



Delaware Health and Social Services

Department of Health and Social Services

Division of Medicaid & Medical Assistance

***Joint Finance Committee Hearing
Fiscal Year 2017***

***Stephen Groff
Division Director
Wednesday, February 24, 2016***

Good afternoon Senator McDowell, Representative Smith, and members of the Joint Finance Committee. I am Steve Groff, Director of the Division of Medicaid and Medical Assistance. Also with me are Lisa Zimmerman, Deputy Director, and Beth Laucius, Chief of Administration.

Thank you for this opportunity to speak with you today. My remarks will focus on the opportunities and challenges the Medicaid program faces as we look forward to FY 2017.



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Overview

- **Medicaid**
- **Delaware Healthy Children Program (CHIP)**
- **Delaware Prescription Assistance Program (DPAP)**
- **Chronic Renal Disease Program (CRDP)**

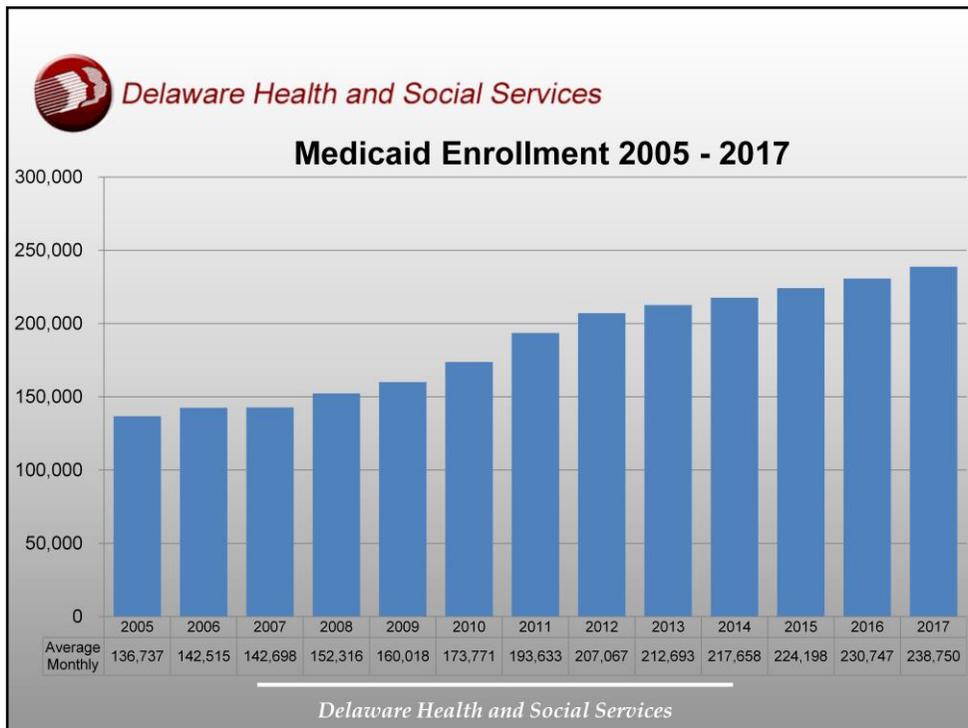
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DMMA currently administers four major health care programs. Medicaid and the Delaware Healthy Children Program (also known as CHIP) are funded with both State and federal dollars.

The Delaware Prescription Assistance Program and Chronic Renal Disease Program are our two 100 percent State-funded programs.

In combination, these programs currently provide health coverage to approximately 244,000 individuals each month, or one in every four Delawareans. Medicaid, alone, is currently serving 230,000 individuals.

Approximately 208,000 adults and children enrolled in Medicaid and CHIP are served through our contracts with two commercial managed care organizations: United Healthcare Community Plan and Highmark Health Options.

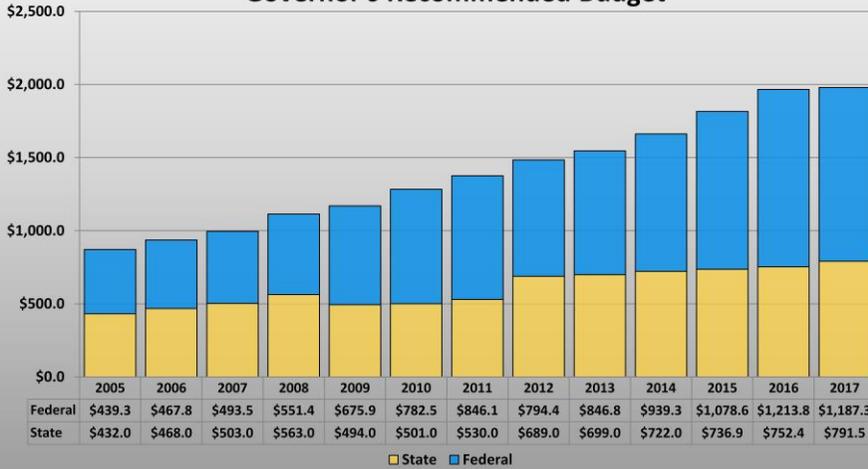


As I have mentioned the past two years, we continue to see lower growth rates than we experienced during the recession.

