can draw 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 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.

■ **Inter-agency collaboration to improve health of D.C. residents.** Better delivery of health care services can sometimes be achieved with better coordination of services. That was the conclusion of MAA and several other D.C. agencies that signed a July 2005 a Memorandum of Understanding (MOU). Parties to the MOU include the Department of Health, Department of Mental Health, Mental Retardation and Developmental Disabilities Administration, D.C. Public Schools, Maternal and Child Health Administration, Family Services Administration, Addiction Prevention and Recovery Administration, and the Department of Youth Rehabilitation Services. The intended results are increased efficiency, increased interagency data sharing, and better coordination of services to beneficiaries.

■ **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 organizations, Medicaid providers, community-based organizations, and the Office of Immunization's Vaccines for Children program, MAA increased the immunization rate of its Medicaid population from 63% in October 2000 to 73% in October 2004, exceeding its original goal of 72% for children below 2 years old. MAA's overall immunization rate for school-age children is 95%. MAA's targeted immunization initiative is improving the health of the District's most vulnerable population.

■ **Focusing on childhood obesity.** Recognizing the increasing need to prevent obesity from an early age, participating managed care organizations conducted a study to establish baseline data on obese and overweight children and youths ages 0-21 years old. As a result of the study, MAA developed guidelines for the identification of care for

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 benefits 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).

obese/overweight children, adopted a mandatory screening age of 2 years old to assess obesity/overweight symptoms based on a height, weight and body mass index, developed an appropriate model for treatment, and trained MCO practitioners on the treatment model in June 2005. To ensure continued refinement of these efforts, MAA established the Obesity Prevention Advisory Committee, comprised of D.C. agencies, the public schools, and community stakeholders.

■ **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.⁸ Using a combination of focus groups, health fair participation, and increased outreach efforts in partnership with managed care organizations, 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, in March 2005 MAA implemented a dental helpline to help beneficiaries locate providers.

■ **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. No 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 confidential 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, 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 takes a broken person and makes him feel whole”

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 Center.

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 someone less fortunate,” he says. “That’s my goal.” For

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 796 xx people to live at home instead of 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. For a beneficiary such as Mimi D. Atkins (see page 15), the HCBS program pays for attendants to help her with daily activities like eating and dressing. For other beneficiaries, the HCBS program may pay for 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 392 beneficiaries a month, up from 197 in FY 2004. These people otherwise would typically be living in a nursing facility. The HCBS program for people with mental retardation and developmental disabilities served an average of 404 beneficiaries a month, an increase from 397 in FY 2004. These people otherwise would be living in an intermediate care facility.¹

■ **Robert Wood Johnson grant will evaluate innovative D.C. program.** The prestigious Robert Wood Johnson Foundation awarded a grant to evaluate the Medical House Call Program (MHCP) for Medicaid beneficiaries. The Medical House Calls Program coordinates all home, hospital and community-based care through home visits to beneficiaries with chronic illnesses and limited mobility. 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 for 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 heavier care needs and less for patients with lesser 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 400 xx beneficiaries more flexibility in the home and community based services they receive. Called "consumer-directed care," the initiative will give beneficiaries more flexibility within a defined budget to decide which services they need to live as independently as possible. They will also have more involvement in the hiring and firing of 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 attached to 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."

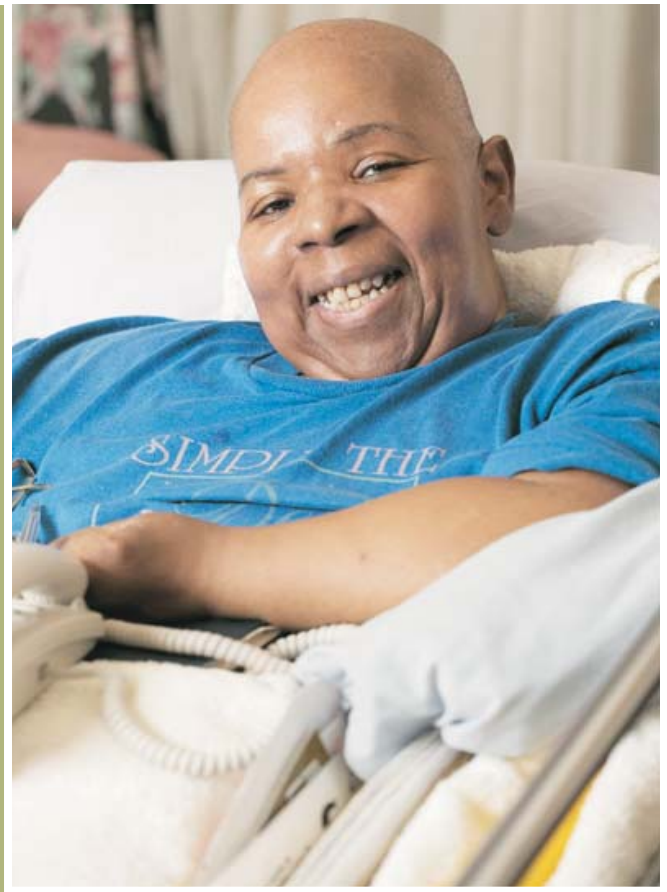
It was obvious that Ms. Atkins's mother, herself approaching 80, couldn't continue to care for her. Medicaid would pay for nursing facility care after Ms. Atkins exhausted her life savings, which, because of the cost of nursing facility care, usually doesn't take long. Instead, a doctor suggested Medicaid's 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 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 set up, how well they're eating, what they do as 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"

