State/Territory: DELAWARE

(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

Thomas R. Carper, Governor June 30, 1998

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: ~~Theodore Mermigos~~ Andrew Wilson Position/Title: ~~Acting~~ Director

Name: ~~Lisa Zimmerman~~ Janneen Boyce Position/Title: Deputy Director

Name: Unkyong Goldie Position/Title: Chief of Administration

*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: October 1, 1998

Implementation Date: February 1, 1999

Subsequent Plan Amendments

State Plan Amendment	Effective Date	Implementation Date
SPA #1	July 1, 1999	
SPA #2	October 1, 2001	August 1, 2001
SPA #3	June 12, 2003	Withdrawn – June 12, 2003
SPA #4	January 1, 2007	October 1, 2009
SPA #5	April 1, 2009	April 1, 2009
SPA #6	July 1, 2010	July 1, 2010
SPA #7	July 1, 2014	July 1, 2014
SPA # DE-CHIP-16-001	January 1, 2017	January 1, 2017
SPA # DE-CHIP-17-003	October 2, 2017	October 2, 2017
SPA # DE-CHIP-18-003	October 12, 2018	October 12, 2018
SPA # DE-CHIP-19-004	July 1, 2018	July 1, 2018
SPA # DE-CHIP-20-0003	March 1, 2020	March 1, 2020
SPA # DE-CHIP-20-0007	October 1, 2020	October 1, 2020
SPA # DE-CHIP-22-005	March 11, 2021	March 11, 2021
SPA # DE-CHIP-22-0014	July 1, 2023	July 1, 2023
SPA # DE-CHIP-20-0004	October 24, 2019	October 24,2019
SPA # DE-CHIP-24-0003	July 1, 2024	July 1, 2024

Summary of Approved CHIP MAGI SPAs:

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
DE-13-0012 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low Income Children MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
DE-13-0013 Effective/ Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
DE-13-0016	Establish	CS14	Children	Incorporate within a separate

Effective/ Implementation Date: January 1, 2014	2101(f) Group		Ineligible for Medicaid as a Result of the Elimination of Income Disregards	subsection under section 4.1
DE-13-0015 Effective/ Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21 CS27	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial Eligibility – Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 8.7 Supersedes the current section 4.1.8
DE-13-0014 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
DE-22-0012 Effective/Implementation Date: July 1, 2022	Non-Financial Eligibility	CS27	Continuous Eligibility	Supersedes the current CS27 SPA MMDL template under SPA #DE-13-0015

Current SPA #: ~~DE-CHIP-22-0014~~ DE-CHIP-24-0003

Purpose of SPA: ~~The purpose of this proposed SPA DE-CHIP-22-0014 is to align services provided to children under Delaware's Title XXI CHIP State Plan with services provided to children under Delaware's Title XIX Medicaid State Plan.~~

The purpose of this proposed SPA DE-CHIP-24-0003 is to align continuous eligibility rules with the new requirements under the Consolidated Appropriations Act (CAA), 2023 and to remove premium requirements from the CHIP program.

Proposed effective date: ~~July 1, 2023~~ July 1, 2024

Proposed implementation date: ~~July 1, 2023~~ July 1, 2024

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Delaware does not have any federally recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska Natives, may participate in the review of amendments to state law or regulation and may offer comments on all program policies, including those relating to provision of child health assistance to American Indian or Alaskan Native children.

TN No: Approval Date Effective Date

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility.

~~The initial month of the continuous period of eligibility is the first month of eligibility. A new period of continuous eligibility will be established beginning with the month following the last month of the previous period of continuous eligibility, when a scheduled renewal is completed and the child is determined to be eligible. A new 12-month period of continuous eligibility will also begin after any break in DHCP eligibility.~~

Continuous eligibility is based on the *effective date* of the child's last eligibility determination at application or renewal. The continuous eligibility period begins:

- On the *effective date* of the child's initial eligibility determination, or
- On the *effective date* of the child's most recent eligibility redetermination or renewal, which begins a new 12-month eligibility period.

Refer to attached MAGI page CS27

~~**CHIP Disaster Relief:**~~

~~At State discretion, temporarily provide continuous eligibility to CHIP enrollees who might otherwise have coverage terminated after a change in circumstances by waiving the following exceptions of the continuous eligibility period to align with Medicaid requirements for beneficiaries who reside and/or work in a State or Federally declared disaster area, to the end of the emergency period:~~

- ~~There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.~~

4.1-PW ☐ **Pregnant Women Option** (section 2112) - The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: *States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully*

residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes

8.1.2. ☒ No, skip to question 8.8.

8.1.1-PW ☐ Yes

8.1.2-PW ☐ No, skip to question 8.8.

