

New Hampshire SIM Stakeholder Meeting

November 21, 2013



Meeting Agenda

1. Introductions
2. General SIM Update
3. Consumer Online Survey Update
4. Additional Cost Overview of Individuals Receiving LTSS
5. SIM Design Update
6. Draft SIM Plan Overview



SIM Stakeholder Meeting

Updated SIM Population Data Summaries

Presented by:

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

November 21, 2013





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November 19, 2013

Ms. Sheri L. Rockburn, CPA, MBA
Director of Finance
Division of Community Based Care Services
Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301

Re: Updated Preliminary Data Summaries for SIM Baseline Model

Dear Sheri:

The New Hampshire Department of Health and Human Services (DHHS) retained Milliman to provide actuarial support related to New Hampshire's State Health Care Innovation Model (SIM) grant. This letter includes several new data summaries to help better understand the cost profile and the acuity of the population in the current LTC system in New Hampshire.

The data summaries included with this letter are preliminary in nature. They will change as we receive feedback and additional information.

DISCLAIMER

The Medicare expenditures for dual eligibles shown in Exhibits A1-A6 and C1-C6 represent estimated Medicare costs for disabled and aged dual eligibles using the CMS 5% sample data for the state of New Hampshire and average Part D pharmacy expenditures. ***These estimates do not represent the Medicare cost for any particular waiver population, but rather represent an average Medicare dual eligible cost.*** A more detailed classification of Medicare beneficiaries could yield better estimates of Medicare expenditures for the various SIM populations.

Please note that the values shown in the attached exhibits D1-D2 and E1-E2 could be understated if Medicaid claims for dual eligibles do not include comprehensive diagnosis coding. More complete diagnosis data is generally available in Medicare data, but person-specific Medicare data is not available for this project.

COST DECILE SUMMARIES

We developed data summaries by expenditure decile for the populations receiving Medicaid long-term care and support services.

Exhibits A1-A6 show expenditure deciles for the SIM population in total grouped by age as follows:

- > Exhibit A1 – Total All Ages
- > Exhibit A2 – Ages Under 18
- > Exhibit A3 – Ages 19-64
- > Exhibit A4 – Ages 65-74
- > Exhibit A5 – Ages 75-84
- > Exhibit A6 – Ages 85+

Exhibit B1 shows counts of individuals from the SIM populations for each decile while Exhibit B2 shows the distribution for each decile.

We also created a decile summary for the following major populations that will be impacted by the SIM model design:

- > Exhibit C1 – Choices of Independence (CFI) waiver enrollees
- > Exhibit C2 – Developmental Disabilities (DD) waiver enrollees
- > Exhibit C3 – Acquired Brain Disorders (ABD) waiver enrollees
- > Exhibit C4 – In Home Supports (IHS) waiver enrollees
- > Exhibit C5 – Nursing home residents
- > Exhibit C6 – BBH consumer population

To develop these exhibits, we summarized total annual spend for SFY 2011 and SFY 2012 for each individual and ranked them from least expensive to most expensive. We then assigned each individual one of ten decile groupings based on that ranking system. For example, the 90%-100% decile group is the most expensive 10% of the population. The 80%-90% decile is the next most expensive 10% of the population.

Expenditures are summarized based on the following service categories:

- > Medicaid ICF/SNF services
- > Medicaid HCBS Waiver services
- > Medicaid CMHC services
- > Medicaid Hospital Inpatient and Outpatient services
- > Medicaid at School services
- > Medicaid – Other services
- > Medicare services (estimated)

Each exhibit shows total annual expenditures, annual expenditure per member and per member per month (PMPM) expenditures and allows for the comparison of expenditure distribution by major service category across individuals with various levels of need.

The Medicare expenditures for dual eligibles represent **estimated** Medicare expenditures for disabled and aged dual eligibles using the CMS 5% sample data for the state of New Hampshire and average Part D pharmacy expenditures. The Medicare PMPM expenditure estimates were assigned to each dual eligible based on their age for each month they were eligible for both Medicaid and Medicare. **These estimates do not represent the Medicare cost for any particular waiver population, but rather represent an average Medicare dual eligible cost.** We will update our Medicare estimates if we get access to the 100% New Hampshire sample data from CMS or develop a more refined estimation methodology based on DHHS input.

