Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment

Prepared for:

Indiana Family and Social Services Administration (FSSA)

Submitted by:

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I. Introduction

The goal of this report – **Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment** – is to assess the Healthy Indiana Plan (HIP) 2.0's Emergency Department Co-Payment Protocol (ED Co-Pay Protocol), developed by the Indiana Family and Social Services Administration (FSSA) and approved by the Centers for Medicare & Medicaid Services (CMS) on February 4, 2016 (see **Appendix A**).[1] The ED Co-Pay Protocol documents how the State's HIP 2.0 emergency room (ER) co-payment policy is to be implemented. The Protocol also outlines how the policy will be tested by defining a group of members who have a graduated co-payment (test group) to see if they will use the ER less for non-emergent reasons, and therefore will use the ER less overall, compared to another group of members who do not have a graduated co-payment (control group).

Per the Special Terms and Conditions (STCs) for Indiana's section 1115 demonstration, Indiana must conduct an independent evaluation of the ER co-pay policy. FSSA engaged The Lewin Group (Lewin) to develop this assessment under the *Healthy Indiana Plan 2.0 Program Evaluation Services Contract*, EDS Number: MD29-5-99-15-LF-0677, *Emergency Room Co-pay Evaluation* deliverable.

Using data provided by the FSSA for the period of January 1, 2016 – December 31, 2016, the report examines the following variables of interest to illustrate the results of the ER co-pay policy:

- Demographic characteristics of the sample (composed of test and control group members)
- ER utilization
- Member payment of ER co-payments
- Nurse hotline use
- Urgent and primary care utilization

These variables were selected in discussion with the State, based on the CMS-approved ED Co-Pay Protocol and available data. Due to variability in the data, results are presented separately by managed care entity (MCE), which are the organizations that administer the HIP 2.0 program.

[1] See *Emergency Department Co-payment Protocol* (February 4, 2016). Retrieved June 12, 2017 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appr-emerg-copay-protocol.pdf.

II. Background

On January 27, 2015, CMS granted the State of Indiana approval to implement a new section 1115 demonstration program – HIP 2.0. The new demonstration, which runs February 1, 2015 through January 31, 2018, expanded Medicaid coverage to individuals with income between 101 percent and 138 percent of the federal poverty level (FPL) while testing a new program structure.

The HIP 2.0 structure was modeled after the original Healthy Indiana Plan 1115 waiver demonstration, which was approved by CMS in 2007 with enrollment beginning in 2008. Original HIP provided low-income Indiana residents a High Deductible Health Plan (HDHP) paired with a Personal Wellness and Responsibility (POWER) Account, which operates similar to a Health Savings Account (HSA). As the nation's first HDHP with HSA model for Medicaid recipients, the aim was to encourage members to be more active purchasers of their health care services.

Upon enactment of the Patient Protection and Affordable Care Act (ACA), Indiana opted to renew its 1115 waiver and create the HIP 2.0 program, aiming to cover all non-disabled adults between the ages of 19 and 64 with income at or below 138 percent of the FPL. With this change, the State also opened HIP enrollment to Section 1931 parents and caretaker relatives and low-income 19 and 20 year olds who were previously eligible for Hoosier Healthwise (HHW), the State's Medicaid managed care program covering pregnant women and children. Section 1931 parents and caretaker relatives and low-income 19 and 20 year olds enrolled in HHW as of January 2015 were transitioned into HIP 2.0 when the program began in February 2015.

HIP 2.0 maintains the consumer-driven principles of the original program while expanding eligibility criteria and building upon its structure. Specifically, the waiver goals are to:

1. Reduce the number of uninsured low-income Indiana residents and increase access to healthcare services
2. Promote value-based decision-making and personal health responsibility
3. Promote disease prevention and health promotion to achieve better health outcomes
4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families
5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance
6. Assure state fiscal responsibility and efficient management of the program

The program provides coverage through a HDHP, administered by a MCE, paired with a POWER Account valued at $2,500. Under HIP 2.0, members who make monthly contributions to their POWER Account, called POWER Account Contributions (PACs), are enrolled in *HIP Plus* – a plan that includes enhanced benefits such as dental and vision coverage. Members with income below 100 percent of the FPL who do not make PACs are placed in the *HIP Basic* plan, a more limited benefit plan that does not include coverage for dental services, vision services, bariatric surgery or temporomandibular joint (TMJ) treatment, and that requires co-payments for most services.