Guidance: *It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))*

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☒ Premiums:

- ~~$10 PFPM for families with children ages one (1) through five (5) with family incomes ranging from 143% FPL through 159% of FPL,~~
- ~~$10 PFPM for families with children ages six (6) through eighteen (18) with family incomes ranging from 134% FPL through 159% of FPL,~~
- ~~$15 PFPM for families with children ages one (1) through eighteen (18) with family incomes ranging from 143% to 160 % through 176% of the FPL, and~~
- ~~$25 PFPM for families with children ages one (1) through eighteen (18) with family incomes ranging from 177% to 212% of the FPL.~~

~~(refer to CHIP MAGI State Plan Page CS21 for information on the effect of non-payment of premiums). Incentives for pre-payment of premiums include the following: Pay three (3) months get one (1) premium free month; pay six (6) months get two (2) premium free months; pay nine (9) months get three (3) premium free months.~~

~~CHIP Disaster Relief:~~

~~At State discretion, premiums may be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in a State or Federally declared disaster area for a specified period of time.~~

8.2.2. ☐ Deductibles:

8.2.3. ☐ Coinsurance or copayments:

8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

~~The public will be notified of cost sharing requirements and any other aspects of the DHCP through the State's Administrative Procedures Act which requires publishing everything that has an impact on State citizens and provides an opportunity for public comment. Information is published in the Delaware Register of Regulations monthly as changes or new initiatives occur (www.state.de.us/research/dor/register.htm). Information will also be initially provided at public meetings and through outreach and educational efforts. Delaware will also use the Health Benefits Manager to educate and continue to do outreach similar to the DSHP.~~

Guidance: *The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.*

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3. ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☒ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify:)
☒ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.
Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type

of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical

benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

~~Since cost sharing is per family per month (PFPM), rather than per member per month, each family will pay the same amount no matter the number of children in the household. The premium rates are significantly less than those allowed by the Balance Budget Act of 1997 for premiums (see chart below). Delaware believes these levels of cost sharing are affordable but, at the same time, provide an incentive for clients to responsibly use health care services.~~

~~Premiums as a Percentage of Income~~									
~~Premium Amount Per Month~~	~~Age~~	~~Family Size~~	~~134% FPL lower limit~~	~~143% FPL lower limit~~	~~159% FPL upper limit~~	~~160% FPL lower limit~~	~~176%FPL upper limit~~	~~177% FPL lower limit~~	~~212% FPL upper limit~~
~~$10 Monthly Premium~~	~~1 through 5~~	~~1~~		~~0.69 %~~	~~0.62 %~~				
	~~1 through 5~~	~~2~~		~~0.51 %~~	~~0.46 %~~				
	~~1 through 5~~	~~3~~		~~0.40 %~~	~~0.36 %~~				
	~~6 through 18~~	~~1~~	~~0.74 %~~		~~0.62 %~~				
	~~6 through 18~~	~~2~~	~~0.54 %~~		~~0.46 %~~				
	~~6 through 18~~	~~3~~	~~0.43 %~~		~~0.36 %~~				
~~$15 Monthly Premium~~	~~1 through 18~~	~~1~~				~~0.93 %~~	~~0.84%~~		
	~~1 through 18~~	~~2~~				~~0.68 %~~	~~0.62%~~		
	~~1 through 18~~	~~3~~				~~0.54 %~~	~~0.49%~~		
~~$25 Monthly~~	~~1 through 18~~	~~1~~						~~1.40 %~~	~~1.17 %~~

Premium	1 through 18	2						1.03 %	0.86 %
	1 through 18	3						0.82 %	0.68 %

*Based on the 2018 Poverty Limit of $12,140 for 1 person, $16,460 for 2, and $20,780 for 3.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Delaware's application form asks for race group including American Indian/Alaskan Native and we accept self-declaration. This information is included in the automated record, which enables us to exclude these families from premium requirements. We will add a statement to the approval notices indicating that American Indian/Alaskan Native families are exempt from premium requirements. The approval notices include a toll free contact number. To exclude American Indian/Alaska Native enrollees from any copayments on non-emergent use of emergency room services, the premium and approval notices will include a statement advising families the AI/AN families are exempt. The notices will advise AI/AN families to call the Health Benefits Manager (HBM) at a toll-free number to identify themselves and request an exemption. MMIS has an exemption code that must be manually entered by the HBM.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. A notice of cancellation will be sent to the family advising the family to report any change in circumstances, such as a decrease in income that may result in eligibility for Medicaid. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated. Refer to attached MAGI page CS21.

CHIP Disaster Relief:

Exception to Disenrollment for Failure to Pay Premiums – At State discretion, premiums may be waived for CHIP applicants and/or enrollees who meet income and other eligibility requirements and who reside and/or work in a State or Federally declared disaster area. The premium balance will be waived if the family is determined to have been residing and/or working in a State or Federally declared disaster area on self-declared application information or other documentation provided by the family.