As you are aware, major health coverage provisions of the Affordable Care Act (ACA) were implemented in January 2014. Among these was the expansion of Medicaid income eligibility leading to the enrollment of approximately 10,000 adults in the “newly eligible” Medicaid eligibility category. These adults have incomes between 100 percent and 138 percent of the Federal Poverty Level. Their costs will be fully funded by the federal government through the end of calendar year 2016. Beginning in January 2017, the state will be responsible for funding 5 percent of their Medicaid costs.

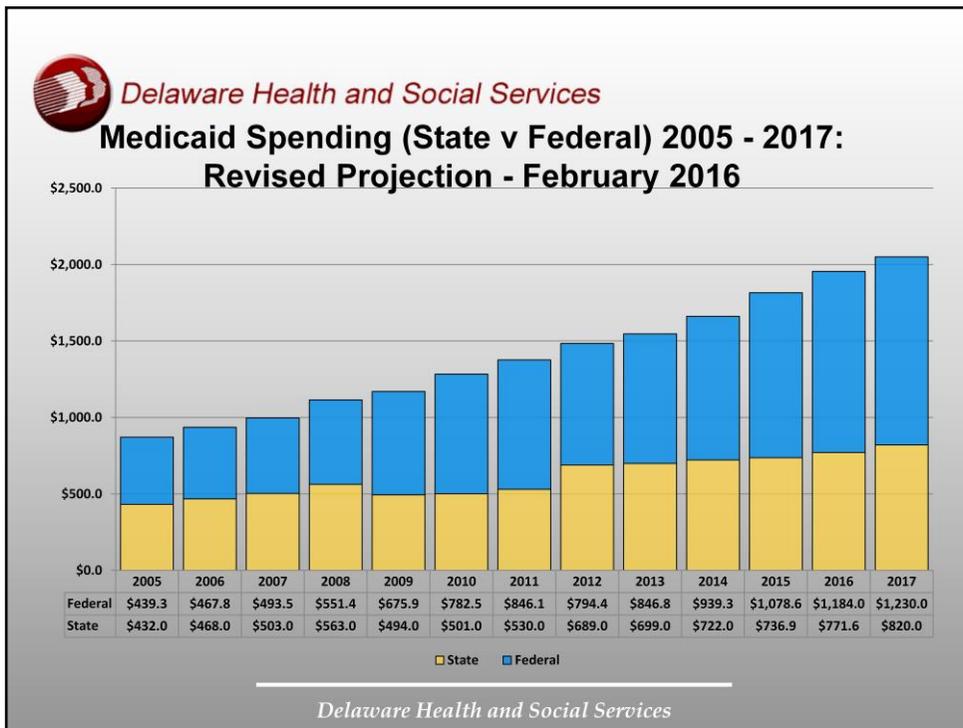


Medicaid Spending (State v Federal) 2005 - 2017:
Governor's Recommended Budget



On the next two pages you will see spending projections at the time the Governor's Recommended Budget was developed and recent projections completed this month. I will be describing the changes in more detail when I present our budget.

The impact of Medicaid spending on the state budget is driven not only by the total cost of the program, but also by the proportion of federal financial participation. In the past this was relatively straight forward with the state and federal governments sharing the cost about equally based on the Federal Medical Assistance Percentage (FMAP) rate set each year. The funding distribution, however, has become much more complex.



Enhanced federal matching funds made available through the Recovery Act reduced the state financial burden between 2009 and 2011. This additional contribution by the federal government ended in 2011. Beginning in 2014 and looking forward, costs will be divided using three different matching rates:

- 1) The regular FMAP will be applied to costs for traditional mandatory eligibility categories;
- 2) Individuals who are newly eligible under the ACA expansion will receive 100% federal funding; and
- 3) Adults eligible under optional expansion criteria established by Delaware in 1996 will receive an enhanced FMAP.

The matching rates for the last two categories will be adjusted between now and 2020 at which time they will level out at 90%.

Our spending chart shows that the distribution of state vs. federal funding has shifted since implementation of the Affordable Care Act, reducing the share of total spending contributed by the state.