Emergency Room Co-Payment Policy

To encourage appropriate use of the ER, HIP 2.0 established graduated co-payments for non-emergent use of the ER: $8 for the first non-emergent visit and $25 for each subsequent non-emergent visit within the same 12 month benefit period.[2] Members do not pay a co-pay for emergent use of the ER. All HIP members are required to pay the co-payment for non-emergent visits, except pregnant women, Native Americans, and members who have met the five-percent income threshold.[3] The co-pay cannot be paid through the member's POWER Account.

In collaboration with CMS, Indiana drafted its *Emergency Department Co-Payment Protocol*, which was approved by CMS and went into effect on February 4, 2016 and is to be implemented for the remainder of the demonstration, through January 31, 2018 (**Appendix A**). The Protocol outlines how the ER co-pay policy is implemented including how an ER visit is determined emergent or non-emergent, when the co-pay is collected from the member, as well as the creation of "test" and "control" groups. The State works directly with and oversees the MCEs' implementation of the Protocol. Documentation of the Protocol is included in the MCEs' contracts and reporting requirements.

Control and Test Groups

To test whether applying a $25 co-payment for subsequent non-emergent ER visits affects subsequent ER utilization, Indiana defined two groups:

- *Control group*: A group of members that is *not* subject to the $25 ER graduated co-payment; control group members pay $8 per non-emergent ER visit, regardless of their number of non-emergent visits. Five thousand members across HIP 2.0's three MCEs participating in 2016 (Anthem, Managed Health Services [MHS], and MDwise) were randomly assigned to the control group, based on CMS-approved selection criteria.
- *Test group*: Includes all other HIP members (excluding the members of the control group); first non-emergent ER visit is subject to the $8 co-payment and all subsequent non-emergent ER visits within the membership year are subject to the $25 co-pay.

Determining and Collecting the Co-Payment

Health care providers are responsible for collecting the co-payment directly from the member. As described in detail below and illustrated in **Exhibit 1**, several factors determine if and when providers collect the co-pay.

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2 The policy is authorized under Section 1916(f) of the Social Security Act. Section 1916(f) of the Social Security Act stipulates that "No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) and section 1916A, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment" and outlines the conditions for imposing cost sharing, most notably that the policy should "test a unique and previously untested use of co-payments" and "is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area."

3 Per federal regulation 42 CFR 447.78, HIP members are not allowed to pay more than five percent of their household income in a given benefit quarter towards HIP cost sharing requirements. This limit is often referred to as the "five-percent threshold" and includes all payments by the member or his/her family members for the following: monthly contributions, co-pays, and Children's Health Insurance Program (CHIP) premiums. HIP Plus members who meet the threshold on a quarterly basis have a PAC amount of $1 (the minimum) for the remainder of the quarter.

Did the member call the nurse hotline prior to visiting the ER? HIP 2.0 required each MCE to establish a 24-hour nurse hotline to serve as a prior authorization process. All members who call their MCE's nurse hotline prior to visiting the ER have their co-pay waived, regardless of whether the nurse hotline advised the member to go to the ER. Providers are instructed to call the member's MCE to verify whether a member called the nurse hotline prior to their ER visit.

Did the provider determine that the visit was emergent? Providers are responsible for making the initial determination of whether a visit is emergent based on whether the member has an emergency condition meeting the *prudent layperson standard*, which is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part."[4]

The prudent layperson is defined as someone who "may not have more than a high school education and does not have training in a medical, nursing, or social work-related field."

If a member's health condition does not qualify as emergent according to the prudent layperson standard, providers must inform the member of the co-payment and refer them to alternative services where the member will not be subject to the co-payment (*e.g.*, an urgent care center). If the member decides to continue with service at the ER, the provider may collect the co-payment at the point of service.

Did the MCE determine that the visit was emergent? All ER claims are subject to additional review by the MCEs to verify whether the visit was emergent or non-emergent. MCEs are required to employ a "layperson reviewer" to review the claims for each ER visit and determine whether it meets the prudent layperson standard.[5] MCEs must also verify whether the member was admitted to the hospital within twenty-four hours of the original visit because if a member was admitted to the hospital within twenty-four hours of the ER visit, his or her visit is deemed emergent.

ER claims that are deemed non-emergent based on this review are paid to the provider less the applicable co-payment amount. If the provider did not collect the co-payment at the time of the visit, the provider may bill the member for the co-pay.

