Working Together for Health

MEDICAID ANNUAL REPORT
FY 2008

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

D.C. DEPARTMENT OF HEALTH CARE FINANCE

On the cover: Dr. Cheryl Focht, Enrique Lopez and Marietta E. Thurston. All beneficiaries named in this report are included with their permission or that of their parent or guardian.

This report is available on the Web at www.dhcf.dc.gov.

Working Together for Health

The Health of Our Children

From Mayor Adrian Fenty

SIXTY-ONE PERCENT OF D.C. CHILDREN COUNT ON THE MEDICAID PROGRAM for health insurance. In the public schools, the percentage is undoubtedly higher. As we build a world-class public school system—as we build a world-class capital city—it is essential that our children be as healthy, as ready to learn, as we can help them be.

We take this responsibility very seriously. Compared with commercial insurers, Medicaid funds a broader range of services and does more to encourage preventive care and a broad view of health. In this report, you will learn how every child of modest family income has access to health insurance in D.C. You will meet Destiny Lawrence, age 6, and the Lopez boys, ages 2 and 10, as they have their annual medical exams. And you will learn about the standard medical record form, a collaborative effort to improve care for our young people.

I am proud that this year we released the first-ever Children's Health Action Plan. When it comes to children, it is essential that all of us—parents, community organizations, caregivers and multiple D.C. agencies—work together. Medicaid provides very substantial funding; this past year, Medicaid and its managed care plans paid $277 million directly to providers of health care for children, especially for children with disabilities.

Every child of modest family income has access to health insurance

Although this year's Medicaid annual report has a special focus on child health (pages 12-15), you will also learn about many other services funded by the Department of Health Care Finance. You will meet Marietta E. Thurston, who is able to live at home instead of in a nursing facility; Victor Musgrove, who has Medicaid coverage here but would be uninsured in most states; and Eurice Marsh, who now has a home of her own after a lifetime of institutions and group housing. By allowing their stories to be told, they help us understand the importance of health care coverage to the 192,026 people enrolled in Medicaid or the D.C. Healthcare Alliance.

This report also reflects my pledge to be transparent and accountable to the D.C. residents I serve. It explains Medicaid and Alliance eligibility, describes how seniors and people with disabilities can learn about the many services available to them, and shows you how Medicaid spent $1.6 billion and the Alliance spent $116 million in FY 2008.

As we continue to work together for health, I thank everyone who has helped the Medicaid and Alliance programs improve the health of District residents. For ourselves and especially for our children, health is so important to our future.

Adrian M. Fenty
Mayor

Our Goal Is Health

From the Director, Department of Health Care Finance

IN THE DISTRICT OF COLUMBIA, THE MEDICAID PROGRAM can make a real impact on the health of the population. Together, Medicaid and the D.C. Healthcare Alliance provide the essential protection of health insurance to one in three Washingtonians. In this annual report, we describe our work in fiscal year 2008 to improve health outcomes by ensuring access to quality health care. Let me start by mentioning some of the highlights of the year, organized by the five themes that run through this report.

- **Ensuring access.** Medicaid covers a higher proportion of the population in D.C. than in any state. Every District resident of modest income can obtain health insurance. See pages 4 and 10.

- **Expanding benefits.** In FY 2008, we continued to expand home and community based services for people who, without these services, otherwise would have to live in a nursing facility or other institution. The Department also won a $26 million grant under the federal "Money Follows the Person" initiative. See pages 7, 16 and 17.

- **Funding quality services.** Our Medicaid managed care contracts include important new provisions to measure and reward quality care, placing D.C. among the leading Medicaid programs in paying for performance. See pages 8 and 11.

- **Meeting beneficiary needs.** With implementation of the new managed care contracts, one organization ended its role as a Medicaid plan and Unison joined as a new plan. With minimal disruption, almost 40,000 members moved to the other plans (page 8). And, as Mayor Fenty mentioned, this annual report includes a special focus on how Medicaid is a leader in meeting the needs of children and youth (pages 12–15).

Our mission is to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services

- **Value purchasing and improving program efficiency.** On October 1, 2008, Medicaid became a new Cabinet agency, the Department of Health Care Finance. With a strong focus on Medicaid and the Alliance, the new department streamlines decision-making and improves accountability (page 6).

For the Medicaid and Alliance programs, 2008 was quite a year of change. To the many people whose work supports these programs—the Mayor's office, District Council, health care providers, federal officials, agency staff and many others—I extend my thanks and look forward to continued progress in the coming year.

Julie Hudman
Director
Department of Health Care Finance

Covering One-Third of D.C. Residents

Every D.C. resident of modest income can obtain quality, affordable health insurance.

THAT'S A STATEMENT THAT VERY FEW STATES CAN MAKE. By stitching together three separate programs—Medicaid, the State Children's Heath Insurance Program (SCHIP), and the D.C. Healthcare Alliance—the District of Columbia has succeeded in covering 192,026 people, almost all of whom otherwise would lack the protection of health insurance. On this page, we describe sources of coverage in the District.

Population Demographics Medicaid and the Alliance Average Month, FY 2008

By Gender and Age	Medicaid	Alliance
Female under 18	23%	0%
Female 18–21	5%	2%
Female 22–64	24%	43%
Female 65 and over`	6%	2%
All Females	*58%*	*47%*
Male under 18	24%	0%
Male 18–21	3%	2%
Male 22–64	11%	50%
Male 65 and over	3%	1%
All Males	*42%*	*53%*
Unknown	0%	0%
By Race/Ethnicity		
African-American	85%	65%
Hispanic	10%	27%
White/Other	3%	3%
Unknown	3%	5%
By Ward		
Ward 1	10%	18%
Ward 2	13%	15%
Ward 3	1%	1%
Ward 4	12%	21%
Ward 5	14%	12%
Ward 6	11%	8%
Ward 7	18%	12%
Ward 8	20%	13%
Unknown	1%	0%
TOTAL	144,910	47,116

Percentages may not sum to 100% due to rounding.

■ **Medicare**. The federal program covers about 73,000 D.C. residents, or about 13% of the population. Regardless of income, almost everyone age 65 and over has Medicare coverage, as do people under 65 who meet Social Security standards of disability.

■ **Employment-based insurance**. This is the single largest source of coverage, although exact numbers are difficult to estimate. This coverage includes a substantial tax subsidy, estimated (nationally) at $1,573 for an individual and $3,825 for family coverage.[1] But employers may not offer coverage, especially small firms and those that pay low wages.[2] Low-wage workers also may find it difficult to afford the premiums and cost-sharing obligations.

■ **Individual insurance**. A few people buy insurance on their own, but it often limits coverage of pre-existing conditions and is costly. For example, a woman aged 50 may face an annual premium of $4,800.[3]

■ **Medicaid and SCHIP**. Medicaid, which in D.C. includes SCHIP, covered an average of 144,910 people a month in FY 2008, 2% more than FY 2007. The federal government pays 70% of Medicaid spending and 79% of SCHIP spending. Under federal rules, Medicaid eligibility is a complicated topic; see page 5.

■ **The Alliance**. All other D.C. residents of modest income—under $28,000 for a family of two—are eligible for coverage from the Alliance, the cost of which is 100% borne by the D.C. government. The Alliance covered an average of 47,116 people a month in FY 2008, a slight increase from FY 2007.

In contrast to many states, the District works to minimize the differences among Medicaid, SCHIP and the Alliance so that beneficiaries can maintain continuity of coverage and medical care despite changes in age and income. In the Lopez family, profiled on page 12, the parents belong to the Alliance while their children have Medicaid. They all belong to the same managed care plan and have all gone to the same doctor for years.

Working to Simplify Eligibility

ELIGIBILITY FOR INSURANCE COVERAGE ranks among the most complex topics in government, but D.C. is working to make it simple. The goal is to cover all uninsured children with family income under 300% of the poverty line and all uninsured adults with income under 200% of the poverty line.[4] Under federal law, Medicaid eligibility is categorical, which means that an individual must fall into a covered category *and* have family income below specified thresholds. Dozens of categories are often combined into three broad groups.

The Federal Poverty Line

Eligibility for public insurance plans often depends on the federal poverty line (FPL). The 2008 FPL is shown below:

Family Size	50% of FPL	100% of FPL	200% of FPL	300% of FPL
1	$5,200	$10,400	$20,800	$31,200
2	$7,000	$14,000	$28,000	$42,000
3	$8,800	$17,600	$35,200	$52,800
4	$10,600	$21,200	$42,400	$63,600

■ **Low-income families with children.** In D.C., this is the largest category, comprising about 72,000 children and 30,000 adults in 2008. Destiny Lawrence, 6 years old, and her mother, Carla Carland, are members of this group; see page 15.

■ **People with disabilities.** About 32,000 beneficiaries have serious disabilities, such as paraplegia, intellectual disability, or serious mental illness. Some people qualify for both Medicare and Medicaid, while others qualify for Medicaid only. Eurice Marsh is a member of this group; see page 7.

■ **Low-income seniors.** Almost everyone age 65 and over qualifies for Medicare, but Medicare doesn't cover long-term care. For a typical member of this group, Medicare covers acute care expenses such as physician and hospital care while Medicaid covers long-term care and pays Medicare premiums and cost-sharing obligations. Marietta E. Thurston (page 17) is among 10,000 members in this group.

Some people in the disabled and senior groups have incomes higher than those shown in the chart but have very high medical expenses. They "spend down" to levels that make them eligible for Medicaid. (This pathway is known as "medically needy" in contrast to "categorically needy.")

