

# JOINT FINANCE COMMITTEE HEARING FISCAL YEAR 2021 BUDGET



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DIVISION DIRECTOR

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE  
Department of Health and Social Services  
February 26, 2020  
Legislative Hall, Joint Finance Committee Hearing Room

Comments available online at <https://dhss.delaware.gov/dhss/pubs.html>

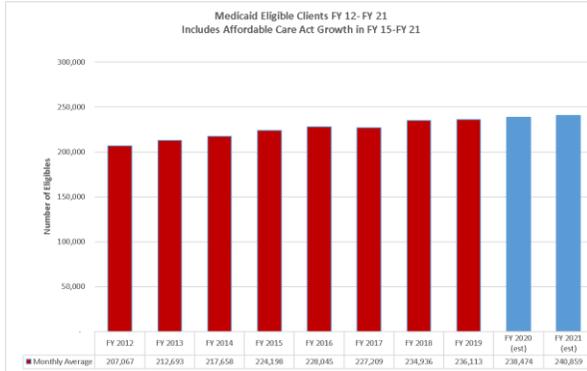
Good Afternoon Senator McDowell, Representative Johnson, members of the Joint Finance Committee and members of the public. I am Steve Groff, Director of the Division of Medicaid and Medical Assistance (DMMA). With me today are Lisa Zimmerman, our Deputy Director, and Alexis Bryan-Dorsey, our Chief of Administration.

Thank you for the opportunity to speak with you today and present our accomplishments and Fiscal Year (FY) 2021 Governor's Recommended Budget.

## DIVISION OVERVIEW

### Mission/Description

Mission: improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner.



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The mission of DMMA is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner.

We do this by providing health care coverage to nearly 250,000 Delawareans enrolled in Medicaid, the Children's Health Insurance Program (CHIP), the Delaware Prescription Assistance Program and the Chronic Renal Disease Program.

January 2020 enrollment included:

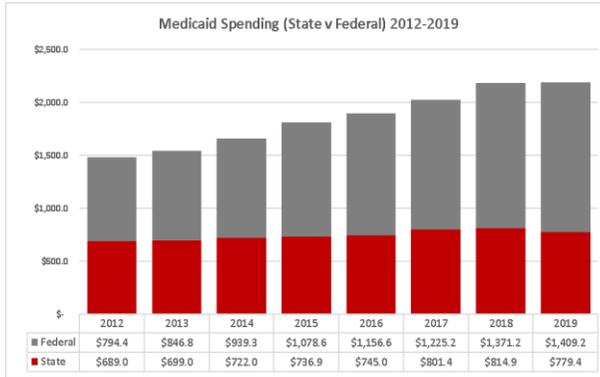
- 234,577 individuals in Medicaid (nearly one in four Delawareans);
- 8,923 children in the Delaware Healthy Children Program (CHIP);
- 2,089 individuals in the Delaware Prescription Assistance Program; and
- 653 individuals in the Chronic Renal Disease Program.

## DIVISION OVERVIEW

### Spending

“Medicaid accounts for a large share of state budgets, about 40 percent of state and local spending on health care.”

Source: Medicaid and CHIP Payment and Access Commission



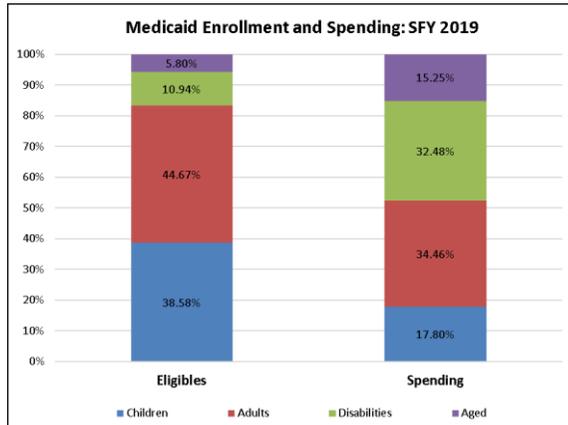
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DMMA’s FY 2020 budget is \$2.4 billion, of which \$1.5 billion reflects federal funding. I would like to focus my remarks on the Medicaid program since that accounts for the vast majority of our spending and the people we serve.