ER claims that are deemed emergent based on this review are paid to the provider in full. If the provider collected a co-payment at the time of the visit, the provider is obligated to refund the member.

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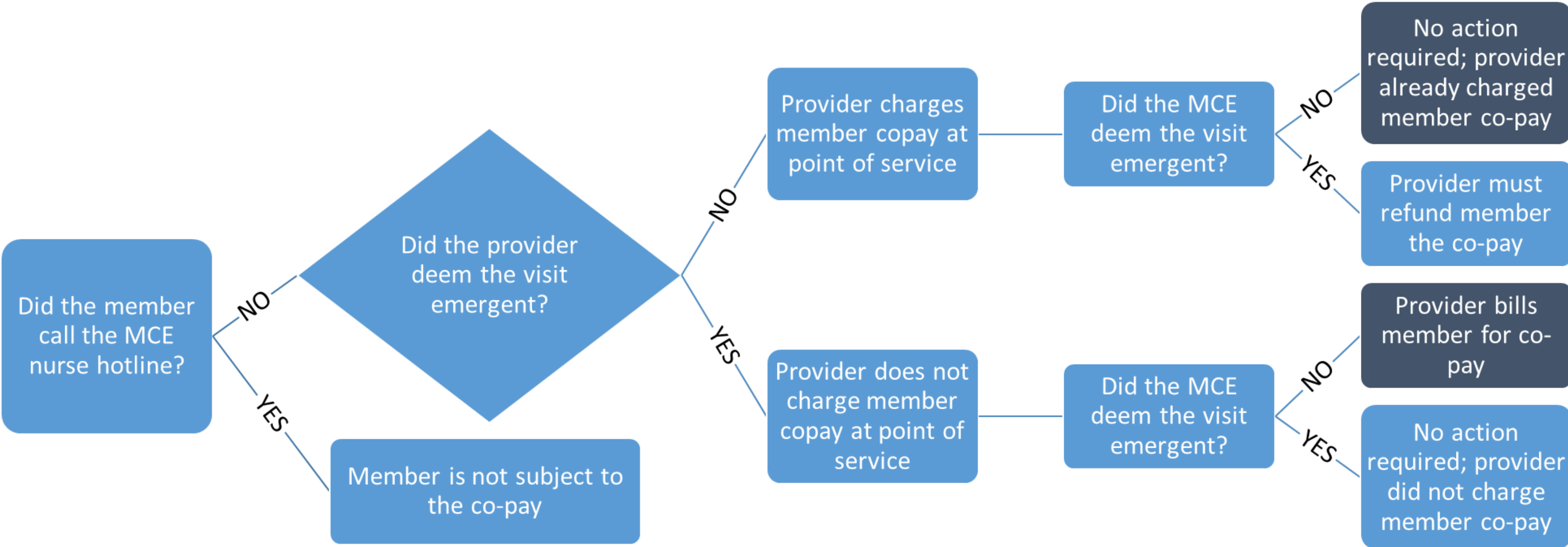
4 From 42 U.S.C. § 1395dd (e) (1), see Indiana Health Coverage Programs Provider Reference Manual: Emergency Services (February 13, 2017). Retrieved March 1, 2017 from http://provider.indianamedicaid.com/media/155514/emergency%20services.pdf.

5 See *Emergency Department Co-payment Protocol* (February 4, 2016). Retrieved March 1, 2017 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appr-emerg-copay-protocol.pdf

Exhibit 1: Process for Determining If and When ER Co-pay is Assessed



Note: Dark shading denotes scenarios for which members are charged a co-pay for non-emergent ER use.

III. Methods

The design for this assessment is based on the CMS-approved ED Co-Pay Protocol. This report presents results for metrics selected for inclusion based on discussions with the State and availability of data.

Study Sample

The Protocol specified the creation of a control group and a test group, as described in the **Background** section above.

Control Group

The control group was designed to be a random sample of approximately 5,000 HIP members who pay a flat co-pay: $8 for *every* non-emergent visit, regardless of the number of their non-emergent ER visits. MCEs are responsible for selecting and repopulating the control group on a quarterly basis using the same methodology used to draw the original control group.[6]

Enrolled HIP members were assigned to the control group and notified of the change in October 2015 (see **Appendix B** for a sample notice from one MCE to its control group members).[7] Prior to their assignment to the control group, these members were charged graduated co-payments for non-emergent use of the ER. Members were assigned using the same formula that CMS uses to select its samples from standard analytical files using health insurance claims. Native Americans and pregnant women were excluded from the control group because they are exempt from cost-sharing. Women who were selected into the control group and later become pregnant were required to be removed from the control group. Due to differences in the implementation of the Protocol by MCEs, members who met the five-percent cost-sharing threshold were included in two MCE control groups (MCE 2 and MCE 3) and were removed from the control group in the third (MCE 1).

