What are your biggest fiscal challenges, currently, for DHSS relative to the Medicaid program?

The major challenge for Delaware is dramatic increase in enrollment we have seen in the past two years. Our total enrollment is 194,200 as of December 2010. This represents a 25% increase over our enrollment in December 2008. At the same time we are facing a loss of enhanced federal funding at the end of June 2011. This means additional state funds will be needed just to maintain the current level of services. Maintenance of Effort requirements in the Affordable Care Act prohibit us from restricting eligibility so we must look to benefits and provider rates, co-payments, chronic care disease management to control costs.

What is the expected impact of health care reform on Delaware Medicaid? What are some potential cost savings or fiscal benefits?

Health care reform should bring an estimated additional 17,000 – 25,000 people onto Medicaid with the expansion of eligibility to 133% of the Federal Poverty Level (FPL) in January 2014. This expansion will be dependent on the state of the economy in 2014, as well as the increased Delaware population. Health Benefit Exchanges, in combination with changes in insurance regulations and government-administered programs, will offer individuals seamless, continuous coverage. Enhanced technology will benefit both the Medicaid program and private sector. Of course developing that technology by January 2013 could bring its own challenges.

With regard to savings, Delaware qualifies as an expansion state under the Affordable Care Act. This is because we extended eligibility to all adults at or below 100% of FPL as part of a demonstration program we implemented in 1996. With the Affordable Care Act, we will receive an enhanced federal matching rate for this group of individuals.

Please find attached a spreadsheet with a preliminary estimate of the fiscal impact of the ACA on the Medicaid program for the years 2014-2020 due to expansion of eligibility and FMAP (Federal match changes). This uses very basic assumptions: estimates of our existing expanded adult population and their costs from our own experience, estimates of newly eligible and their costs from Kaiser materials, 50% base FMAP prior to ACA enhancements. This does not account for the woodwork effect which may add significant costs. It also does not take into account other ACA changes such as use of modified adjusted gross income
(MAGI) because, quite frankly, we do not know how many of these factors will ultimately be defined. This preliminary estimate shows:

- **Without ACA:** In 2014 we would serve 31,568 adults below 100% of the FPL at a total cost of $382.6 million, $191.3 million of which would be GF.

- **With ACA:** In 2014, we would serve nearly 50,000 adults below 133% of the FPL at a total cost of $475.3 million, $95.7 million of which would be GF.

- **In summary:** In 2014 the ACA would allow us to serve an additional 18,183 adults (between 100-133% of FPL) but the state share of costs would be reduced from $191.3 million to $95.7 million.

- **Over the entire period 2014-2020,** total program costs for these two groups would increase by $746.7 million, but the state share of costs would actually be $1.2 billion less.

**Are there any quality improvement initiatives that have been implemented or are looking into, such as improving care or reducing costs for clients with chronic conditions?**

We believe the most effective changes can be made with regard to lifestyle issues. Delaware’s Medicaid Managed Care Programs currently provide some level of disease management programs and we are looking to advance more in the area of smoking cessation and obesity initiatives. Additionally, the Affordable Care Act provides for grant opportunities that would allow us to do even more.

As a member of the Health Prevention and Promotion Council, we are receiving support from a diverse group of stakeholders in developing realistic evidence based approaches to gain better health outcomes and disease management for the population, as well as cost benefit to the Medicaid program.

We know that in Delaware the leading cause of death for Delawareans is heart disease, with the actual causes of heart disease being tobacco, poor diet, and lack of exercise. Obesity is the second leading preventable cause of death. In 2009, 36.1% of adults in Delaware were overweight, and an additional 27.6% were obese. Sadly, the numbers aren’t much better for children. In 2008, 17% of Delaware’s children were overweight, with 24% considered obese. In the period from 1990 – 2007, the number of obese adults in Delaware doubled.

In 2009, 54,400 adults in Delaware were told they had diabetes, with an additional 36,000 being told they were pre-diabetic. Studies show that a two year window exists to be able to reverse the trend and keep a pre-diabetic person from developing the disease. If pre-diabetics undertake lifestyle changes allowing them to achieve a 5 – 7% weight loss, we will reduce the onset of Type II diabetes by 58%.
Strong financial benefits can be felt as well. Today, medical expenditures in Delaware connected to obesity are $207-million, with the cost of care related to smoking coming in at $473-million. In addition to those numbers, adults in Delaware diagnosed with diabetes have medical expenditures that are 2.3 times higher than those without diabetes. It is estimated that medical expenditure savings following a 50% reduction of prevalence in diabetes and high blood pressure (and the heart disease, cerebro vascular disease, and renal disease that accompany it) would be $33-million per year in the short run, and $92.4-million in the medium run.

The Affordable Care Act offers grants to pilot innovation in the areas of health delivery, prevention and wellness.

**What is Delaware Medicaid’s role in the Health Insurance Exchange planning process? What are implications of Medicaid being designated the lead agency? What specific issues are being looked at currently?**

Because Medicaid is a public insurance carrier and our mandate is to integrate Medicaid with the private commercial market as part of the exchange, Delaware felt it seemed appropriate to have our Medicaid office apply for the $1-million grant to help create the exchange. However, the process will be a collaborative effort among several agencies including the Department of insurance, the Division of Social Services, our state’s Information Resource management, and the Delaware health care Commission. As part of the planning process, we plan to host forums, roundtables, and focus groups with a variety of stakeholders including small business, private insurance carriers, brokers, and agents to provide input into the structure of the health insurance exchanges.