Medicaid is a joint federal-state program. The Federal Medical Assistance Percentage (FMAP) is the federal matching rate. FMAP rates vary depending on the type of service and eligibility category of beneficiaries. Delaware expanded eligibility to adults with incomes below the federal poverty level in 1996, qualifying us as an early expansion state under provisions of the Affordable Care Act. Consequently, services for our adult expansion enrollees are paid with 90% federal funding.

## DIVISION OVERVIEW

### Diverse Beneficiary Populations



“Medicaid spending per enrollee varies sharply by eligibility group.”

Source: Kaiser Commission on Medicaid and the Uninsured



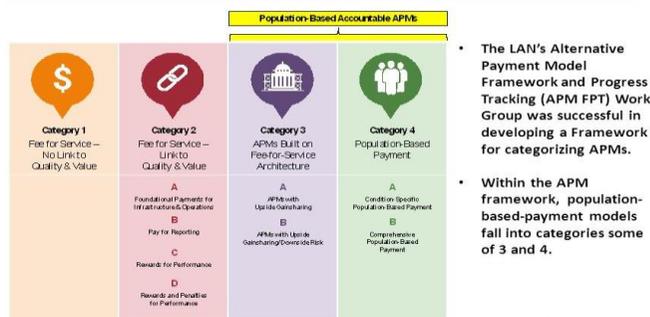
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Medicaid provides health care coverage to low-income children and adults, seniors, and individuals with disabilities. Medicaid provides benefits not typically covered by other insurers, including long-term services and supports and Medicare cost-sharing for some individuals who are eligible for both programs. Since its inception, the program has evolved from welfare-based coverage to become the nation’s primary payer for certain types of care such as nursing home care and home and community-based services. Additionally, Medicaid accounts for a significant portion of spending on mental health services and treatment for substance use disorder. As the chart shows, children and low-income adults represent the majority of those enrolled in the Delaware Medicaid program but account for substantially less spending.

# ACCOMPLISHMENTS

## Value-Based Purchasing with MCOs

### APM Framework Work Group



- The LAN's Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group was successful in developing a Framework for categorizing APMs.
- Within the APM framework, population-based-payment models fall into categories some of 3 and 4.



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HCP LAN  
Health Care Payment Learning & Action Network

As Secretary Walker has already discussed, health care spending in Delaware is not aligned with our overall health status and health care spending increases are not sustainable. The Health Care Spending Benchmark, established under Executive Order 25, will link the growth of health care spending to the overall economy of the state. The initial Spending Benchmark is set at 3.8% per capita spending growth in calendar year 2019 and decreases after that. Per capita spending increases in the Delaware Medicaid program have fluctuated but averaged around 4% over the time period between FY 2012 and FY 2019, and our goal is to be in line with or lower than the set benchmarks by utilizing a variety of value-based purchasing options.

DMMA is committed to the benchmarking exercise and the impact transparency and accountability will have on health care delivery. This is a critical to our efforts to elevate the role of value in reimbursement. The majority of services in Delaware's Medicaid and DHCP programs are administered by two Managed Care Organizations (MCOs): Highmark Health Options and AmeriHealth Caritas. Our 2018 managed care contracts included, for the first time, quality performance measures and value-based purchasing requirements with potential financial penalties. We realize that change will not occur overnight but these are significant foundational steps to improve health outcomes and contain spending growth.

The purpose of the three-year agreement is to transition the system away from traditional fee-for-service, volume-based care to a system that focuses on rewarding and incentivizing improved patient outcomes, value, quality improvements and reduced expenditures. The managed care organizations will be required to implement provider payment and contracting strategies that promote value over volume and reach minimum payment threshold levels.

## ACCOMPLISHMENTS

### Children with Medical Complexity



"Please don't dismiss our children. Please don't dismiss our families. We, like you, work very hard to make sure our children have everything they need to be successful in life. Our children just need a whole lot more to succeed. They need a whole lot more to be safe. They need a whole lot more to live and to live with quality of life. They are, in fact, children first; not in any way defined by their diseases. They are singers, dancers, huggers, flirts and pranksters. They are our hearts."

Maria Olivere, Franki's Mom



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Nationally, Medicaid and CHIP covered about half (48%) of children with special health care needs in 2016. Medicaid provides a wide range of medical and long-term care services, many of which are not covered at all or available only in limited amounts through private insurance, and makes coverage affordable for many children with special health care needs and their families.

In 2018, DMMA published a Plan for Managing the Health Care Needs of Children with Medical Complexity. I am pleased that we have formally established the Children with Medical Complexity Advisory Committee (CMCAC) to continue this important work to strengthen the system of care for these children and their families. The CMCAC is a multidisciplinary collaboration of many stakeholders including state agencies, payers, providers and families. The committee's work addresses access to health care services, coordination of benefits, and models of care.