Test Group

The test group includes all other HIP members who are not selected into the control group in the given quarter, excluding members who are exempt from cost-sharing (*i.e.*, pregnant women, Native Americans, and individuals subject to the five-percent cost sharing threshold). Test group members pay graduated co-payments for non-emergent use of the ER: $8 for their first non-emergent visit and $25 for all subsequent non-emergent visits within the same 12-month benefit period. Those who are exempt from cost sharing do not have to pay co-pays.

Data Sources

This assessment utilizes FSSA enrollment data, FSSA encounter data, and other operational reports provided by the three MCEs participating in HIP 2.0 in 2016: Anthem, MHS, and MDwise. Timeframes of data used differ due to availability of data from these sources. The participating

[6] At any point during 2016, there might be times when the control group included fewer than 5,000 members.

[7] MCEs implemented the control group before Indiana received official approval of its Emergency Department Co-payment Protocol on February 4, 2016. See *Emergency Department Co-payment Protocol* (February 4, 2016). Retrieved March 1, 2017 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appr-emerg-copay-protocol.pdf

MCEs and the FSSA provided the data used in this assessment. The report does not identify the respective MCEs in the presentation of the data; the MCEs were randomly assigned the labels MCE 1, MCE 2, and MCE 3. The assignments remain constant throughout the report.

Exhibit 2 outlines the data source and description, timeframe included in data analysis, relevant metric and level of observation, and any exclusions applied for the analysis. Further detail on each data source and its use in the assessment is provided below the exhibit.

Exhibit 2: Data Sources, Descriptions, and Timeframes

Data Source & Description	Timeframe Included in Data Analysis	Metric & Level of Observation	Exclusions Applied for the Analysis
FSSA Enrollment Data ▪ Contains information on members' demographics (*e.g.,* age, gender), enrollment status (open, closed or denied), and eligibility categories (*e.g.,* aid category, and whether the member met any special eligibility criteria, such as Transitional Medical Assistance (TMA[8])) ▪ Identifies the sample used for Urgent and Primary Care Services Utilization metrics	▪ February 1, 2015 – May 31, 2017	*Metric* ▪ Demographic Characteristics *Level of Observation* ▪ Member/month	▪ Exclude members not eligible for the following HIP Medical Assistance aid categories: Regular Plus (MARP), Regular Basic (MARB), State Plus (MASP), State Basic (MASB) and State Plus with Co-pays (MAPC) ▪ Exclude members outside the ages of 19-64; members with a closed or denied enrollment status (not a current member of HIP 2.0); members with no identified MCE assignment due to data issues known to the State
FSSA Encounter Data ▪ Includes MCE-paid health care service claims submitted to the State including claim information such as date of service, service type, procedure, provider, and place of service	▪ Incurred January 1, 2016 – December 31, 2016; paid through May 31, 2017	*Metric* ▪ Urgent Care Services Utilization ▪ Primary Care Services Utilization *Level of Observation* ▪ Claim	▪ Exclude members not eligible for the following HIP Medical Assistance aid categories: Regular Plus (MARP), Regular Basic (MARB), State Plus (MASP), State Basic (MASB) and State Plus with Co-pays (MAPC) ▪ Exclude members outside the ages of 19-64; members with a closed enrollment status (not a current member of HIP 2.0); members with no identified MCE assignment due to data issues known to the State; pregnant women and Native Americans

[8] TMA participants are low-income parents/caretaker relatives who have an income between 19 – 185 percent of the FPL who would lose Medicaid coverage due to increased earnings, but who, under TMA, continue to receive Medicaid services for up to one year.