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Moving Forward

- **Implementing Health Affordability Provisions of the Affordable Care Act**
- **Leveraging Managed Care to Promote Better Health Outcomes**

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Last year I took the opportunity to discuss the evolution of the Medicaid program over its fifty year history. We continue our efforts to mature the program by highlighting care coordination and best practices to ensure positive health outcomes; patient centered planning and self-direction to support individuals in community-based settings; innovative strategies to look beyond traditional medical models and address social determinants of health; payment reform to realign financial incentives with quality care; and program integrity to measure performance and monitor compliance.

Major health coverage provisions of the ACA were implemented in January 2014. These included the start of coverage under the Federal Marketplace and expansion of Medicaid coverage to adults with incomes below 138 percent of the poverty level. We continue to promote enrollment efforts to ensure health care coverage. Our focus, however, has moved toward other opportunities to encourage preventive services to achieve healthy outcomes.

We are now in the second year of our new MCO contracts with United Healthcare and Highmark Health. MCOs administer the majority of medical services in Delaware and we viewed these partnerships as an opportunity to restructure the delivery of Medicaid services in Delaware. Our focus in the coming year will be improved care coordination for our beneficiaries. We will also be looking to the final Managed Care regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) which are expected to be published in May 2016.



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Moving Forward

- **Enhancing Information Technology**
- **Strengthening Partnerships to Support System Delivery Reform**

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In addition to modernization of the State's integrated eligibility system to support ACA requirements, DMMA is engaged in the development of a new Medicaid Enterprise System (MES) to support all business processes including claims processing, provider enrollment, consumer support, plan management, and program integrity. This system, scheduled to go live in 2016, will improve agency efficiency and meet new federal standards for continued enhanced federal financial participation. In addition, we are excited about the new Data Warehouse/Decision Support System rolling out in the next few months which will greatly enhance capacity to analyze our data in more meaningful ways.

Finally, DMMA is maximizing opportunities to leverage our role as a health care payer to support system delivery goals of our sister agencies. Most notably over the past year is our continued collaboration with the Division of Substance Abuse and Mental Health in implementing the PROMISE program to improve integration of behavioral health and acute health services and support individuals with Serious and Persistent Mental Illness (SPMI). We are also collaborating with multiple agencies in the implementation of the Pathways to Employment Program to support employment and financial empowerment across disabilities. Finally, we are partnering with the Division of Public Health in the Contraceptive Access Now (CAN) initiative to reduce the impact of unintended pregnancies.



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Moving Forward

- **Quality Improvement and Value Based Purchasing**

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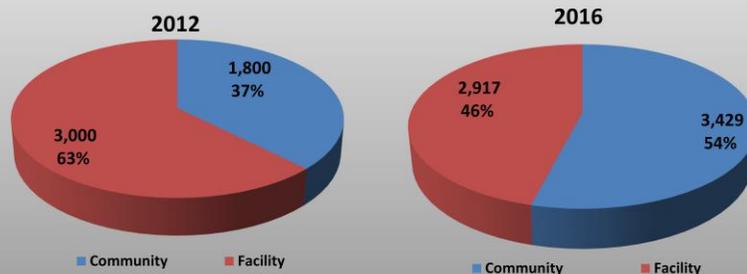
As we look to the coming year, I would like to highlight our priority areas.

Medicaid will continue to advance efforts to implement multi-payer health system transformation. We are collaborating with our MCOs to promote value-based purchasing arrangements in alignment with recommendations from the Delaware Center for Health Innovation (DCHI). We will provide financial support to assist in care coordination at the practice level and continue to enhance new care management strategies related to integration of pharmacy and medical services and behavioral health with acute health services. These changes will support the triple aim of better outcomes, improved health care experience, and slowing cost growth trends.



Moving Forward

- **Managed Care Delivery of Long Term Services and Supports**



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As I have discussed in prior years, DMMA moved long term services and supports (LTSS) into our managed care delivery system in April 2012. The goals of this delivery reform were to rebalance a system heavily biased toward facility-based care, increase integration of LTSS with overall medical management to improve health outcomes, expand consumer choices to improve consumer satisfaction, and create a financing structure to avoid costly services in facility-based settings. Expanded services include assisted living; chore services; home delivered meals; day habilitation; consumer directed attendant care; adult day services; emergency response systems; and home modifications.

The charts above demonstrate the progress made to date. The program has reduced the number of individuals receiving care in nursing facilities and reduced the overall proportion of individuals receiving facility-based care from 62 percent to 46 percent. More importantly, access to community-based LTSS has increased to allow more individuals to receive supports and avoid or delay the need for more intensive services.

We are also heavily engaged in transition activities related to the Home and Community-based Services Final Rule. The third iteration of the plan is currently out for public comment and we will be holding public hearings in all three counties early in March. We have completed provider and consumer surveys which are currently under review. We will begin site visits in the coming weeks.



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Thank You

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I wish to thank you for this time, and now I am happy to answer any questions you may have.