CO-MORBIDITY SUMMARIES

We developed several exhibits to help assess the acuity of the various populations that will be impacted by the SIM model design. Exhibits D1-D2 shows the prevalence of the top 25 diagnostic categories as assigned by the CMS-HCC risk adjustment system used for the Medicare Advantage program for each population.

Exhibit D1 shows the prevalence rates for the population in total for SFY 2012. Exhibit D2 shows the prevalence rates for the 10% most expensive individuals in each population for SFY 2012. We included prevalence rates for the following populations:

- > Choices of Independence (CFI) waiver enrollees
- > Developmental Disabilities (DD) waiver enrollees
- > Acquired Brain Disorders (ABD) waiver enrollees
- > In Home Supports (IHS) waiver enrollees
- > Nursing home residents
- > BBH consumer population
- > Total population

Exhibit E1 shows the distribution of the number of conditions for the population in total for SFY 2012. Exhibit E2 shows the distribution of the number of conditions for the 10% most expensive individuals in each population for SFY 2012.

Please note that the values shown in Exhibits D1-D2 and E1-E2 could be understated if Medicaid claims for dual eligibles do not include comprehensive diagnosis coding. More complete diagnosis data is generally available in Medicare data, but person-specific Medicare data is not available for this project.

DATA RELIANCE AND IMPORTANT CAVEATS

We used FFS Medicaid cost and eligibility data for June 2010 through December 2012 and other DHHS information to develop the historical data summaries shown in this letter. This data was provided by DHHS. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Milliman prepared this letter and the accompanying appendices for the specific purpose of providing preliminary data summaries for use in the development of the baseline population and financial model of the current LTC system in New Hampshire. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by the management of DHHS. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. This letter should only be reviewed in its entirety.

The results of this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

I am a Principal and Consulting Actuary for Milliman, a member of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of my knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The terms of Milliman's contract with the New Hampshire Department of Health and Human Services signed on November 16, 2012 apply to this report and its use.





Ms. Sheri L. Rockburn
November 19, 2013
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Please call me at (262) 796-3434 if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "John D. Meerschaert".

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

JDM/laa

Overview of Actuarial Analysis

- Purpose of analysis
 - Provide information during SIM design grant period
 - Establish baseline information to be used in:
 - High-level projections for SIM design grant report
 - More detailed modeling for next SIM application
 - Part of the process has been to identify gaps in available data and how to address them in future steps
- New data summaries for today's discussion
 - Expenditure “decile summaries” for SIM population (ten groupings of individuals ranked from most expensive 10% to least expensive 10% of population)
 - Total population, by age group, and by SIM population
 - Detailed exhibits and documentation to be distributed via SIM website

Known Gaps in Available Data

- Medicare data
 - DHHS does not have access to Medicare data that can be linked to individual dual eligibles in Medicaid data
 - Current data summaries use “average” Medicare expenditures for <65 and 65+ dual eligible population in New Hampshire
 - We are working with DHHS to develop more refined estimates
 - Limits ability to identify individuals with co-morbidities due to missing Medicare diagnosis codes
- Private insurance data
 - Collected through the New Hampshire Comprehensive Health Care Information System (CHIS)
 - CHIS data is near the end of a major update
 - Data cannot be included during design grant time period

State Health Care Innovation Model (SIM) Baseline Summaries

High Level Summary of Populations Receiving Medicaid LTSS

Population: Total

	SFY 2011			SFY 2012
Member Months	240,465			243,859
Number of Individuals	27,006			27,299
% that are dual eligible	52%			52%
		<u>Annual Per</u>		<u>Annual Per</u>
<u>Expenditures by Service</u>	<u>Expenditures</u>	<u>Individual</u>	<u>Expenditures</u>	<u>Individual</u>
Medicaid ICF/SNF	\$190,315,614	\$7,047	\$202,192,918	\$7,407
Medicaid HCBS Waiver	\$255,267,052	\$9,452	\$263,741,020	\$9,661
Medicaid CMHC	\$74,372,759	\$2,754	\$72,861,434	\$2,669
Medicaid Hospital IP and OP	\$26,628,858	\$986	\$28,936,315	\$1,060
Medicaid at School	\$22,537,915	\$835	\$21,700,772	\$795
Medicaid - All Other Covered Services	\$87,649,251	\$3,246	\$85,232,930	\$3,122
Medicare (estimated)	\$149,544,812	\$5,537	\$150,769,167	\$5,523
Total Medicaid and Medicare (estimated)	\$806,316,260	\$29,857	\$825,434,556	\$30,237