Data Source & Description	Timeframe Included in Data Analysis	Metric & Level of Observation	Exclusions Applied for the Analysis
MCE-Reported Data*			
MCE STC General Services Utilization (GSU) Reporting **GSU 7: Type of Emergency Room Utilization** ▪ Provides total, emergent, and non-emergent ER visits by test group and control groups ▪ Includes counts of ER claims per 1,000 member months for the test and control groups	▪ January 1, 2016 – December 31, 2016 ▪ Reported quarterly on the last day of the month, following a 90-day claims lag period after the close of the reporting period	*Metric* ▪ Emergent ER Utilization ▪ Non-Emergent ER Utilization *Level of Observation* ▪ Plan and quarter, separately for test and control groups	▪ Control group excludes pregnant women and Native Americans ▪ MCE 1 excluded members who met the five-percent cost-sharing threshold and repopulated the control group; MCE 2 and MCE 3 included members who met the five-percent cost-sharing threshold in their control group
MCE STC GSU Reporting **GSU 8: Frequency of Emergency Room Utilization** ▪ Includes data, by test and control groups, for members enrolled continuously for 180 days ▪ Includes data, by test group and control groups, for members with one, two, three to nine, or ten or more ER visits during the reporting period	▪ January 1, 2016 – December 31, 2016 ▪ Reported quarterly on the last day of the month, following a 90-day claims lag period after the close of the reporting period	*Metric* ▪ Overall ER Utilization *Level of Observation* ▪ Plan and quarter, separately for test and control groups	

Data Source & Description	Timeframe Included in Data Analysis	Metric & Level of Observation	Exclusions Applied for the Analysis
MCE STC Reporting **MO-CPAY2: HIP ER Co-Payment Report** ▪ Reports on number of members, by test and control groups, who had an ER visit and the associated ER co-payment applied to that visit ▪ In each reporting period, members can be counted more than once as they may incur more than one co-pay during the reporting period	▪ May 1, 2016 – December 31, 2016 ▪ Reported monthly on the sixth day of each month following the end of the experience period	*Metric* ▪ Members Who Incurred the ER Co-Payment and Whose Co-Payment was Waived *Level of Observation* ▪ Plan and quarter, separately for test and control groups	▪ Control group excludes pregnant women and Native Americans ▪ MCE 1 excluded members who met the five-percent cost-sharing threshold and repopulated the control group; MCE 2 and MCE 3 included members who met the five-percent cost-sharing threshold in their control group
Nurse Hotline Calls ▪ Reports on number of unique members, by test and control groups, who called each MCE's nurse hotline prior to reporting to the ER	▪ January 1, 2016 – December 31, 2016 ▪ Reported once for this assessment ▪ MCE 1 and MCE 2 provided data; MCE 3 data was not available	*Metric* ▪ Nurse Hotline Use *Level of Observation* ▪ Plan and quarter, separately for test and control groups	
List of Members in the Control Group ▪ Lists members ever enrolled in the control group between February 1, 2015 – and April 30, 2017 ▪ Members can move from the test to the control group as the control group repopulates on a quarterly basis ▪ Used to identify control group members in the enrollment and encounter data	▪ January 1, 2016 – December 31, 2016	*Metric* ▪ N/A *Level of Observation* ▪ Member	

Data Source & Description	Timeframe Included in Data Analysis	Metric & Level of Observation	Exclusions Applied for the Analysis
List of Members who Met the 5% Threshold ▪ Lists members who met the five-percent income threshold in each calendar quarter	▪ January 1, 2016 – December 31, 2016	*Metric* ▪ N/A *Level of Observation* ▪ Member and quarter	▪ Control group excludes pregnant women and Native Americans ▪ MCE 1 excluded members who met the five-percent cost-sharing threshold and repopulated the control group; MCE 2 and MCE 3 included members who met the five-percent cost-sharing threshold in their control group

* See **Appendix C** for additional detail.

FSSA Enrollment Data

FSSA enrollment data was used to determine if the test and control groups' memberships had comparable demographic characteristics. Additionally, it was used to identify eligible members for inclusion in the study sample for a subset of metrics (Urgent and Primary Care Services Utilization). Basic validations of the enrollment data were conducted to ensure consistent and expected data elements, including open, denied, or closed status, MCE assignment, and inclusion of required data elements; results were reviewed and discussed with the State.[9]

FSSA Encounter Data

In HIP 2.0, MCEs were required to develop provider networks to provide "a sufficient number and geographic distribution of primary care and urgent care facilities to serve the expected enrollment" to encourage alternatives to the ER.[10] In addition, they were required to provide members after-hours instructions on the most appropriate setting of care based on need. The after-hours directions could be to call back the next day to schedule an appointment or suggest other care settings, including primary and urgent care settings.