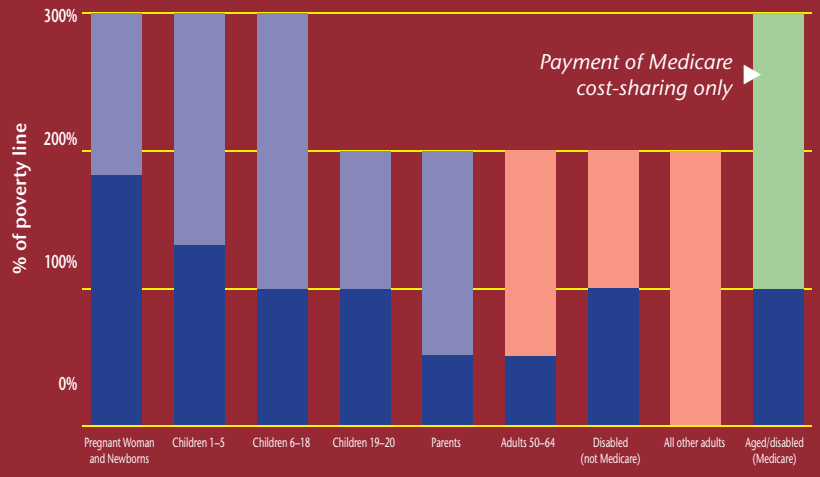
A rare exception to these categories is that D.C. Medicaid covers about 1,500 childless adults aged 50-64 with incomes under 50% of the poverty line. Victor Musgrove is an example; see page 9. This coverage is made possible through a waiver of federal rules.

All other adults with incomes under 200% of the poverty line are eligible for Alliance coverage. Julieta and Roberto Lopez are examples; see page 12.

Eligibility is determined by the Income Maintenance Administration of the D.C. Department of Human Services. Applications are available at one of seven IMA neighborhood service centers, at libraries, at Giant, Safeway, and CVS stores, by telephone at 202-724-5506 or on the web at www.dhs.dc.gov.

Eligibility Standards for D.C. Health Programs, September 2008

Dark blue = Medicaid; light blue = SCHIP; rose = Alliance



Reorganizing to Improve Effectiveness

ON OCTOBER 1, 2008, THE DEPARTMENT OF HEALTH CARE FINANCE (DHCF) WAS CREATED, instantly becoming the largest D.C. department in terms of spending. DHCF replaces what was the Medical Assistance Administration (MAA) within the Department of Health.

Creation of the new Cabinet-level department should improve effectiveness and accountability within the Medicaid and Alliance programs. Previously, both MAA and Department of Health managers were responsible for all aspects of Medicaid and the Alliance, which together represented 88% of Department of Health spending. Now, decision-making should be quicker and lines of accountability better defined. DHCF will focus on providing health insurance coverage to almost 200,000 D.C. residents while the Department of Health focuses on key public health priorities such as HIV/AIDS, reducing preventable infant deaths, and emergency preparedness.

District-wide coordination of health care policy will continue to occur in the Mayor's Cabinet, which includes the directors of Health, Mental Health, Disability Services, Health Care Finance, and other departments.

As Medicaid has grown over the past 40 years to become the largest single expenditure for state governments, more and more states have elevated the role of the Medicaid agency. D.C. joins seven states in having a Cabinet-level agency for Medicaid. In another 17 states, Medicaid is a stand-alone agency ranking equally with other agencies such as the Department of Health. In the other 26 states, Medicaid remains a branch of a larger agency such as health or human services. [5]

Medicaid Funding Helps Other D.C. Agencies

DHCF pays over $100 million a year to other D.C. government agencies for services provided to Medicaid beneficiaries. Of this sum, 70% is provided by the federal government, thereby bringing in outside funds that are essential to the provision of services to many of the District's most vulnerable residents. For the District, the goal is to use available federal funding while ensuring that all inter-agency payments are consistent with complex federal regulations.

Although some agencies, such as Fire and Emergency Medical Services, bill services to other health insurers, other agencies are not as familiar with health care billing forms and procedure codes. DHCF therefore established the five-person Public Provider Liaison Unit in FY 2008. Staff members provide Medicaid-related technical assistance to sister agencies while developing expertise in the other agency's programs and services. The result is improved billing processes and inter-agency collaboration.

The main services provided by other agencies to Medicaid beneficiaries include case management, mental health care, and school-based health care for students with individual education plans (IEPs). In FY 2009, outpatient services provided by the Addiction Prevention and Recovery Administration to children and youth also will become eligible for Medicaid payment.

Eurice Marsh

After a lifetime of institutions and group housing, Eurice Marsh has a home of her own.

Ms. Marsh, 62 years old, was born with a severe intellectual disability. She doesn't know how old she is, nor how long she has lived in Washington. Much of what she says is hard to follow, especially to a visitor unaccustomed to her West Indies lilt.

She knows her own mind, however. "I like to go for walks, I like to cook, I like to shop," she says. "Every day, I go to school. They treat me good." She's also very social, always ready to shake hands or hug her friends.

Ms. Marsh was born in the Virgin Islands, where she didn't make it past third grade because of seizures and behavioral problems. Decades ago she came to Washington and was diagnosed with severe mental retardation, which generally corresponds to an IQ between 26 and 40.[6] She was institutionalized repeatedly at St. Elizabeth's Hospital, the hospital for people with mental illness, which she does not have.

Over the decades, understanding and care of people with intellectual disabilities has improved dramatically across the country. In recent years, Ms. Marsh lived with five other people in an intermediate care facility for the mentally retarded (ICF/MR). Then in October 2008, she moved to her own apartment—a move she has wanted for quite a while.

Eurice Marsh at home with Admire Seray Allie, an aide who usually works with her from 2:00 pm to midnight.

In her simply furnished space in Northwest, the only anomaly is an employee time clock on the living room wall. For safety, an aide is always in the apartment. The level of care is tailored to each person; across the hall lives an intellectually disabled man who rides Metrobus on his own. Each weekday, Ms. Marsh joins a group program at Wholistic Services Inc. Participants are trained in survival skills such as recognizing "exit" signs, go on field trips to the Smithsonian and other sights, and even enjoy occasional visits by a piano player. "I love to dance," says Ms. Marsh, breaking into a quick demonstration.

"Every day is good"

In her own apartment, Ms. Marsh is gaining independence, and doing more to help her aides prepare meals and do chores. "I know she's happy to be here," says Johannes Jones, a Wholistic Services manager. "After brushing her teeth, she wiped down the sink. I was impressed—it showed she really wanted to live here." She cries less and her behaviors have improved. Every two weeks she walks to the bank to cash a check for $60, which she earns by taking out the trash at the day program.

Ms. Marsh, who has had no family contact for decades, turns to her caregivers. "I talk with them," she says. "I love them and they love me." Under the supervision of a court-appointed guardian, she is in the care of the Department on Disability Services. Medicaid pays for her medical care, the day program, her rent, and her aides. Moving to the apartment was funded by the national "Money Follows the Person" demonstration program (page 16). Ms. Marsh was among the first ten people in D.C. to benefit.

"Every day is good," says Ms. Marsh. "I'm glad I have an apartment."

Managing Care and Promoting Quality

TWO-THIRDS OF MEDICAID BENEFICIARIES, AND ALL ALLIANCE BENEFICIARIES, are enrolled in a managed care plan.

FY 2008 was a year of major change, as the Department signed new contracts with each plan. The Unison Health Plan became a Medicaid plan, while another managed care organization ended its role with Medicaid. Almost 40,000 members successfully transitioned to a new plan, with about half opting to choose a plan and about half being auto-assigned by Medicaid.

Managed Care Enrollment, September 2008

	Medicaid	Alliance	Total
D.C. Chartered Health Plan	57,323	15,858	73,181
Health Right	19,565	15,174	34,739
Unison	13,484	14,933	28,417
HSCSN	3,480	0	3,480
Total	93,852	45,965	139,817

Notes:

1. FY 2008 monthly averages are not shown because of changes in the roster of managed care plans during the year.
2. Health Services for Children with Special Needs (HSCSN) does not bear financial risk in the same way that the three managed care organizations do.

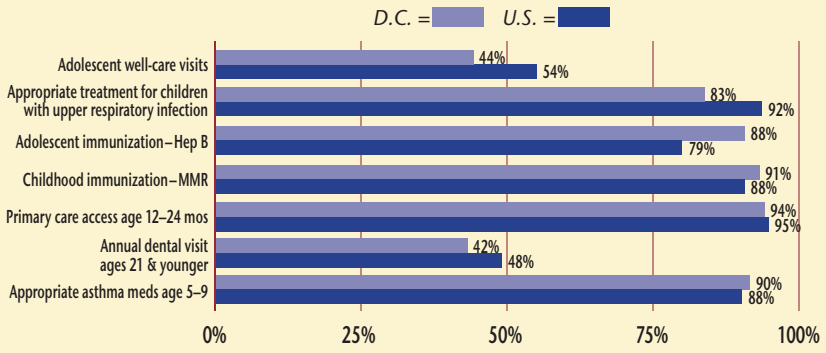
HEDIS Quality Results for Medicaid MCOs

Each year Medicaid assesses managed care performance in part by using well-accepted measures developed by the National Committee for Quality Assurance (NCQA). Healthcare Effectiveness Data and Information Set (HEDIS) measures are collected from each of the three managed care organizations using strict criteria that enable comparison with Medicaid managed care plans nationwide. (Because of its unique focus, HEDIS data are not collected from the Health Services for Children with Special Needs plan.)