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries

Decile Summary

Population: Total All Ages

SFY 2012 Population Expenditure Distribution

Decile	Number of Individuals	Member Months	Percent Dual Eligible	Total Annual Expenditures	Percentage of Total Annual Expenditures
90-100%	2,728	32,324	68%	\$284,656,698	34%
80-90%	2,729	32,257	88%	163,932,290	20%
70-80%	2,728	30,675	79%	125,262,573	15%
60-70%	2,728	29,306	72%	90,260,879	11%
50-60%	2,729	27,781	61%	63,813,305	8%
40-50%	2,728	26,594	53%	43,561,506	5%
30-40%	2,728	23,473	34%	27,635,809	3%
20-30%	2,729	19,938	28%	15,923,652	2%
10-20%	2,728	13,698	26%	7,921,994	1%
0-10%	2,744	7,813	14%	2,465,849	0%
Total	27,299	243,859	52%	\$825,434,556	100%

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries

Decile Summary

Population: Total All Ages

SFY 2012 Population Expenditure Distribution

Annual Per Member Expenditures

Decile	Percent Dual Eligible	Annual Per Member Expenditures							Total
		Medicaid ICF/SNF	Medicaid HCBS Waiver	Medicaid CMHC	Medicaid Hospital IP and OP	Medicaid at School	Medicaid All Other	Medicare (estimated)	
90-100%	68%	\$15,980	\$59,531	\$3,776	\$2,912	\$1,721	\$11,978	\$8,447	\$104,346
80-90%	88%	32,963	7,495	1,397	1,143	898	2,865	13,309	60,070
70-80%	79%	14,605	12,036	2,062	1,477	1,574	3,524	10,640	45,917
60-70%	72%	4,998	10,720	2,790	1,328	1,408	3,059	8,784	33,087
50-60%	61%	2,966	4,546	4,019	1,357	1,218	2,992	6,284	23,383
40-50%	53%	1,361	1,450	4,375	1,007	600	2,642	4,532	15,968
30-40%	34%	807	574	3,725	779	319	2,111	1,815	10,130
20-30%	28%	307	227	2,660	409	143	1,243	846	5,835
10-20%	26%	112	83	1,392	156	62	637	462	2,904
0-10%	14%	5	12	506	38	10	188	139	899
Total	52%	\$7,407	\$9,661	\$2,669	\$1,060	\$795	\$3,122	\$5,523	\$30,237

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries

Decile Summary - Counts of Individuals

Population: Total All Ages

SFY 2012 Population Member Distribution

Decile	CFI Waiver Enrollees	DD Waiver Enrollees	ABD Waiver Enrollees	IHS Waiver Enrollees	Nursing Home Residents	BBH Consumers	Total
90-100%	173	1,588	151	36	624	156	2,728
80-90%	159	327	9	35	2,096	103	2,729
70-80%	576	544	10	63	1,333	202	2,728
60-70%	937	596	8	60	688	439	2,728
50-60%	507	529	7	40	578	1,068	2,729
40-50%	222	366	3	32	375	1,730	2,728
30-40%	144	259	3	16	352	1,954	2,728
20-30%	110	174	2	4	245	2,194	2,729
10-20%	95	145	0	3	194	2,291	2,728
0-10%	74	148	2	2	28	2,490	2,744
Total	2,997	4,676	195	291	6,513	12,627	27,299

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries Decile Summary Comparison by Age Group - All SIM Populations

SFY 2012 Annual Per Member Expenditures

Decile	Age <18	Age 18-64	Age 65-74	Age 75-84	Age 85+	Total
90-100%	\$58,538	\$130,581	\$100,257	\$76,768	\$68,468	\$104,346
80-90%	22,716	73,151	64,844	61,673	61,026	60,070
70-80%	14,200	47,136	56,459	55,671	57,259	45,917
60-70%	9,738	32,708	45,803	48,288	52,711	33,087
50-60%	6,911	23,431	37,935	39,999	45,770	23,383
40-50%	4,894	17,370	32,098	33,240	37,237	15,968
30-40%	3,264	12,428	25,299	26,816	29,859	10,130
20-30%	2,032	7,455	17,851	19,327	22,404	5,835
10-20%	1,093	3,775	9,870	11,620	13,232	2,904
0-10%	395	1,204	3,366	4,254	4,991	899
Total	\$12,365	\$34,898	\$39,394	\$37,768	\$39,296	\$30,237
 # of Individuals	 8,130	 11,456	 2,045	 2,637	 3,689	 27,299