We are currently working on a Workforce Capacity Study in collaboration with the University of Delaware, Center for Disability Studies to learn more about the availability of home health services. We are also developing a Family Focus Group and Survey study in collaboration with Vital Research to gather input from families regarding care delivery and ways to improve the system.

## ACCOMPLISHMENTS

### Long-Term Services and Supports (LTSS)



LTSS refer to a broad range of supportive services needed by people who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition.

Source: O'Shaughnessy, C. The Basics: National Spending for Long-Term Services and Supports (LTSS), 2012. National Health Policy Forum, 2014. Available online at [http://www.nhpf.org/library/the-basics/Basics\\_LTSS\\_03-27-14.pdf](http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf).



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Medicaid is the primary payer for institutional and community-based long-term services and supports (LTSS). Historically, Medicaid LTSS spending has been disproportionately institutional rather than community-based. We continue to prioritize rebalancing and supporting individuals in community-based, inclusive settings. The percentage of total LTSS spending that is associated with home and community-based services increased from 39.6% in FY 2013 to 47.8% in FY 2016.

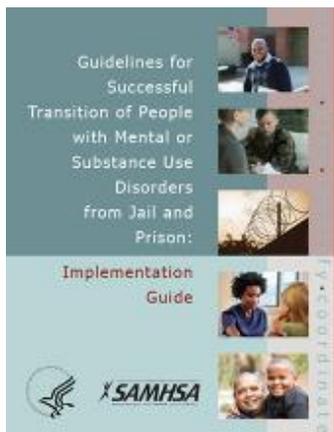
One model of care is the Program of All-Inclusive Care for the Elderly (PACE). PACE benefits include, but are not limited to, all Medicaid and Medicare covered services. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses an enrollee's needs, develops care plans, and delivers all services (including health, social, and supportive services).

Our current PACE program at St. Francis LIFE provides complete medical, health and social services in a centralized location to 268 individuals in Wilmington and New Castle County. This spring, we look forward to our second PACE site opening in Newark.



## ACCOMPLISHMENTS

### Justice Involved Population



Upon release from jail or prison, many people with mental or substance use disorders continue to lack access to necessary services and, too often, become enmeshed in a cycle of costly justice system involvement —Pew Center on the States (2011)



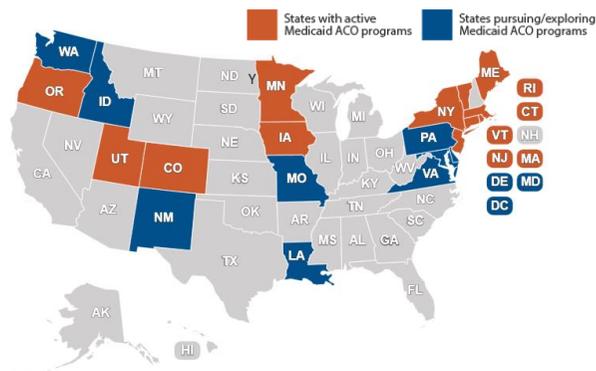
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DMMA, in collaboration with the Department of Correction, Division of Social Services, DSAMH and our MCOs, implemented the In-Reach/Care Model, for the justice involved population on January 1, 2020. Individuals incarcerated will no longer have their Medicaid eligibility terminated. Their eligibility will be suspended and they will remain enrolled with their MCO. This will enable the MCOs to perform in-reach to facilitate provide transition services and care coordination prior to the individual's release.

Newly released Medicaid members will have immediate access to mental health, substance use disorder and other medical care. The goal of this is program is to provide a smoother transition to the community, ensure continuity of care, prevent adverse health outcomes, and reduce recidivism.

## LOOKING AHEAD

### Accountable Care Organizations (ACOs)



State-based Medicaid accountable care organizations (ACOs) are becoming increasingly prevalent across the country, with more and more states pursuing ACOs as a way to improve health outcomes and control costs through greater provider accountability.