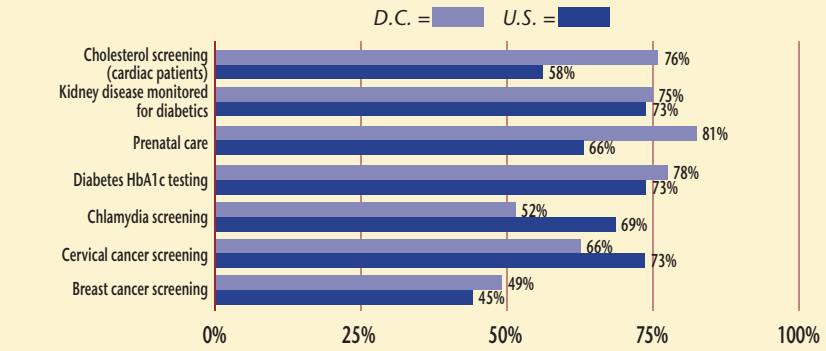
Medicaid's new contracts with the MCOs include innovative provisions to encourage high performance on HEDIS and customer satisfaction measures. They also greatly expand the Department's ability to monitor the quality of care and service provided to Medicaid beneficiaries.

The charts at right show some of the most important HEDIS measures out of the dozens that are collected. The D.C. figures are averages for the three MCOs that served beneficiaries in calendar year 2007. Averages are weighted by enrollment.

Selected Medicaid HEDIS Children's Measures, CY 2007



Selected Medicaid HEDIS Adult Measures, CY 2007



Note: One D.C. plan opted to calculate 2007 rates using only one type of data rather than also using medical record review, as in the previous year. This change likely accounts for the decrease in D.C. rates compared with national rates.

Victor Musgrove

A common misconception is that Medicaid insures everyone who is poor. It doesn't. In fact, D.C. runs one of the few Medicaid programs where someone like Victor Musgrove would have a chance of coverage.[7]

Mr. Musgrove, 58 years old, is too young for Medicare, too healthy for disability benefits, too sick to work, and too poor to pay for his own health care. Under federal law, Medicaid only covers people in designated categories, and Mr. Musgrove doesn't fit a category. He has Medicaid only because D.C. sought and received a federal waiver allowing coverage of 1,500 adults in the 50–64 age group whose income is under $5,200 a year for an individual.

Mr. Musgrove lives near the Minnesota Avenue Metro with his mother and brother, in a compact house near a park. In his younger years, he did odd jobs, including construction, garden work and seven years for the railroads. Over the past 15 years, he has had worsening arthritis in both knees. "I couldn't carry a ladder any more, so I had to stop that," he says. "I couldn't trust my balance on the roofs." He developed other health problems, including congestive heart failure, chronic kidney disease, hepatitis, and alcohol abuse. (He's since stopped drinking.) He survives on almost no money, receiving food stamps but no cash assistance. "I used to be able to count on picking up a day or two of labor," he says. Now, that option is "real limited."

Victor Musgrove at home in Deanwood, with Chico

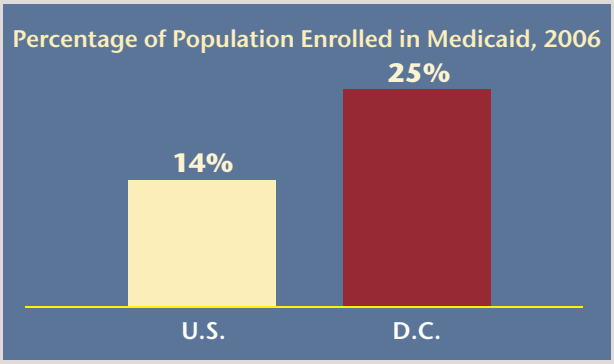
Over the years, he took a lot of naproxen, the over-the-counter anti-inflammatory drug. "Before I was taking that, I could barely walk," he recalls. Naproxen and a history of alcohol use increase the risk of gastrointestinal bleeding, which Mr. Musgrove occasionally noticed. Then on August 23 this year, he almost died, lying unconscious in his basement due to severe bleeding. His family didn't realize he was downstairs. "If it wasn't for the dog raising Cain, I probably would have lay there and bled to death," he says. An ambulance rushed him to United Medical Center (formerly Greater Southeast Community Hospital). He was comatose for five days, in acute kidney failure and septic shock. The hospital charged $106,007 for the 16-day stay, which was paid for by Unison, his Medicaid managed care plan.

The hospital bill came to $106,007

Now recovering, he is trying to regain weight, eating multiple, small meals. He has stopped taking naprosyn, taking ibuprofen instead, "but mostly I try to stay off my knees." Although weak and short of breath, he welcomes visitors and likes to joke with the neighbors. He hopes that his health problems will qualify him for Supplemental Security Income (SSI) payments of $637 a month, but the decision is months away. "I'm going to find some kind of income in the meantime," he says. "Maybe indoor painting or something, but I do get short of breath real quick."

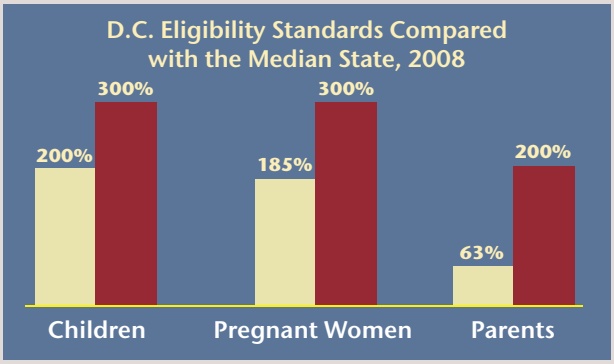
D.C. Medicaid in National Context

ON THESE PAGES WE DESCRIBE D.C. IN THE CONTEXT OF MEDICAID PLANS NATIONWIDE. Readers should keep in mind that comparing a city with entire states can be misleading. For example, the cost of living in D.C. is higher than in almost all states. Please note also that some D.C. numbers in the charts may differ from numbers elsewhere in this report due to definitional differences in the source documents. Nevertheless, with appropriate caveats it can be instructive to see how D.C. Medicaid differs from, and is similar to, programs in the states. In the charts, the yellow bars refer to the U.S. while the red bars refer to D.C.



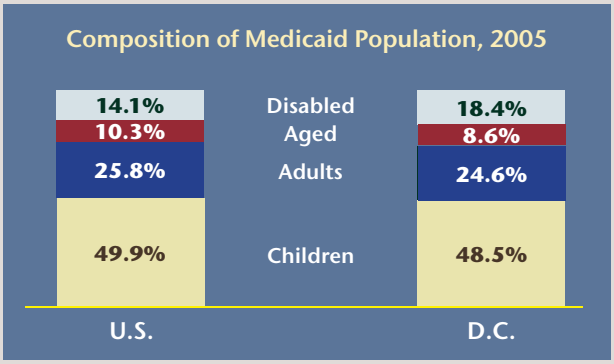
Access

The percentage of the population enrolled in Medicaid is higher in D.C. than in any state. After D.C., the highest percentages are New York, Louisiana, New Mexico and Maine at about 20%. It is also true that the percentage of the population living under the poverty line is higher in D.C. than in 49 states. For both statistics, D.C. is probably similar to other major cities, although detailed data are not available.[8]



Eligibility Standards

Federal law sets minimum and maximum income limits by eligibility category. Limits are expressed as percentages of the federal poverty line, as shown on page 5. The chart compares D.C. limits with those of the median state. For children, D.C.'s limits are as inclusive as those of any state. For parents of children on Medicaid, D.C.'s limits are more inclusive than all but one or two states. For the disabled and aged categories, recent comparative data are not available.[9]

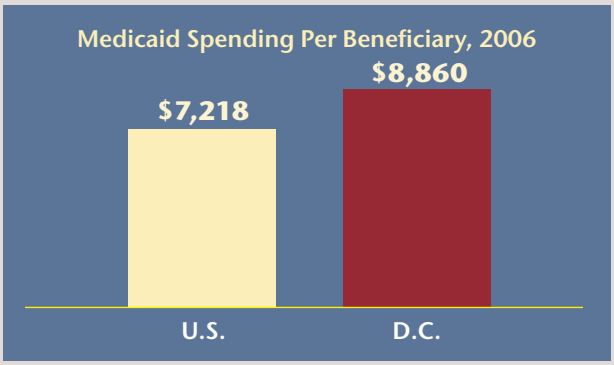


Medicaid Population

The D.C. Medicaid population includes a higher percentage of aged and disabled beneficiaries (27%) than the national average (24%). As shown on page 22, beneficiaries in the disabled and aged groups are four to six times more costly per person than beneficiaries in the children and adult groups.[10]

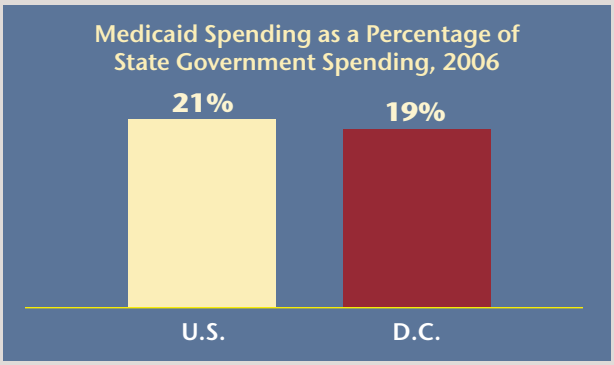
Spending per Beneficiary

D.C. spending per beneficiary was 23% higher than the national average in 2006. This figure ranges widely across the U.S., depending on the cost of living, payment rates to providers, the scope of covered services, and the composition of the Medicaid population. D.C. ranked 13th; New Jersey and Alaska were highest, at about $12,000, while Georgia and Tennessee were lowest, at just over $5,000.[11]