Guidance: *Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and*

efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: *Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))*

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4. ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

9.10 Provide a 1-year projected budget (Section 2107(d)) (42CFR 457.140).

CHIP Budget FFY 2023

STATE: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2023	FFY 2023	FFY 2023
State's enhanced FMAP rate	75.28%	75.28%	75.28%
Benefit Cost			
- Insurance Payments			
- Managed care		$25,323,201	$25,323,201
- per member/per month rate		$299	
# of enrollees		5,200	5,200
- Fee for Service		$5,307,360	$5,307,360
Total Benefit Costs		$30,630,561	$30,630,561
- (Offsetting beneficiary cost sharing payments)			
Net Benefit Costs		$30,630,561	$30,630,561
- Cost of Proposed SPA Changes - Benefit		$177,355	$177,355
- -			
Administrative Costs			
- Personnel		$115,719	$115,719
- General Administration		$1,040,000	$1,040,000
- Contractors/Brokers		$272,658	$272,658
- Claims Processing		$117,996	$117,996
- Outreach/marketing costs			
- Health Services Initiatives	$48,000		$48,000
- Other			
Total Administrative Costs		$1,546,373	$1,594,373
- 10% Administrative Cap		$3,403,396	$3,403,396
- Cost of Proposed SPA Changes			
- Federal Share		$24,356,309	$24,356,309
- State Share		$7,997,980	$7,997,980
Total Program Costs		$32,354,289	$32,354,289

Budget Assumptions

- ~~Client growth will decrease throughout FFY 2023 until redeterminations start~~
- ~~Capitation rates paid to commercial managed care organizations will increase an average of 2.5% based on new contracts;~~
- ~~Enhanced Federal FMAP will start at 75.28% and "step down" during the PHE unwinding.~~
- ~~The primary cost driver of adding coverage of EPSDT benefits is our NEMT benefit.~~

CHIP Budget FY 2024

STATE: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2024	FFY 2024	FFY 2024
State's enhanced FMAP rate	71.80%	71.80%	71.80%
Benefit Cost			
Insurance Payments			
Managed care		$33,052,341	$33,052,341
per member/per month rate		$254	
# of enrollees		10,842	10,842
Fee for Service		$9,980,438	$9,980,438
Total Benefit Costs		$43,032,779	$43,032,779
(Offsetting beneficiary cost sharing payments)		0	0
Net Benefit Costs		$43,032,779	$43,032,779
Cost of Proposed SPA Changes - Benefit			
Administrative Costs			
Personnel		$130,000	$130,000
General Administration		$180,000	$180,000
Contractors/Brokers		$250,000	$250,000
Claims Processing		$400,000	$400,000
Outreach/marketing costs			
Health Services Initiatives	$50,000		$50,000
Other			
Total Administrative Costs		$960,000	$1,010,000
10% Administrative Cap		$4,781,420	$4,781,420

- Cost of Proposed SPA Changes		($83,438)	($83,438)
- Federal Share		$31,526,907	$31,526,907
- State Share		$12,382,434	$12,382,434
Total Program Costs		$43,909,341	$43,909,341

Budget Assumptions

- Capitation rates paid to commercial managed care organizations are based on CY 24 contracts.
- Enrollment is projected to steadily increase through FFY 24 due to disenrollment of Medicaid children during the Public Health Emergency Unwinding and the conintuous coverage of eligible children.
- The program change is to eliminate cost sharing.

CHIP Budget FY 2025

STATE: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2025	FFY 2025	FFY 2025
State's enhanced FMAP rate	72.11%	72.11%	72.11%
Benefit Cost			
Insurance Payments			
Managed care		$37,714,784	$37,714,784
per member/per month rate		$259	
# of enrollees		12,129	12,129
Fee for Service		$ 11,392,539	11,392,539
Total Benefit Costs		$49,107,323	49,107,323
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs		$49,107,323	$49,107,323
Cost of Proposed SPA Changes - Benefit			
Administrative Costs			
Personnel		$130,000	$130,000
General Administration		$180,000	$180,000
Contractors/Brokers		$250,000	$250,000
Claims Processing		$400,000	$400,000
Outreach/marketing costs			
Health Services Initiatives	$50,000		$50,000
Other			
Total Administrative Costs		$960,000	$1,010,000
10% Administrative Cap		$5,456,369	$5,456,369
Cost of Proposed SPA Changes		0	0
Federal Share		$35,868,939	$35,868,939
State Share		$13,873,037	$13,873,037
Total Program Costs		$49,741,976	$49,741,976

Budget Assumptions

- FFY 25 enrollment is based on the impacts for continuous coverage of children.

- Capitation rates paid to commercial managed care organizations will increase an average of 2.5% based on new contracts;
- Enrollment is projected to remain steady due to the conintuous coverage of eligible children.
- The program change is to eliminate cost sharing.