New Resource Center Helps Residents Navigate 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.

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 similar condition; 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.

When you can no longer live at home on your own, the options are baffling. Home health care, assisted living, nursing home? 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 204-3540, or email inquiries to info@resourcecenter.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

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 organizations and then the MCOs pay physicians, hospitals, pharmacies and other providers. The other 46,000 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 7.1 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, while other Medicaid programs in this region 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. Xx Need to add pharmacy claims.

■ **Increased communication with providers.** In FY 2005, MAA’s claims processing contractor handled 76,000 phone calls from providers with an average answer time under 30 seconds. Comparable data aren’t available for FY 2004 because of a change in the scope of work. In addition, MAA and its contractor increased their provider education efforts, which include quarterly newsletters, brochures on reducing billing errors and other topics, and one-on-one visits from Medicaid field representatives.

Monthly Averages of Participating Providers

	FY 2003	FY 2004	FY 2005
Physicians	1,693	1,742	1,752
Pharmacies	181	181	190
Nurse practitioners	26	34	43
Dentists	19	20	23
Medical equipment & supplies	51	53	61
Transportation (excluding amb.)	146	152	181
Lab & X-ray providers	439	400	378

Note: A provider is defined as “participating” if it bills Medicaid at least 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 the productivity of the D.C. workforce.
- 92% of the \$1.22 billion that Medicaid spent on health care in FY 2004 was paid to D.C. health plans and providers. Of the rest, 6% went to Maryland, 1% to Virginia and 0.5% to other states.
- Medicaid is the single largest source of federal government funding to the D.C. government. Medicaid is cost-shared 70/30 between the two levels of government, so every D.C. 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.

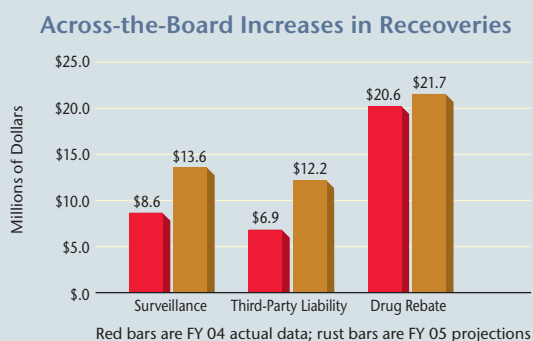
■ **SUR recoveries rise 58%.** In FY 2005 MAA expects to recover \$13.6 million as a result of its surveillance and utilization review (SUR) activities, a 58% jump from FY 2004. Update. The SUR unit monitors payments to health care providers and investigates possible overpayments. These can reflect unintentional 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 \$12.2 million in FY 2005, up 76% from 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 organizations. This effort paid off with a big increase in recoveries.

■ **Focus on cost avoidance.** Although surveillance and TPL activities bring in easily countable 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 decreases in SUR and TPL recovery dollars.

■ 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. To that end, 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 eligibility matches with providers. XX Check.

■ **\$21.7 million in revenue from drug rebates.** Drug rebate revenue rose 5.3% 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. The rebates offset \$xx million in projected pharmacy spending in FY 2005.



- **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 let a contract for a transportation broker that will coordinate requests for service, supervise the service provided by individual transportation services, and monitor providers for fraud. About 3,700 beneficiaries a month use these services.⁹
- **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.
- **Plans 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 of Medicaid 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

John Morrison 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 xx 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 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 of 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 94,000 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 organizations.

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 for combating fraud in the Vaccines for Children program.

■ **Milka Shepard**, a program specialist, joined Medicaid 16 years ago, and now reports to Robert Maruca, 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 PAYMENTS IN CONTEXT

In FY 2005, payments for care are projected to be \$1.26 billion, a 3.4% increase from FY 2004. The increase reflects a 1.9% increase in average monthly enrollment and a 1.4% increase in average monthly payments 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 payments by responsibility center for FY 2004 through FY 2006, while the table on page 23 offers insight into detailed spending patterns in FY 2004. A "recipient" is a beneficiary who receives a specific service at least once in a month.