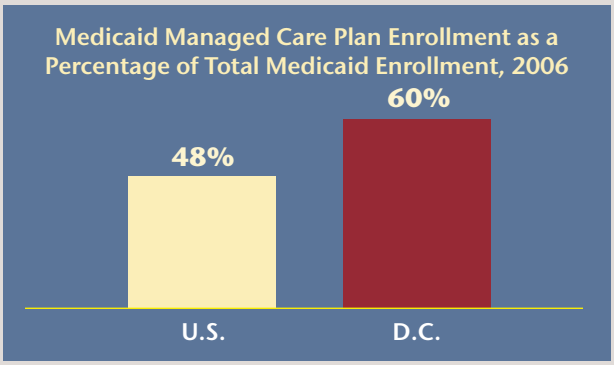
Medicaid in the Budget

Several years ago Medicaid became the single biggest item in state budgets, a position that is unlikely to change anytime soon. (The No. 2 item is K-12 education.) Missouri, Maine and Pennsylvania have the highest percentages, at almost one-third. Wyoming, Hawaii and West Virginia have the lowest, at 10% or less. D.C. is about in the middle.[12]



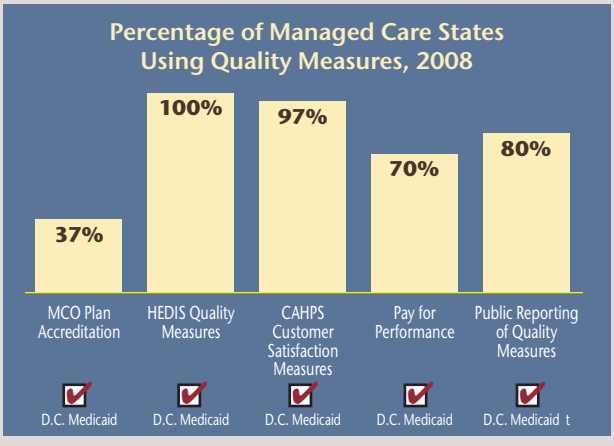
Managed Care

States vary widely in their use of managed care, here defined to mean enrollment in HMOs and other organizations that assume financial risk for providing comprehensive services. Nationwide, 48% of Medicaid beneficiaries are enrolled in managed care organizations, vs. 60% in D.C. In 29 states and D.C., at least 25% of the Medicaid population is in managed care. In those 30 Medicaid programs, typically about two-thirds of beneficiaries belong to MCOs.[13]



Managed Care Quality

For the 30 Medicaid programs with at least 25% managed care enrollment, the chart shows the percentage using each of five quality tools listed in a recent survey. In each case, D.C. already uses the tool or will do so in FY 2009.[14]



Medicaid's Leadership in

"DO YOU COUGH AT ALL WHEN YOU'RE RUNNING AROUND?" "Tell me a green vegetable that you like." "Back off on the sports drinks a bit." "Practice talking to yourself in the mirror. Make eye contact."

Dr. Cheryl Focht is talking with Enrique Lopez, 10 years old, during his annual visit to Mary's Center in Adams Morgan. She's screening for asthma, instilling good eating habits, and offering gentle advice on social situations—just as she does hundreds of times a year with other children. It's an approach that comes naturally to pediatricians, and one that Medicaid has encouraged for decades.

When Medicaid was enacted in 1965, much of the original justification was to improve the health of low-income children, who often had serious unidentified and untreated health problems. In 1967 Congress enacted the benefits package that has governed Medicaid care for children ever since.[15] The package's name, awkward but accurate, is "early and periodic screening, diagnosis, and treatment" (EPSDT).

Dr. Cheryl Focht shows a growth chart to Enrique Lopez

In many ways, EPSDT, with its emphasis on preventive care, a broad conception of good health, and the importance of a "medical home," was 40 years ahead of its time. Today, many clinicians and policy analysts advocate just those goals for the health care system overall.

Nationwide, about 30% of children are covered by Medicaid or the related State Children's Health Insurance Program. In the District, it's 61%. By providing health insurance in the first place and then by promoting comprehensive, preventive care, Medicaid makes a big difference in the lives of D.C. children.

For data on Medicaid care for children, see pages 14–15.

Enrique and his family—parents Roberto and Julieta and brother Alexis, now 2—are a good example. For the past 12 years, the Lopezes have come every year to Mary's Center, a busy clinic serving a largely Hispanic patient population. Mr. Lopez's work as a house cleaner gives him no access to subsidized employment-based insurance. Nor can the family afford a plan in the individual insurance market, which would cost them at least $4,500 a year.[16] Both children have Medicaid, while both parents have Alliance coverage. Thanks to the District's policy of promoting seamless coverage (page 4), all family members are enrolled in the D.C. Chartered Health Plan and all receive their care at Mary's Center. Dr. Focht is their doctor. "I like her very much," says Ms. Lopez.

Child Health

Julieta and Alexis Lopez at the Mary's Center clinic

When Enrique was a toddler, Dr. Focht discovered an undescended testis, a problem easily fixed if caught. "I asked the surgeon what would happen if he didn't have the operation," recalls his father. "He said, 'Simple—you may not be a grandfather.'" Dr. Focht also noticed and treated a touch of pediatric asthma, now resolved. "We feel so relieved we can come here," says Enrique's mother. Without Medicaid and the Alliance, "it would be very, very hard." Before Mr. Lopez had Alliance coverage, he relied on health fairs for checkups and was thankful he had no major health problems.

After Enrique's check-up, Alexis wasn't quite so cooperative. Urged by Dr. Focht to toddle a few steps, he mostly stamped his feet and screamed. The doctor carried on with the rest of her head-to-toe exam, listening to lung sounds, asking about home life, and offering suggestions on reducing separation anxiety.

For pediatricians, it's all in a day's work. "Early intervention is far more effective than delayed remediation," says Dr. Mark Weissman at Children's National Medical Center. Every day, he is on the lookout for problems that should be addressed early; common ones are asthma, speech and hearing issues, dental hygiene, obesity, lead poisoning, and learning disabilities. "Ten to fifteen percent of kids may have issues with learning and attention," he says. "That's a big number." At Mary's Center, 30% to 40% of Dr. Focht's patients have speech delays. The center even sponsors a play group specifically for these children. Both doctors find it easier to provide preventive care to Medicaid patients. "The EPSDT focus—the preventive care focus—is by definition absent from the commercial plans," says Dr. Weissman. "The commercial plans pay for it, they encourage it, but Medicaid elevates it to the next level."

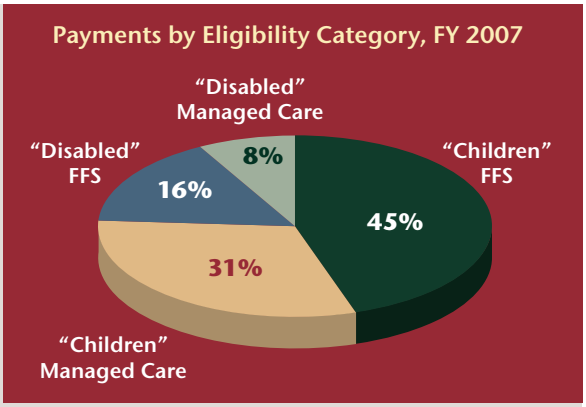
Medicaid elevates preventive care to the next level

In D.C., the EPSDT program is called HealthCheck. An important tool for physicians taking care of children is the web-based EPSDT/HealthCheck Tracking System, developed by D.C. Medicaid in collaboration with physicians and managed care plans. It includes seven standardized medical record forms, each of which shows recommended assessments for different age groups (see page 15). Using the tracking system, clinicians with the required security permissions can check whether their patients have already received immunizations and assessments appropriate for their age groups. "If you're a kid in D.C. getting EPSDT care from a provider who uses the form, you are getting care that is among the most comprehensive in the country," says Dr. Weissman.

Payments for Children and Youth

In FY 2007, D.C. Medicaid, including its managed care plans, made $277 million in payments for services to children and youths age 0-20. On this page we describe how the money was spent.

THE CHART AT RIGHT SPLITS PAYMENTS by the broad eligibility category of the beneficiary and by whether payments were made by one of the managed care plans or by fee-for-service Medicaid. Of the $277 million, 76% was spent on the 70,528 beneficiaries in the "children" category and 24% was spent on 6,095 children and youths who qualify for Medicaid due to disability. Per person, $3,016 was paid for beneficiaries in the "children" category and $10,773 for those in the "disabled" category. Although most children are in managed care, managed care only represented 39% of payments because children in the fee-for-service sector have more extensive health needs. As well, some services for managed care beneficiaries are paid on a fee-for-service basis.