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries

Decile Summary

Population: Choices for Independence Waiver Enrollees

SFY 2012 Population Expenditure Distribution

Annual Per Member Expenditures

Decile	Percent Dual Eligible	Annual Per Member Expenditures							Total
		Medicaid ICF/SNF	Medicaid HCBS Waiver	Medicaid CMHC	Medicaid Hospital IP and OP	Medicaid at School	Medicaid All Other	Medicare (estimated)	
90-100%	75%	\$280	\$27,987	\$1,730	\$6,595	\$0	\$31,323	\$9,574	\$77,490
80-90%	88%	708	25,071	1,882	2,469	0	5,398	11,953	47,481
70-80%	87%	384	20,557	1,172	1,874	0	3,535	12,541	40,063
60-70%	92%	364	18,115	802	1,366	0	2,038	13,472	36,157
50-60%	92%	262	15,253	658	1,251	0	1,708	13,284	32,416
40-50%	90%	416	12,543	442	1,286	0	1,670	12,270	28,628
30-40%	86%	411	10,387	241	1,031	0	1,520	10,899	24,489
20-30%	83%	817	7,254	323	1,038	0	1,421	7,652	18,503
10-20%	85%	755	3,954	180	866	0	747	4,639	11,141
0-10%	82%	313	958	37	246	0	258	1,916	3,728
Total	86%	\$471	\$14,208	\$747	\$1,802	\$0	\$4,960	\$9,820	\$32,008

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries

Decile Summary

Population: Developmentally Disabled Waiver Enrollees

SFY 2012 Population Expenditure Distribution

Annual Per Member Expenditures

Decile	Percent Dual Eligible	Annual Per Member Expenditures							Total
		Medicaid ICF/SNF	Medicaid HCBS Waiver	Medicaid CMHC	Medicaid Hospital IP and OP	Medicaid at School	Medicaid All Other	Medicare (estimated)	
90-100%	58%	\$3,366	\$125,759	\$652	\$1,580	\$2,003	\$16,318	\$6,465	\$156,142
80-90%	70%	211	83,653	861	1,144	2,004	7,414	8,126	103,413
70-80%	72%	232	63,456	440	1,143	2,029	6,987	8,394	82,682
60-70%	63%	1,726	44,882	443	1,258	2,729	7,136	7,475	65,648
50-60%	57%	441	30,068	692	730	4,732	5,179	6,091	47,933
40-50%	54%	69	21,806	887	605	4,364	3,281	5,688	36,700
30-40%	44%	75	15,958	588	647	3,500	2,798	4,700	28,265
20-30%	41%	82	8,593	484	564	3,711	2,871	4,144	20,450
10-20%	30%	52	3,587	850	490	1,930	2,670	2,748	12,328
0-10%	6%	11	1,059	112	203	499	1,266	166	3,316
Total	49%	\$626	\$39,834	\$600	\$836	\$2,747	\$5,587	\$5,394	\$55,624

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries

Decile Summary

Population: Nursing Home Residents

SFY 2012 Population Expenditure Distribution

Annual Per Member Expenditures

Decile	Percent Dual Eligible	Annual Per Member Expenditures							Total
		Medicaid ICF/SNF	Medicaid HCBS Waiver	Medicaid CMHC	Medicaid Hospital IP and OP	Medicaid at School	Medicaid All Other	Medicare (estimated)	
90-100%	83%	\$72,768	\$256	\$23	\$1,867	\$0	\$3,949	\$12,557	\$91,419
80-90%	97%	46,821	31	10	565	0	833	15,353	63,613
70-80%	98%	43,379	7	6	385	0	591	15,363	59,730
60-70%	98%	39,770	7	10	438	0	464	15,230	55,919
50-60%	97%	35,318	18	16	425	0	638	14,186	50,601
40-50%	96%	28,628	105	17	661	0	723	11,937	42,072
30-40%	94%	20,746	165	11	754	0	720	8,437	30,832
20-30%	91%	13,484	132	23	753	0	592	5,697	20,680
10-20%	90%	7,106	235	32	571	0	392	3,079	11,415
0-10%	89%	2,398	163	22	209	0	171	1,447	4,408
Total	93%	\$31,041	\$112	\$17	\$663	\$0	\$907	\$10,329	\$43,068