The D.C. Medicaid Budget			
Notes			
1. The fiscal year runs from October 1 through September 30.			
2. FY 05 numbers are projections as of September 2005.			
3. FY 06 numbers are budgeted numbers as approved XXXX, XX, 2005 by D.C. Council.			
4. "MAA administration" excludes other costs of administering Medicaid, such as the cost of eligibility determination borne by the Income Maintenance Administration.			
Responsibility Center	Actual FY 2004	Projected FY 2005	Budgeted FY 2006
Disproportionate Share Hospital Payments (6020)	\$ 40,566,000	\$ 40,188,012	
Day Treatment (6030)	\$ 27,291,000	\$ 26,530,713	
Inpatient Hospital (6050)	\$ 249,270,000	\$ 272,787,923	
Outpatient Hospital (6060)	\$ 25,007,000	\$ 19,276,729	
Insurance Premiums (6070)	\$ 289,754,000	\$ 305,689,430	
Nursing Facilities (6140, 6080)	\$ 182,048,000	\$ 176,977,991	
Intermediate Care Facilities for the Mentally Retarded (6110)	\$ 77,317,000	\$ 78,405,445	
Physician Services (6120)	\$ 17,053,000	\$ 18,389,101	
Residential Treatment (6130)	\$ 13,089,000	\$ 14,033,602	
Vendor Payments (6150)	\$ 162,754,000	\$ 169,731,140	
Cost Settlement (6160)	\$ 11,300,000	\$ 22,977,417	
St. Elizabeth's Hospital (6170)	\$ 34,559,000	\$ 25,956,923	
D.C. Public Schools (6180)	\$ 19,636,000	\$ 19,375,879	
D.C. Child & Family Services (6190)	\$ 48,736,000	\$ 41,960,556	
Waivers	\$ 22,655,000	\$ 30,143,548	
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	141,729	
Average Payment per Enrollee per Month	\$ 732	\$ 742	

TABLE NOT IN FINAL DESIGN

Responsibility Center	Actual FY 2004	Average Payments per Month	Average Recipients per Month	Average Payments 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	-	\$	\$
Day Treatment (6030) <i>Day treatment programs for people with mental illness</i>	\$ 27,291,000	-	\$	\$
Inpatient Hospital (6050) <i>Inpatient hospital services</i>	\$ 249,270,000	-	\$	\$
<i>Medicare crossover claims</i>	\$	-	\$	\$
Outpatient Hospital (6060) <i>Emergency services</i>	\$ 25,007,000	-	\$	\$
<i>Non-emergency services</i>	\$	-	\$	\$
<i>Medicare crossover claims</i>	\$	-	\$	\$
Insurance Premiums (6070) <i>Mostly payments to managed care organizations. Also includes some payments by Medicaid of Medicare premiums.</i>	\$ 289,754,000	-	\$	\$
Nursing Facilities (6140, 6080) <i>Nursing facilities</i>	\$ 182,048,000	-	\$	\$
<i>Medicare crossover claims</i>	\$	-	\$	\$
Intermediate Care Facilities for the Mentally Retarded (6110)	\$ 77,317,000	-	\$	\$
Physician Services (6120) <i>Physician services</i>	\$ 17,053,000	-	\$	\$
<i>Medicare crossover claims</i>	\$	-	\$	\$
Residential Treatment (6130) <i>Non-hospital inpatient care for people with mental illness</i>	\$ 13,089,000	-	\$	\$
Vendor Payments (6150) <i>Pharmacy</i>	\$ 162,754,000	-	\$	\$
<i>Home health care</i>	\$	-	\$	\$
<i>Medical transportation (e.g., wheelchairs)</i>	\$	-	\$	\$
<i>Federally qualified health centers</i>	\$	-	\$	\$
<i>Durable medical equipment</i>	\$	-	\$	\$
<i>Personal care (assistance with activities of daily living)</i>	\$	-	\$	\$
<i>Mental health clinics</i>	\$	-	\$	\$
<i>Lab & x-ray (facilities separate from hospitals and clinics)</i>	\$	-	\$	\$
<i>Private clinics</i>	\$	-	\$	\$
<i>Hospice</i>	\$	-	\$	\$
<i>Dental</i>	\$	-	\$	\$
<i>Other vendor payments (e.g., optometrist, rehabilitation)</i>	\$	-	\$	\$
<i>Drug rebates</i>	\$	-	\$	\$
<i>Medicare crossover claims</i>	\$	-	\$	\$
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	-	\$	\$
St. Elizabeth's Hospital (6170) D.C.-owned psychiatric hospital	\$ 34,559,000	-	\$	\$
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	-	\$	\$
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	-	\$	\$
Waivers <i>Innovative programs operated under waivers from the federal government. Waivers typically provide services that allow people to remain at home even though they are at risk of being placed in an institution.</i>	\$ 22,655,000	-	\$	\$
MAA Administration (6010) <i>Includes MAA staff and payments to the contractors that process Medicaid claims and perform related functions. Excludes Medicaid administration costs borne by other agencies, such as the Income Maintenance Administration.</i>	\$ 30,704,000	N/A	N/A	N/A
Total	\$ 1,251,739,000			