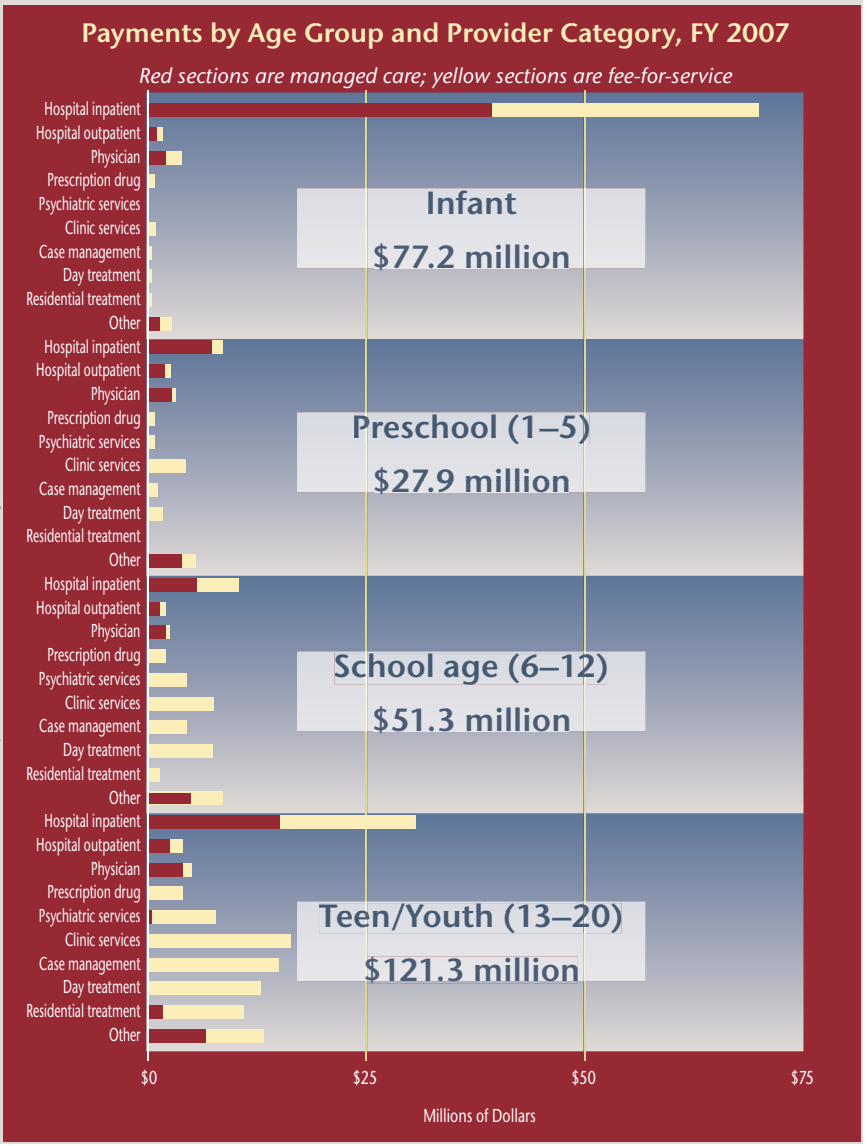
The chart on the right shows expenditures for the ten leading provider categories (in terms of total payments for children and youths), divided into four broad age groups.

Infancy is the most expensive year for children in the Medicaid program, reflecting birth expenses for all beneficiaries as well as large expenses for babies needing neonatal intensive care, often for months. Accordingly, inpatient hospital care for infants is by far the single largest expense in the chart.

For preschoolers, Medicaid expenses are relatively modest, with the leading categories of service being hospital inpatient, hospital outpatient (which includes emergency room care), physician and clinic.

For children aged 6-12, expenses for hospital and physician care are generally similar to those for preschoolers while case management, psychiatric services and day treatment become notable. These services are often provided or coordinated by other D.C. agencies such as the Department of Child and Family Services or D.C. Public Schools.

Teenagers and youths (ages 13-20) account for the largest amount of spending ($121.3 million). Hospital inpatient care is particularly significant, reflecting obstetric care. Payments for clinic services, case management, day treatment, and residential treatment for children and youths with mental health problems are also notable.



HealthCheck Screening Guidelines in D.C.

In D.C., as in each state, the Medicaid program consults with local health professionals to develop recommended assessments and screenings by age. Screenings, by definition, are for patients without signs or symptoms of illness. EPSDT guidelines also call for diagnosis, treatment and follow-up care as needed for health conditions that a child may develop.

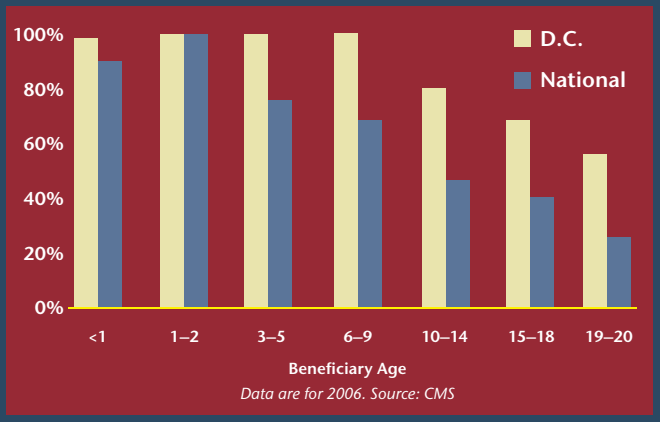
Screening and Assessment	Periodicity
History Height and weight Physical exam Development and behavioral assessment Immunization status and updates Anticipatory guidance on injury, violence and nutrition	At birth and 2-4 days At 1, 2, 4, 6, 9, 12, 15, 18 and 24 months Annually thereafter (except ages 7 and 9)
Head circumference	At 1, 2, 4, 6, 9, 12, 15, 18 and 24 months
Sleep position counseling	At birth and 2-4 days At 1, 2, 4, and 6 months
Hereditary and metabolic screening	At 2–4 days
Vision	Tested at ages 3, 5, 6, 8, 10, 12, 15 and 18 Questions posed at other visits
Hearing	Tested at birth, 6 months, ages 5, 6, 8, 10, 12, 15, 18 Questions posed at other visits
Blood pressure	Annually starting at age 3
Hematocrit or hemoglobin	9 months and 13 years, with additional interim tests for those at risk of anemia
Urinalysis	Age 16
Lead screening	12 months and 24 months, with additional screening annually up to age 5 for those at risk of lead poisoning
Tuberculosis screening	12 months , with additional screenings annually for those at risk of tuberculosis
Cholesterol screening	Annually starting at age 3
Sexually transmitted diseases Pelvic exam for females	Annually starting at age 11
Dental evaluation and referral	15 months and annually starting at age 3

For more information on the HealthCheck EPSDT program in D.C.:
www.brightfutures.org/healthcheck

Destiny Lawrence, 6 years old, and her mom, Carla Carland, at a recent check-up at Children's National Medical Center. Destiny had her annual physical exam and is up to date on her immunizations. "I just want to make sure she's healthy," says her mom. "I don't want to just bring her when she's sick."

D.C. EPSDT Screening Rates Exceed National Averages

D.C. Medicaid children receive higher percentages of recommended screenings than national averages, according to the Centers for Medicare and Medicaid Services. The chart on the right shows the actual number of screenings as a percentage of the expected number. The expected number reflects the number of screenings recommended for a child of a certain age times the number of children in the age group, adjusted for children with only part-year Medicaid eligibility. For more information, go to www.cms.hhs.gov, choose "Medicaid" then "EPSDT" then "State Agency Responsibilities."

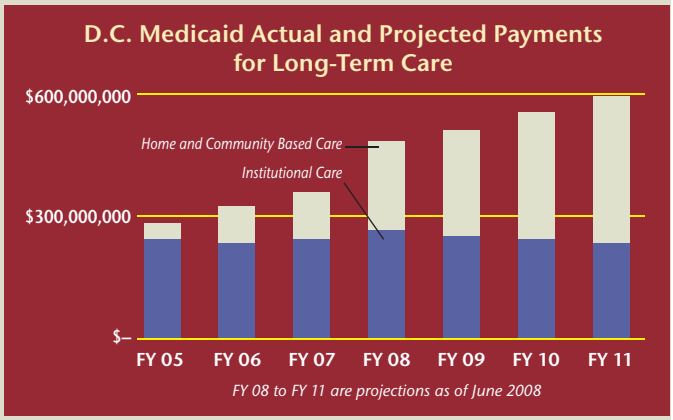


Data are for 2006. Source: CMS

Improving Long-Term Care

MEDICAID IS BY FAR THE SINGLE MOST IMPORTANT funding source for long-term care nationwide. Over the past 25 years, emphasis has shifted from institutional care to home and community based services that allow seniors and people with disabilities to remain at home if possible. These services are often called "waiver programs" because the federal government waives regulatory requirements that date from the one-size-fits-all approach to long-term care.

In FY 2008, the federal government awarded D.C. a five-year, $26.4 million grant under the "Money Follows the Person" program. These funds will help Medicaid transition 1,110 people from institutional care settings to more home-like arrangements. Eurice Marsh (page 7) was one of the first people to benefit from the grant.



Aging and Disability Resource Center

For some people, life changes in a heartbeat—a stroke, a fall, a car accident. For others, there's a growing realization that they can no longer live at home on their own. Either way, there's a pressing need to learn about living options from that moment forward.

To help residents understand the many District, federal and community programs available for seniors and people with disabilities, the D.C. Aging and Disability Resource Center (ADRC) opened its doors August 13, 2008. An accompanying website is at www.adrcdc.org. The center is run by the D.C. Office on Aging with partial funding from Medicaid.

ADRC staff can answer many questions about options such as meals on wheels, personal care attendants, nursing homes, case management, and assisted living. If necessary, an ADRC staff member can even do an in-home assessment of what kinds of help a person needs to continue living at home. A staff member of the D.C. Income Maintenance Administration is available within the ADRC office to determine eligibility for programs such as Medicaid home and community based services.

Even if a person is ineligible for assistance, staff members and the ADRC website can provide referrals to numerous other resources within the District.

Above all, the goal is to help people in need navigate the complex social services system. "Yes, we are a government entity, but we are *advocates*," says John Thompson, the ADRC director.

ADRC staff member Lisa Stephen-Collins and her colleagues assist the public at 1134 11th Street NW (corner of M St), phone 202-724-5626, TTY 202-724-8925. ADRC can also be reached via 311.

Marietta E. Thurston

As a young woman, Marietta E. Thurston was a nurse at Washington-area hospitals, including the old Casualty Hospital on Capitol Hill. In the early 1970s, she developed asthma. Although the disease is common, Mrs. Thurston's asthma was uncommonly severe—so severe that she had to stop work in 1975. "I was always in and out of the hospital," she recalls. Fortunately, she was able to qualify under Social Security disability rules for Medicare at about age 33. Medicare paid most of her health care expenses, while her husband's income supported them both.