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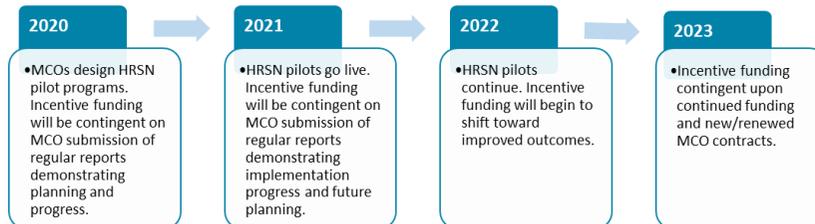
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Accountable Care Organizations (ACOs) create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. ACOs that lower health care costs while meeting performance standards are rewarded through shared savings arrangements. Patient and provider participation in an ACO is purely voluntary.

DMMA issued the final ACO regulation this month. The ACO application will be published next week. The general parameters of the application rely on primary care attribution, enrollment of at least 5,000 Medicaid members per ACO/MCO contract, and provide for increasing financial risk over a three year period. The goal is to have MCOs contract with at least two ACOs beginning January 1, 2021. Flexibility will be given to the MCOs and ACOs to negotiate contracts within the general program design set forth by DMMA.

## LOOKING AHEAD

### Social Determinants of Health



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Consistent with the objectives of the Delaware Health Fund, DMMA is implementing multi-year strategies that address individual health-related social needs (HRSN) and impact community-level social determinants of health (SDOH). These strategies involve working with our Medicaid managed care partners, providers, community-based organizations, and partner state agencies to incorporate SDOH into existing and future initiatives.

Beginning this year, DMMA will make incentive funding available to Medicaid MCOs that agree to design and implement an HRSN pilot program targeting health-related housing or food/nutrition needs. In partnership with community-based organizations and providers, MCOs will launch targeted interventions such as medically tailored meals, increased access to home-delivered meals (beyond the state-defined home and community-based services benefit), food prescription programs, and lead abatement.

## LOOKING AHEAD

### Adult Dental Benefit



Forty-four percent of low-income adults ages 20 to 64 have untreated tooth decay, and five percent of adults have lost all of their teeth.

Source: Center for Health Care Strategies, Inc.



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Senate Substitute I for Senate Bill 92, enacted in 2019, directs DMMA to establish an adult dental benefit. Adult dental coverage is optional for state Medicaid programs but most offer at least an emergency dental benefit. It has been a long standing priority of DMMA to offer preventive and restorative dental treatment for our adult population to address negative health outcomes associated with the lack of oral health care. The benefit will enable Medicaid enrolled adults to receive up to \$1,000 of dental care per year. An additional \$1,500 may be available for qualifying emergency or supplemental care when medically necessary.

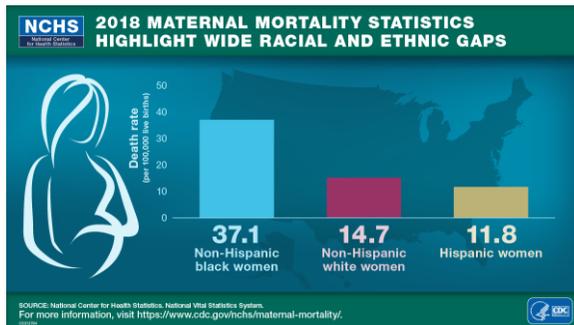
Unfortunately we will be unable to meet the April 1, 2020 implementation date included in the legislation. We are working closely with the Centers for Medicare and Medicaid Services, but estimate an additional six months will be needed to receive all the necessary federal approvals and complete the subsequent administrative tasks necessary to begin the program. The projected implementation date is now October 1, 2020.

We apologize for the inconvenience this will cause to our beneficiaries who are waiting for these critically needed services and assure you that we will continue to move forward as quickly and expeditiously as possible.

I also want to express my appreciation for the continued support and collaboration of the Governor, Lt. Governor, General Assembly, Dental Society, and other stakeholders.

## LOOKING AHEAD

### Maternal Mortality



Wide racial and ethnic gaps exist between non-Hispanic black (37.1 deaths per 100,000 live births), non-Hispanic white (14.7), and Hispanic (11.8) women.

Source: National Center for Health Statistics



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The National Center for Health Statistics recently released maternal mortality statistics for 2018 indicating that the maternal mortality rate is 17.4 per 100,000 live births in the United States. Additionally, there is wide racial and ethnic disparity in maternal mortality rates. Medicaid was the principal source of payment for 44.4% of deliveries in Delaware in 2018.