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

State Health Care Innovation Model (SIM) Baseline Summaries

Decile Summary

Population: Bureau of Behavioral Health Consumers

SFY 2012 Population Expenditure Distribution

Annual Per Member Expenditures

Decile	Percent Dual Eligible	Medicaid		Medicaid			Medicare (estimated)	Total	
		ICF/SNF	HCBS Waiver	CMHC	Hospital IP and OP	at School			
90-100%	46%	\$494	\$8,627	\$19,095	\$5,633	\$1,967	\$10,953	\$5,163	\$51,932
80-90%	46%	74	552	9,344	2,175	955	4,935	4,855	22,891
70-80%	47%	20	219	6,580	1,251	422	3,265	4,618	16,374
60-70%	28%	3	103	5,672	1,006	260	2,811	2,077	11,933
50-60%	21%	11	81	4,511	678	182	1,974	1,064	8,502
40-50%	19%	3	35	3,372	423	101	1,381	699	6,014
30-40%	19%	0	19	2,289	266	71	974	482	4,101
20-30%	21%	0	10	1,460	139	41	574	341	2,565
10-20%	25%	0	2	815	69	13	282	241	1,423
0-10%	2%	0	1	380	16	4	113	15	528
Total	27%	\$60	\$965	\$5,349	\$1,165	\$401	\$2,725	\$1,954	\$12,619

* Please refer to Milliman's November 19, 2013 report for a description of methodology and assumptions.

SIM Design Update

Three LTSS Budget Pricing Model Options

Option 1. Service pricing originating from the provider/agency

Pros	Cons
Tailored to individual need	Work needed to examine
Provides for creative, low-cost solutions	Potentially more difficult to get through approval process
Supports person centered approach	Potential price variation for the same service at same intensity level
Reflects real costs of service	Geographic variation
Takes into account geography	Range of pricing (MCOs)
Allows for individual choice	MCO rate setting could be a challenge

Three LTSS Budget Pricing Model Options

Option 2. Standardized fee schedule

Pros	Cons
Reduces need to examine request	Not tailored to individual
Straight forward projects of cost	May increase costs
Works well with hourly staff costs	No price differences per region
All diagnosis/services treated the same	All diagnosis/services treated the same
All providers treated the same	All providers treated the same
Easier to align fee scheduled with available budget funds	Favors larger organizations
	Potential insensitivity to unit cost pressure
	May limit ability to compete