In 2003, Mrs. Thurston's husband died and she suffered a stroke that requires her to use a wheelchair. "Once my husband passed, I didn't want to go to a nursing home," she recalls. "I was having a lot of trouble paying for my medicines because they're so expensive." (Mrs. Thurston lives on Social Security, now $963 a month.) Although Medicare covers hospital and doctor bills, it doesn't pay for long-term care. A social worker, Monica Thomas, helped Mrs. Thurston enroll in Medicaid and its home and community based services program, intended for people who otherwise would have to be in a nursing home. "The D.C. program is really remarkable compared with what other states do," says Ms. Thomas. "It's an amazing gift for someone to be able to stay at home."

Marietta Thurston at home in Columbia Heights

Today, Mrs. Thurston lives in a very nice subsidized seniors' building in Columbia Heights. Her tidy apartment sports Redskins banners on the doors, family photos on the wall, and a parade of stuffed bears on the back of the sofa. Welcoming a visitor recently, she felt and looked good. She didn't need her home oxygen, she had just powered her wheelchair over to see a friend, and she had had her hair done that afternoon. Her health is precarious, however. "If I get sick from a cold, then everything I've got wrong goes out of whack," she says. "I've had pneumonia three or four times in the past year." In addition to asthma and the stroke, her illnesses include kidney failure, diabetes, congestive heart failure, phlebitis, and chronic obstructive pulmonary disease. Last year's diagnosis of kidney failure was something of a blessing, because she started receiving dialysis (paid for by Medicare) three times a week. "This is the longest I've been away from the hospital, because the dialysis has been keeping the fluid down," she says.

"They keep me going"

Medicaid pays for 12 hours a day of help from a personal care aide. Her regular aide, Iris R. Shade, has been with her almost a year. A registered nurse, Cynthia Lee, visits as often as needed to oversee Mrs. Thurston's 19 medications. Mrs. Thurston is also enrolled in the Medical House Call program at Washington Hospital Center, funded by both Medicare and Medicaid. Physician Eric DeJonge or nurse-practitioner Michelle Sullivan visit at least monthly in an effort to keep Mrs. Thurston healthy and out of the hospital. Ms. Thomas, the social worker, also stops in regularly. "They're all very good to me," says Mrs. Thurston. "They keep me going."

How Much Does Medicaid Pay?

MEDICAID PAYS FOR HEALTH CARE EITHER DIRECTLY ON A FEE-FOR-SERVICE BASIS or indirectly through the managed care plans. In FY 2007, when payments for care were $1.4 billion, about 78% of payments were made on a fee-for-service basis and about 22% through the managed care plans. In fee-for-service Medicaid, specific fees exist for over 10,000 services, over 30,000 drug products and over 600 types of hospital stays. This table shows fees for some common items, defined using the standardized codes shown in parentheses. Because payment methods are complex, payments on specific claims can differ from those shown here. For further information on payments, see pages 22 and 23.

Service	Payment	Comment
Management of hospital care, level 2, per day. Typically 25 minutes of patient care. (CPT 99232)	$27.96	Most common physician service
Physician fee for emergency room visit, level 5. Usually immediate significant threat to life or physiologic function. (CPT 99285)	$75.02	Most common ER visit code from physicians. The hospital is paid separately.
Obstetric care by a physician, including prenatal and post-natal care with vaginal delivery (CPT 59400)	$1,500.00	Most common major procedure. The hospital is paid separately.
Comprehensive oral evaluation (D0150)	$77.50	Most common dental service
Hospital fee for emergency room visit, with qualifying emergency diagnosis	$141.24 to $218.47	Rates are hospital-specific. The physician is paid separately.
Hospital inpatient stay for psychosis (AP-DRG 430)	$8,229.32*	Most common reason for inpatient admission. Average length of stay is 7.2 days.
Hospital inpatient stay for normal newborn (AP-DRG 629)	$1,124.61*	Second most common reason for inpatient admission. Average length of stay is 2.5 days.
Hospital inpatient stay for vaginal delivery (AP-DRG 373)	$4,519.42*	Third most common reason for inpatient admission. Average length of stay is 2.4 days.
Day of nursing home care	$176.00 to $391.00	Rates vary by facility depending on facility cost and average patient acuity
15 minutes of personal care assistance (HCPCS T1019)	$4.08	Most common procedure code in Medicaid overall; see page 17
Therapeutic foster care of a child, per day (HCPCS S5145)	$61.64	Common service for foster children
Prescription for aspirin, 81 mg tablet (taken daily to reduce the risk of heart attack and stroke)	$2.37	Most commonly prescribed drug
Prescription for hydrochlorothiazide, 25 mg tablet (diuretic to treat high blood pressure)	$5.02	Second most commonly prescribed drug
Prescription for amlopidine, 10 mg tablet (treatment for high blood pressure)	$19.23	Third most commonly prescribed drug

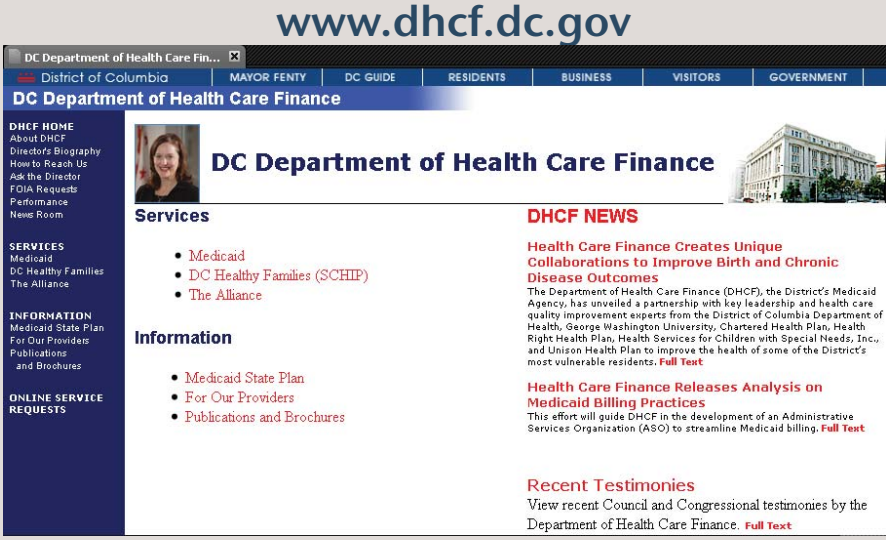
** Figures are average actual payments per stay in FY 2007, reflecting both base payments per AP-DRG and outlier payments for unusually expensive stays.*

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 $1.52 billion that Medicaid spent on health care in FY 2008 was paid to D.C. providers. Of the remainder, 5% went to Maryland, 1% to Virginia and 2% to other states.
- Medicaid is the single largest source of federal funding for the D.C. government, bringing in $1.1 billion in FY 2008. The federal government paid 70% of each D.C. Medicaid dollar and 79% of each D.C. SCHIP dollar.

Improving Technology to Improve Service

D.C. Medicaid is in the middle of the largest technology upgrade in the program's history. These improvements will enable improved service and more efficient program administration over the next 10 to 20 years. Here is a list of major projects, starting from the largest.



■ **Medicaid Management Information System (MMIS).** The claims processing system, which is owned by the Department and operated by ACS Government Healthcare Solutions, is the heart of Medicaid administration. For two million claims a year, the MMIS checks beneficiary eligibility and coverage of services, calculates payment, and takes into account payments from other insurers. The current MMIS is being replaced with a new system already proven in other Medicaid programs. Advantages include: integration with the new Medicaid web portal; real-time processing that gives providers immediate feedback about claim payments and denials; increased storage capacity and easier change management through the use of DB2 file structures; user-friendly screens that will make it easier for Department and ACS staff to use the system; desktop access to electronic copies of many kinds of documents; improved tracking of inquiries to the Medicaid provider call center; and easier configuration of system edits that ensure that claims are billed and paid appropriately.

■ **Web portal.** The Medicaid program's new web portal at www.dhcf.dc.gov is already offering information to beneficiaries and providers about Medicaid eligibility, benefits, and payments. Starting in FY 2009, beneficiaries will be able to search online for Medicaid providers. Providers also will be able to enroll in Medicaid through the portal. Later in the year, providers will be able to submit claims, check the status of submitted claims, verify a patient's Medicaid eligibility, and view fee schedule information online.

■ **Pharmacy Benefit Management (PBM).** A new PBM system was implemented in June 2008. Even as the pharmacist fills the prescription, the Medicaid PBM system advises the pharmacy's computer system whether the patient is eligible for Medicaid, how much the pharmacy will be paid, and how much the beneficiary should pay. The new system also is easier to configure, allowing changes in formularies and other payment policies to be made faster and less expensively.

■ **Patient data hub.** The data hub will enable three D.C. hospitals, six clinics and several Department of Health programs to share clinical information about Medicaid beneficiaries, subject to stringent confidentiality safeguards. Integrated patient records will provide clinicians with more accurate information, enable better coordination of care (especially for people with chronic illnesses), and help eliminate duplicative and unnecessary services. As of November 2008, the Department was reviewing proposals from private-sector firms to build the hub. Funding is largely from a $9.8 million "Medicaid Transformation Grant" awarded to D.C. by the federal government.

■ **Casenet.** This tool will improve case managers' efficiency in managing delivery of health care to Medicaid beneficiaries. Case managers will no longer need to fill out 32 different paper forms. The software automates tracking of individual cases through the three basic functions of intake, eligibility, and care delivery. It also enables tracking of phone calls, generation of letters, and compilation of documents used throughout the life cycle of a beneficiary's case. It will be implemented in FY 2009.

Spending Dollars Wisely

Tightening Provider Standards

Suppliers of durable medical equipment (DME) provide wheelchairs, walkers and other tools that help the elderly and people with disabilities live as independently as possible. Although many suppliers are reputable businesses, this area has been prone to fraud and abuse across the U.S. Because suppliers do not need professional education or licenses, perpetrating fraud can be as simple as opening a post office box and submitting claim forms using actual or stolen Medicaid beneficiary numbers.