Senate Concurrent Resolution 66 was passed in January requesting that DMMA study the option of extending postpartum coverage through first year postpartum as a strategy for reducing preventable maternal mortality and closing the disparity in the maternal mortality rate among black women and women of other races. We look forward to providing our findings later this Spring and actively collaborating with the Division of Public Health, the Maternal Mortality Review Commission, community members and other stakeholders to explore the use of policy levers in Medicaid to improve care for pregnant women and their infants.

## FY 2021 GOVERNOR'S RECOMMENDED BUDGET

### FY 2021 Governor's Recommended Budget (\$ in thousands)

	GF	ASF	NSF	Total
FTEs	81.2	0.0	107.4	188.6
Dollars (\$)	776,718.2	78,418.3	1,522,700.7	2,377,837.2

**Budget Definitions:**

GF – General Funds  
ASF – Appropriated Special Funds  
NSF – Non-Appropriated Special Funds  
FTEs – Full Time Equivalent Positions



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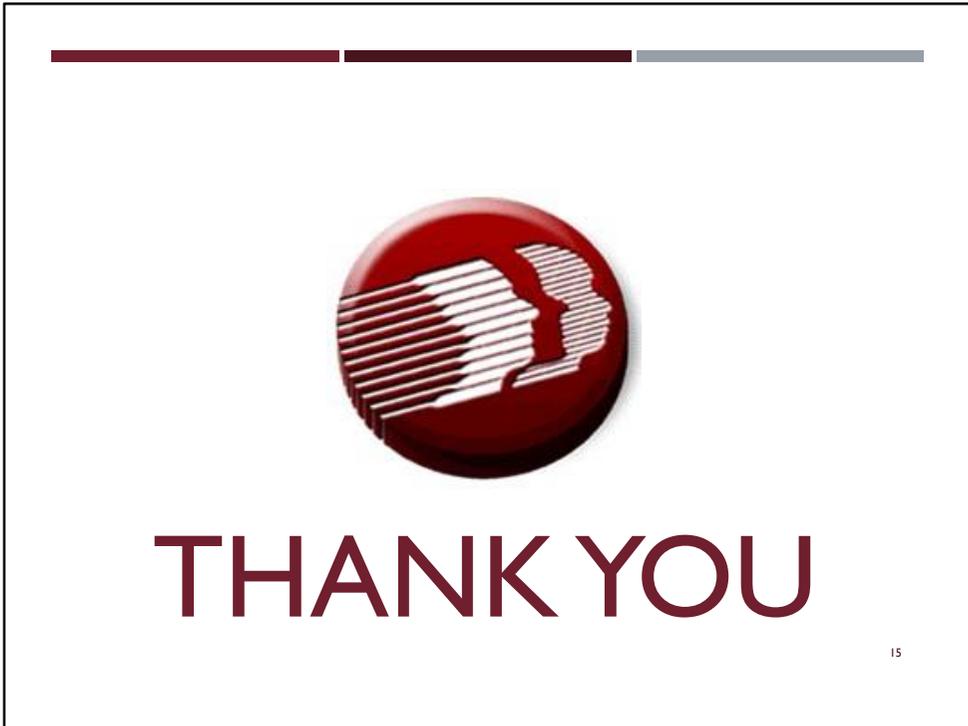
The slide above shows the budget included in the FY 2021 Governor's Recommended Budget (GRB).

Our Division's FY 2021 GRB is:

- \$776.718.2 [Seven Hundred Seventy-Six Million, Seven Hundred Eighteen Thousand, Two Hundred Dollars] in General Funds (GF);
- \$78,418.3 [Seventy-Eight Million, Four Hundred Eighteen Thousand, Three Hundred Dollars] in Appropriated Special Fund (ASF) spending authority; and
- \$1,522,700.7 [One Billion, Five Hundred Twenty-Two Million, Seven Hundred Thousand, Seven Hundred Dollars] in Non-Appropriated Special Funds (NSF).

Highlights include:

- \$10.2 million negative inflation/volume adjustment to maintain FY 2020 service levels in the Medicaid program. Monitoring enrollment and spending is an ongoing responsibility of DMMA. Throughout the year we adjust projections to reflect the latest enrollment and spending information. Adjustments made in December reflect reduced spending attributable primarily to continued leveling in program enrollment.
- \$2.8 million adjustment in the Delaware Healthy Children Program to offset a projected loss in federal funding due to an 11.5% reduction in the federal matching rate.



Thank you for the opportunity to share with you the challenges and opportunities facing the Division of Medicaid and Medical Assistance.

I am happy to answer any questions.