Three LTSS Budget Pricing Model Options

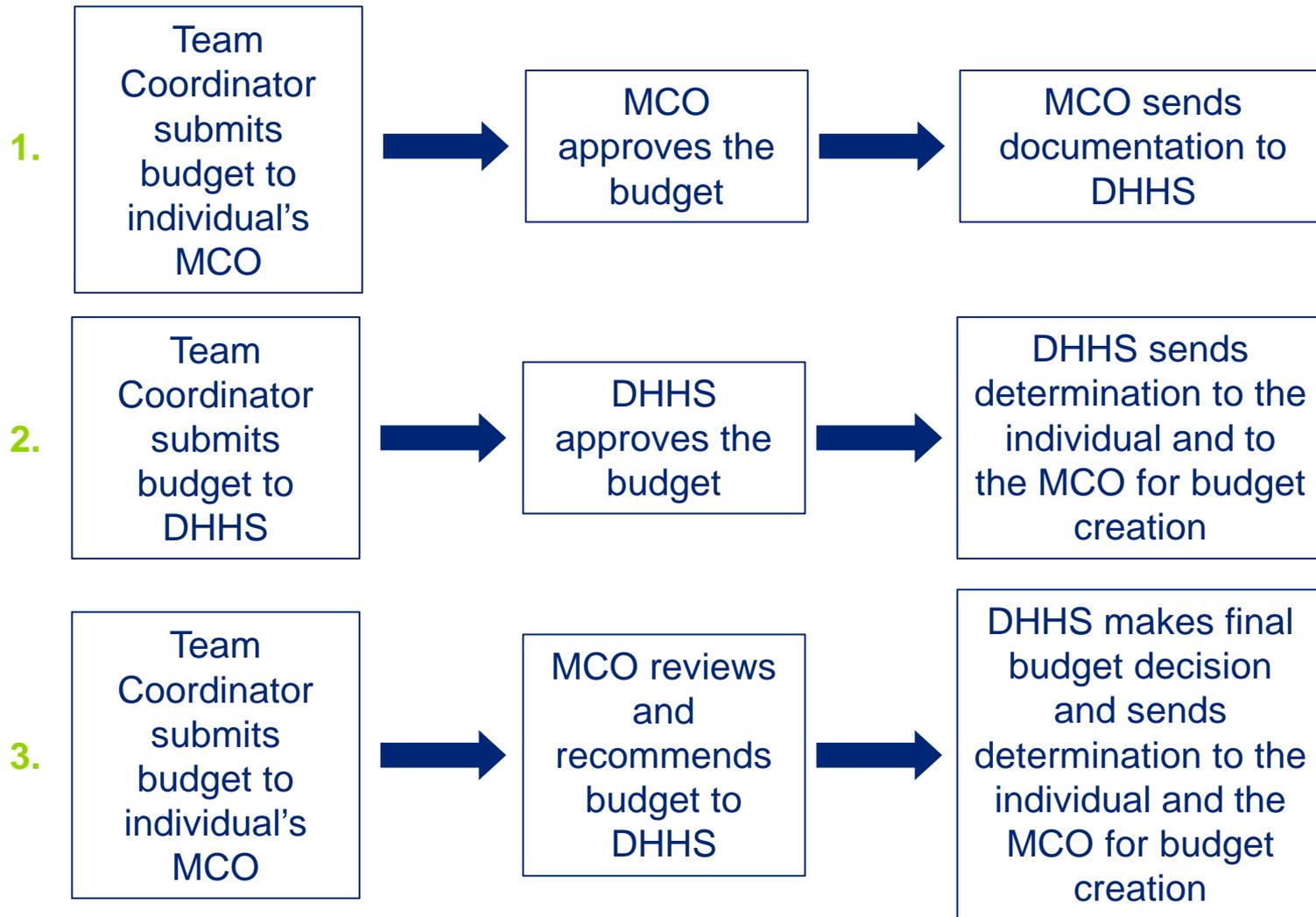
Option 3. Modified standardized fee schedule based upon differentiating state factors*

Pros	Cons
Could work well if state and other factors modify rates	Potential disagreement over modification factors
All diagnosis/services treated the same	All diagnosis/services treated the same
Takes into account geography	May not reflect actual costs of services
Levels playing field of providers	Could lead to unfair competition, e.g. agencies going outside services area

*Example of a differentiating state factor is the weight/scale of services in northern NH compared to services in southern NH

Three LTSS Budget Approval and Appeal Options

- In each scenario, the Team Coordinator creates the LTSS budget and the individual has the right to fair hearings and appeals



Option # 1

1. **Team Coordinator creates the LTSS budget**
2. **Team Coordination submits budget to individual's MCO**
3. **MCO approves the budget**
4. **MCO sends documentation to DHHS**

**Individual can appeal budget through the appeal process described in the MCO contracts*

Pros	Cons
Gives MCOs control over financial risk of waiver services	Could have different bundles being approved based on MCO
	Potential lack of consistency in approval standards; would need to establish criteria
	Timeliness of approval and appeal process may not occur

Option # 2

1. Team Coordinator creates the LTSS budget
2. Team Coordinator submits budget to DHHS
3. DHHS approves the budget
4. DHHS sends determination to the individual and to the MCO for budget creation.