In May 2008, D.C. Medicaid published new regulations to reduce this area of vulnerability. DME suppliers must maintain a physical facility with posted hours of operation. Key employees must undergo background checks. The rule also describes grounds for denying an application to enroll as a Medicaid supplier. Without such specificity, even suppliers convicted of fraud elsewhere could challenge a denial.

All current DME suppliers were required to re-enroll, subject to a series of formal approvals by the Office of Quality Management and Program Integrity. Medicaid staff now conduct site visits to each applicant in the D.C. area.

In FY 2008, the Medicaid program made $13.4 million in payments to DME suppliers.

Maximizing Drug Rebates

In FY 2008, Medicaid received more than $20 million from drug manufacturers through two rebate programs. One program will be expanded in FY 2009.

Under federal law, drug manufacturers must provide Medicaid programs with prices as low as they offer to any other purchaser. This provision is implemented through rebates from manufacturers based on detailed documentation submitted by Medicaid. In FY 2008, D.C. received $18.8 million in rebates for drugs dispensed by community pharmacies. In FY 2009, the program will be expanded to draw rebate on drugs dispensed through physician offices and hospital outpatient departments.

Under the second program, which D.C. implemented in FY 2007, manufacturers can offer additional rebates to make their products more competitive. Like other Medicaid programs, D.C. maintains a preferred drug list that takes prices into consideration prices, along with other factors. Through the first three quarters of FY 2008, these rebates totaled $1.4 million.

In FY 2008, Medicaid spending on prescription drugs dispensed by community pharmacies was $68.4 million. This figure includes the savings from rebate but excludes spending by the managed care plans.

Medical Director Dr. Bob Vowels

As its new medical director, Medicaid chose an old hand, Dr. Bob Vowels.

Dr. Vowels joined Medicaid in July 2008 after working for the D.C. Department of Health since 2000, with responsibilities that included licensing all health facilities in the District, medical direction of the HIV/AIDS Administration, and incident commander of the anthrax evaluation and dispensing unit that treated 18,000 people during two weeks in 2001.

"A lot of my focus this first year is going to be on quality and program integrity," he says.

Coverage and payment policies at the Department of Health Care Finance affect the care received by one-third of Washingtonians, even though the Department does not provide services directly. For Dr. Vowels, the immediate priorities are technology assessment (what drugs, devices and procedures should be covered), patient safety, and defining the medical director role at a time when payers are doing more to encourage value for money in health care. "The right care for the right person at the right time," is how Dr. Vowels, an internist, summarizes the goal.

Working for Beneficiaries

The mission of the Department of Health Care Finance is to improve health outcomes by providing access to comprehensive, cost effective and quality health care services for residents of the District of Columbia. The Department comprises approximately 166 employees who work to ensure that this mission is fulfilled. In this section, we describe some of the work our public servants do.

Diane Fields

Diane Fields, a lawyer in the Office of Policy, joined the Medicaid program in 2006. She manages the rules and regulatory process that contribute to the effectiveness of the Medicaid program. Since joining the Office of Policy, Diane has been called upon to assemble teams from across the agency to resolve a wide range of issues pressing upon the agency. Earlier this year, she co-chaired a group whose charge was to draft new rules, policies and procedures for durable medical equipment (DME) suppliers. Diane believes that the changes created by the DME team will reduce opportunities for fraud while ensuring that beneficiaries have access to quality goods and services (see page 20). She uses an action-oriented approach when bringing colleagues together to solve problems. "You have to do more than just talk about problems to get things done. Team members are motivated to not only bring their individual expertise to the process, but also to believe that their participation is central to finding the best solutions possible," Diane says.

Derrick Bailey

Derrick Bailey is a public provider liaison in the newly formed Public Provider Liaison Unit of the Office of Policy (page 6). Derrick joined the D.C. government in March 2008 from Medicaid's claims processing contractor, ACS Government Healthcare Solutions, where he previously was the provider relations manager. Derrick assists other D.C. agencies in navigating the complex world of Medicaid health care billing, payment and policies. These agencies provide millions of dollars of services to Medicaid beneficiaries but their staff expertise is typically in program services, not the intricacies of health care claim forms. With his five years at ACS, Derrick has a detailed working knowledge of billing systems that he is glad to share with his colleagues. Derrick sees his job as translating claims processing intricacies into the information needed to keep services and funds moving smoothly through the system.

Eva Kao

Eva Kao works as a computer analyst in the Office of Program Operations. She began working for Medicaid in 1996 and has worked for the D.C. government since 1982. She is a member of a three-person group that assists DHCF staff with a wide variety of computer issues. Eva is trained as a programmer, so she helps with network and email problems as well as the Medicaid web pages. Eva also works with the Medicaid Management Information System (MMIS), the highly complex system that processes Medicaid claims. She generates MMIS data reports that her colleagues in Program Operations use to investigate claims issues. She also works on implementation of the new MMIS (page 19). Eva says that debugging and fixing computer programs are among her favorite challenges. She is known for her sense of humor and is always ready to do whatever needs to be done with a smile on her face.

Understanding Medicaid Spending

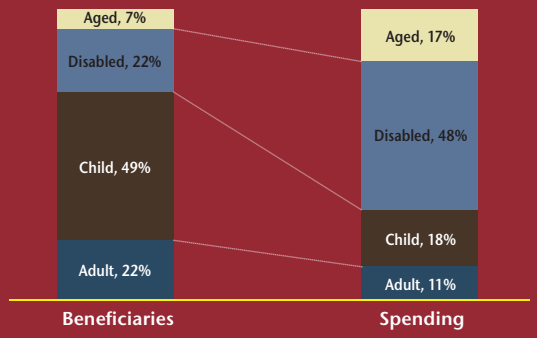
TO UNDERSTAND MEDICAID FINANCES, it helps to analyze spending by broad groupings of beneficiary eligibility and type of service. In the table on this page, several dozen eligibility categories are collapsed into four broad groups.[19] Although the groupings are simplifications of a very complex program, the following discussion should illuminate the drivers behind Medicaid spending.

The Adult and Children groups together account for 71% of enrollment but just 29% of spending. This is a relatively healthy population similar to a commercially insured population but with more emphasis on obstetrics and pediatrics. Most beneficiaries are enrolled in one of three managed care organizations that receive monthly premiums from Medicaid.

The most expensive overall group comprises people with disabilities. These 30,997 people represented 22% of enrollment but 48% of spending. Many live in nursing facilities or homes for people with developmental disabilities, while others are enrolled in "waiver" programs that provide long-term care in the community.

The Aged group—who are almost always dually eligible for Medicare and Medicaid—are the smallest group but also often misunderstood. Although Medicare may be their primary coverage for acute care, they often need expensive long-term care not covered by Medicare. This group represented 7% of enrollment and 17% of spending.

Eligibility and Spending, FY 2007



"Children" are under age 21, "Adults" are 21–64, "Aged" are 65 and over, and "Disabled" may be of any age group.

Summary of Medicaid Payments, FY 2007

	Broad Eligibility Category				
Total Spending	**Adult**	**Child**	**Disabled**	**Aged**	**Total**
Beneficiaries	*30,923*	*70,258*	*30,997*	*9,867*	*142,046*
Acute care	$35,364,123	$87,418,906	$375,039,355	$25,387,254	$523,209,637
Long-term care	$596,512	$34,702,144	$221,389,526	$198,438,587	$455,126,768
Medicare cost-sharing	$314,193	$584	$12,970,658	$9,873,671	$23,159,106
Insurance premiums	$121,869,149	$125,501,841	$61,947,837	$2,850	$309,321,677
Subtotal	**$158,143,976**	**$247,623,475**	**$671,347,376**	**$233,702,361**	**$1,310,817,189**
Not specific to individuals					$76,204,109
Total Spending					**$1,387,021,298**

	Broad Eligibility Category				
Percentage Split of Spending	**Adult**	**Child**	**Disabled**	**Aged**	**Total**
Beneficiaries	*22%*	*49%*	*22%*	*7%*	*100%*
Acute care	3%	6%	27%	2%	38%
Long-term care	0%	3%	16%	14%	33%
Medicare cost-sharing	0%	0%	1%	1%	2%
Insurance premiums	9%	9%	4%	0%	22%
Subtotal	**11%**	**18%**	**48%**	**17%**	**95%**
Not specific to individuals					5%
Total Spending					**100%**

	Broad Eligibility Category				
Per Beneficiary per Month	**Adult**	**Child**	**Disabled**	**Aged**	**Total**
Acute care	$95	$104	$1,008	$214	$307
Long-term care	$2	$41	$595	$1,676	$267
Medicare cost-sharing	$1	$0	$35	$83	$14
Insurance premiums	$328	$149	$167	$0	$181
Subtotal	**$426**	**$294**	**$1,805**	**$1,974**	**$769**
Not specific to individuals					$45
Total Spending					**$814**

Notes:

1. *Totals are by date of payment and therefore differ from the table on p. 23, which is by date of service.*
2. *"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.*
3. *This table excludes Medicaid administrative costs as well as $10 million in Medicaid payments of Medicare Part B premiums for dually eligible beneficiaries.*
4. *The "Disabled" eligibility category includes beneficiaries who qualify for Medicaid due to disability regardless of age.*
5. *Benficiary counts in each broad elgibility category were extrapolated based on percentages of total enrollment in September 2007.*