MEDICAID ADMINISTRATION

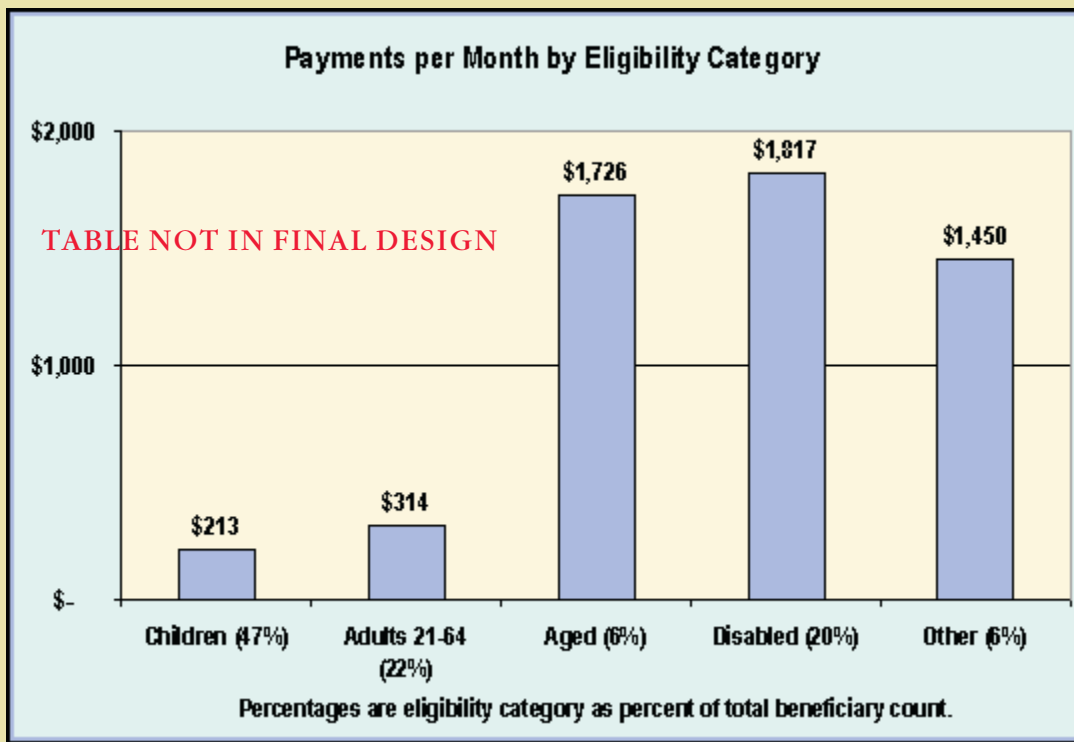
The Medical Administration Agency (MAA) is the lead agency for administering the Medicaid program. MAA spending on Medicaid administration in FY 2005 is projected to be \$36.7 million. This figure includes both the salaries of Medicaid staff and payments to contractors, such as those that process Medicaid 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 totalled, however, Medicaid is still much cheaper to administer than commercial insurance, where the cost of administration averages 13.6% of payments for care, according to CMS.¹¹

PATTERNS OF PAYMENT

Medicaid spending is highly correlated with the type of eligibility a beneficiary has. On average, payments are 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 payments. They are primarily enrolled in Medicaid managed care organizations.

On the other hand, payments are relatively high for people aged 65 or more and for people with disabilities. For some of these people, 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 have similar needs) represent 31% of Medicaid enrollment but 76% of Medicaid payments.



For More Information

Information Need	Resource	Contact Information
Am I eligible for Medicaid?	D.C. Department of Human Services, Income Maintenance Administration	202-724-5506 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@dcreourcecenter.com 2311 Martin Luther King Ave. SE (near Anacostia Metro; walk-ins welcome)
Who do I call if I have questions about my Medicaid benefits?		
I'm a federal policy analyst or a journalist who needs information about D.C. Medicaid policy or budget.	Office of the Medicaid director	202-442-5988
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: 202-906-8418 Eligibility certification: 202-610-1847 Other inquiries: 202-906-8319
I'm a health care provider. how do I obtain prior authorization for services?	?? xx	??xx
How do I get a job at MAA?	??xx	??xx
All other inquiries	D.C. Medical Assistance Administration	202-724-5988 www.doh.dc.gov



This report was a collaborative effort between the D.C. Department of Health, Medical Assistance Administration, and ACS Government Healthcare Solutions.

DRAFT