**Individual can appeal through the DHHS fair hearings and appeals process*

Pros	Cons
Responsibility remains with state	Processing may be less timely than option #1
	MCOs do not control financial risk

Option # 3

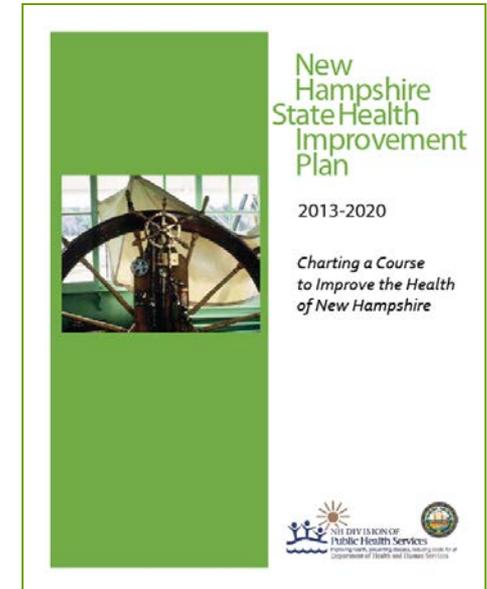
1. **Team Coordinator creates the LTSS budget**
2. **Team Coordinator submits budget to individual's MCO**
3. **MCO reviews and recommends budget to DHHS**
4. **DHHS makes final budget decision and sends determination to the individual and the MCO for budget creation**

**Individual can appeal through the DHHS fair hearings and appeals process*

Pros	Cons
Streamlines appeal process as opposed to option #1	Timely processing may not occur; additional step in process is time consuming
Easier tracking of pattern of denials/approval rates for customer service	Less control of capitated funds on MCO side
Gives MCO more financial control than option #2	
Allows for MCO and state collaboration to meet needs of individual	

Alignment with Public Health

- The Division of Public Health Services recently released a State Health Improvement Plan that introduces initiatives focused in the following areas:
 1. Tobacco
 2. Obesity/Diabetes
 3. Heart Disease & Stroke
 4. Healthy Mothers & Babies
 5. Cancer Prevention
 6. Asthma
 7. Injury Prevention
 8. Infectious Disease
 9. Emergency Preparedness
 10. Misuse of Alcohol and Drugs
- Individuals receiving LTSS are not targeted populations for strategic communications about or enrollment in these programs
- We have identified three strategies for encouraging individuals with LTSS participation in these public health initiatives:
 - The LTSS Reimbursement Account could be used to fund transportation necessary for individuals to participate in these programs
 - Public health programs need to be identified in the an individual's Life Plan
 - The facilitation of participation in these programs can be a measurable aspect of the Team Coordinator function
 - The training certification program for the Team Coordinator can include a public health awareness component





Substance Misuse

- There is a significant opportunity to address substance misuse needs within the LTSS population through SIM, specifically by:
 - Including substance use disorders (SUD) treatment within an individual's Life Plan
 - Including a substance misuse awareness component in the training certification program for the Team Coordinator
 - Including a measure within the evaluation of Team Coordinator effectiveness that focuses on the utilization of available substance misuse services
 - Including non-traditional services relating to SUD treatment within the contingency pool for individuals participating in the consumer-directed budget initiative

The rationale behind including substance misuse in this model is to incentivize individuals to seek a variety of different treatment options

Legal and Regulatory Changes

Initiative	Rule Change	Statute Change	MCO Contract Change	State Plan Amendment	Waiver Authority
Risk and Prevention Based LTSS Eligibility	X	X		X	X
Life Plan Planning and Creation	X		X		
Multi-Payer Team Coordinator Payments (currently eligible)	X	X			
Multi-Payer Team Coordinator Payments (not currently eligible)	X	X			X
Multi –Payer Health Homes	X	X	X	X	X
Expanded Consumer Directed Care Budgeting	X		X		X
Provider Quality and Price Transparency	X		X	X	X
Global Triple Aim Incentive Pool	X	X	X		X
Reinsurance Pool Operationalization	X		X	X	X
Payment Policy for PCP’s Receiving LTSS Certification	X	X	X	X	
Medical Necessity Criteria for Individuals who Receive LTSS	X	X	X	X	
Nursing Home/Hospital Re-Admission Incentive Program	X		X	X	X
New Hampshire Hospital Admission Incentive Program	X		X	X	X
Expanded Availability of LTSS-type Services Across all Waivers	X		X	X	X
Health Information Technology Initiatives	X	X			

Draft SIM Plan Overview

Upcoming Schedule

November 2013

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

December 2013

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			



Workgroup Meetings



Stakeholder Meetings