Medicaid Spending in 2008

Services	FY 2007	FY 2008 (Preliminary)
Disproportionate Share Hospital Payments	**$68,342,857**	**$69,560,857**
Supplementary payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients		
Day Treatment	**$17,133,498**	**$18,187,084**
Day treatment programs for people with mental illness		
Inpatient Hospital	**$283,558,521**	**$312,855,495**
Payments to acute-care hospitals for inpatient care		
Outpatient Hospital	**$27,505,845**	**$27,826,387**
Payments to acute-care hospitals for outpatient care		
Insurance Premiums	**$316,797,900**	**$321,652,566**
Mostly payments to managed care organizations. Also includes some payments by Medicaid of Medicare premiums.		
Intermediate Care Facilities for the Mentally Retarded	**$84,704,487**	**$82,024,234**
Residential care for beneficiaries with intellectual disabilities		
Physician Services	**$22,190,916**	**$23,442,521**
Residential Treatment	**$10,028,574**	**$7,519,500**
Non-hospital inpatient care for people with mental illness		
Nursing Facilities	**$171,891,906**	**$180,891,055**
Vendor Payments		
Pharmacy	$65,844,463	$68,392,488
Home health and personal care	$56,987,047	$76,125,083
Durable medical equipment	$12,142,172	$13,444,695
Medical transportation	$10,409,230	$16,437,623
Federally qualified health centers	$9,302,403	$10,590,404
Private clinic	$9,009,331	$10,911,269
Lab & x-ray	$4,065,014	$4,601,724
Hospice	$2,515,706	$3,160,819
Dental	$2,103,901	$8,014,296
Mental health clinic	$934,037	$4,364,073
Other	$1,563,174	$5,831,889
Cost Settlement	**$39,460,921**	**$9,861,111**
Net impact of retroactive payment adjustments due to cost settlements for providers paid based on their costs		
D.C. Mental Health & St. Elizabeth's Hospital	**$24,640,387**	**$35,047,590**
Addiction, Prevention and Recovery Administration	**$8,626**	**$0**
Services to Medicaid beneficiaries		
D.C. Fire & EMS	**$3,574,244**	**$3,579,130**
Emergency ambulance service		
D.C. Public Schools	**$20,362,998**	**$14,262,765**
Payment to DCPS for health services provided to students enrolled in Medicaid, typically for students with disabilities		
D.C. Child & Family Services	**$58,192,133**	**$50,718,015**
Payment to CFS for health services provided to clients enrolled in Medicaid, typically for managing care for people with disabilities		
Waivers (Innovative programs operated under waivers from the federal government)		
Elderly & Physically Disabled Waiver	$32,856,736	$49,202,436
For people at risk of nursing home placement		
Developmental Disability Waiver	$31,190,925	$77,334,579
Services for people with intellectual disabilities		
Childless Adult Waiver	$12,857,143	$11,811,603
Childless adults age 50-64 enrolled in managed care		
HIV 1115 Waivers	$1,898,348	$1,728,171
Initiatives to prevent or delay serious illness for HIV+ individuals		
Subtotal Payments for Care	**$1,402,073,443**	**$1,519,379,462**
DHCF Aministration	**$34,210,070**	**$44,115,558**
TOTAL	**$1,436,283,513**	**$1,563,495,020**
Average Enrollees per Month	142,406	144,910
Average Spending per Enrollee per Month	$820	$874

Notes:
1. *The fiscal year runs from October 1 through September 30. Expenses are tallied on an accrual basis.*
2. *FY 2008 numbers are preliminary as of November 2008.*
3. *Prescription drug spending includes the net effect of rebates (credit) and "clawback" payments to the federal government (debit).*
4. *"DHCF Administration" excludes costs of administering Medicaid borne by other agencies, such as the cost of eligibility determiniation borne by the Income Maintenance Administration.*

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1. 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.

2. Gary Claxton, Jon R. Gabel, Bianca DiJulio et al., "Health Benefits in 2008: Premiums Moderately Higher, while Enrollment in Consumer-Directed Plans Rises in Small Firms," *Health Affairs* web exclusive Sept. 24, 2008, pp. w497-w498. See also 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; and Catherine Hoffman, Karyn Schwartz and Jennifer Tolbert, *The Uninsured: A Primer*, Pub. No. 7451-03 (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2007). Both reports contain analysis of the characteristics of people who are or are not covered by employment-based insurance.

3. The premium, from www.ehealthinsurance.com, is for an woman aged 50 enrolled in an HMO plan with zero deductible, 0% coinsurance and a $30 copayment for an office visit.

4. Groupings have changed from the FY 2007 report in order to be consistent with current data reporting practices within the Department of Health Care Finance. See note 19.

5. D.C. Primary Care Association, *Dollars and $ense: A Proposal to Maximize the Efficiency of DC's Health Care Dollars to Improve Quality and Access for District Residents* (Washington, D.C.: DCPCA, May 2007).

6. Thomas H. Ollendick and Carolyn S. Schroeder, eds., *Encyclopedia of Clinical Child and Pediatric Psychology*, (New York: Kluwer Academic Publishers, 2003), pp. 371-373.

7. Stan Dorn, Sharon Silow-Carroll, Tanya Alteras et al., *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2004).

8. The percentages were calculated using July 1, 2006 population data and Dec. 31, 2006, Medicaid enrollment data. Population data from U.S. Census Bureau, *Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2007*. Medicaid enrollment from Eileen R. Ellis, Dennis Roberts, David M. Rousseau, et al., *Medicaid Enrollment in 50 States: December 2006 Update* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2008). For the percentage of the population living under the poverty line, see U.S. Census Bureau, *Current Population Survey*, 2008 Annual Social and Economic Supplement, Table POV46, available at www.census.gov/hhes/www/poverty/poverty07.html.

9. Donna Cohen Ross, Aleya Horn, and Caryn Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Washington, D.C.: Center on Budget and Policy Priorities, 2008).

10. The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2008.

11. Spending per enrollee was calculated using spending figures from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured estimates based on data from CMS-64 reports, July 2007, and enrollment numbers from Ellis et al., *Medicaid Enrollment in 50 States: December 2006 Update*. All spending includes state and federal expenditures. Expenditures include benefit payments and disproportionate share hospital payments but do not include administrative costs, accounting adjustments, or the U.S. Territories.

12. The U.S. percentage is from the National Association of State Budget Officers, *2006 State Expenditure Report* (Washington, D.C.: NASBO, 2007), Table 29. The D.C. percentage is calculated from District expenses for total governmental activities found in the *2006 Comprehensive Annual Financial Report* (CAFR) (Washington, D.C.: Government of the District of Columbia, 2006), Financial Section, Exhibit 1-b, and from 2006 Medicaid expenditures in *Working Together for Health, Medicaid Annual Report 2007* (Washington, D.C.: D.C. Department of Health, Medical Assistance Administration), p. 23.

13. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Managed Care Penetration Rates by State as of June 30, 2007* (Washington, D.C.: KCMU, 2008). An alternative definition of managed care also includes enrollment in primary care case managed plans. However, primary care case managers take far less financial risk for the cost of care than do managed care organizations.

14. Vernon Smith, Kathleen Gifford, Eileen Ellis et al., *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2008), Appendix A-7b.

15. Edward L. Schor, Melinda Abrams and Katherine Shea, "Medicaid: Health Promotion and Disease Prevention for School Readiness," *Health Affairs* 26:2 (March/April 2007), pp. 420-429; Sara Rosenbaum and Paul H. Wise, "Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT," *Health Affairs* 26:2 (March/April 2007), pp. 382-393.

16. The premium, from www.ehealthinsurance.com, is for a typical D.C. plan with a $2,500 deductible and 20% coinsurance for a family with the demographic profile of the Lopezes.

17. U.S. Department of Health and Human Services, Office of Inspector General, *Medicaid Provider Enrollment Standards: Medical Equipment Providers,* OEI-04-05-00180 (Washington, D.C.: DHHS, October 2006).

18. D.C. Department of Health, Medical Assistance Administration, "Notice of Final Rulemaking," *District of Columbia Register* 55:22 (May 30, 2008), pp. 6153-6158.

19. Groupings have changed from the FY 2007 report in order to be consistent with current data reporting practices within the Department of Health Care Finance. One significant change is splitting the FY 2007 "Family" group into the FY 2008 "Adults" and "Children" groups. Another is that people under age 65 with Medicare coverage were in the "Dual" group in FY 2007 but the "Disabled" group this year.

For More Information

Information Need	Resource	Contact Information
Am I eligible for Medicaid? What do I do if my Medicaid card expires?	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?	Department of Health Care Finance, Office of Disabilities and Aging (ODA) Aging and Disability Resource Center	ODA: 202-442-5939 ADRC: 202-724-5626; www.adrcdc.org
I have a question about my Medicaid benefits.	Managed care: Call your health plan Fee-for-service: Department of Health Care Finance All beneficiaries: Ombudsman	D.C. Chartered Health Plan: 800-408-7511, 202-408-4720 Health Right: 877-284-0282, 202-218-0380 Unison: 800-701-7192 HSCSN: 866-937-4549 Fee-for-service: 202-442-5988 Ombudsman: 202-442-5988
I have a complaint about my Medicaid managed care plan.	Managed care complaint hotline Ombudsman	Hotline: 800-788-0342 Ombudsman: 202-442-5988
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 hotline Office of Program Operations Managed Care Member Services	866-758-6807 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: 202-906-8319 Other inquiries: 202-906-8319
I'm a health care provider. How do I obtain prior authorization for services?	Pharmacy: ACS Government Healthcare Solutions Other: Department of Health Care Finance	Pharmacy provider: 800-273-4962 Other: 202-272-9679
How do I get a job at the Department of Health Care Finance?	D.C. Human Resources	202-442-9700
I'm a policy analyst or journalist with questions about Medicaid policy or budget.	Policy: Department of Health Care Finance Budget: Office of Audit and Finance	202-442-5988 202-442-9118
All other inquiries.	Department of Health Care Finance	202-442-5988; 825 North Capitol Street, N.E., Suite 5135, Washington, D.C. 20002

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