The encounter data was linked to the enrollment data for the eligible members using the process detailed below in the **Metrics** section. HIP 2.0 encounter data was used to identify urgent and primary care visits for the control and test groups. This data included standard claims information reported by the MCEs to the State. Basic validations of the encounter data were conducted to ensure consistent and expected data elements, such as date distributions and monthly membership counts; results were reviewed and discussed with the State.[11]

MCE-Reported Data

The four datasets received from the MCEs[12] and included in this assessment are described in this section. Additional detail about the MCE-reported data is included in **Appendix C.**

1. *Special Terms and Conditions (STCs) Reports*

HIP MCEs are contractually obligated to submit a series of reports to the Indiana Office of Medicaid Policy and Planning (OMPP) describing HIP 2.0 performance metrics, including ER utilization. This assessment includes data from the following reports, as reported by each MCE:

- STC Quarterly GSU Report 7 (QR-GSU7): Type of Emergency Room Utilization
- STC Quarterly GSU Report 8 (QR-GSU8): Frequency of Emergency Room Utilization
- STC Monthly and Year-to-Date Co-pay Report 2 (MO-CPAY2): HIP ER Co-Payment Report

The data in this report includes MCE reporting for quarters two through four of Demonstration Year 2 (DY2) and quarter one of Demonstration Year 3 (DY3) of HIP 2.0. These reporting periods

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9 State feedback received on July 14 and July 25, 2017.

10 See *Emergency Department Co-payment Protocol* (February 4, 2016). Retrieved March 1, 2017 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appr-emerg-copay-protocol.pdf

11 State feedback received on July 14 and July 25, 2017.

12 Validation or verification of MCE reports was outside the scope of this assessment.

reflect ER visits with dates of service from January 1, 2016 through December 31, 2016, adjudicated as of March 31, 2017 (**Exhibit 3**).

Exhibit 3: MCE STC Quarterly GSU Reporting Timeframes

Reporting Period	Experience Period	Adjudicated Claims Through
DY 2, Quarter 2 (submitted July 31, 2016)*	January 1, 2016 – March 31, 2016 (Q1 2016)	January 1, 2016 – June 30, 2016
DY 2, Quarter 3 (submitted October 31, 2016)*	April 1, 2016 – June 30, 2016 (Q2 2016)	April 1, 2016 – September 30, 2016
DY 2, Quarter 4 (submitted January 31, 2017)*	July 1, 2016 – September 30, 2016 (Q3 2016)	July 1, 2016 – December 31, 2016
DY3, Quarter 1 (submitted April 30, 2017)	October 1, 2016 – December 31, 2016 (Q4 2016)	October 1, 2016 – March 31, 2017

*Note: MCEs resubmitted these reports to OMPP on February 28, 2017. MCE 3 resubmitted GSU 7 for all four reporting periods on June 30, 2017.

Within STC reports, MCEs provide data for the following groups: HIP Regular Basic Members, HIP Regular Plus Members, and State Members (including both State Basic and State Plus members). This data was aggregated across all members in the respective categories.

The STC Monthly and Year-to-Date Co-pay Report 2 (MO-CPAY2): HIP ER Co-Payment Report is reported monthly by the MCEs. The assessment uses data from May through December 2016.

2. Number of Members who Called their MCE's Nurse Hotline

Each MCE was required to establish a 24-hour nurse hotline for members to call prior to visiting the ER to receive advice on the most appropriate place to seek care, based on their unique needs. Implementation of the nurse hotline was in part designed to encourage members to seek non-emergent care in more appropriate settings, such as primary and urgent care locations.

In addition, members who call their MCE nurse hotline before presenting at the ER have the co-pay waived, regardless of whether the nurse hotline advised the member to go to the ER and regardless of whether the visit was determined emergent or non-emergent (refer to **Exhibit 1**, above). Members who do not call the nurse hotline prior to presenting at the ER are subject to the applicable $8 or $25 co-pay.

MCE 1 and MCE 2, provided data on the number of members who called and did not call the nurse hotline prior to visiting the ER for the first and subsequent non-emergent visit for January 1 – December 31, 2016. MCE 3 did not provide this data at the time of report development; therefore, it is not included.

3. List of Members in the Control Group

Each MCE is responsible for tracking members enrolled in the control group. Through the FSSA, the MCEs provided Lewin a list of members ever enrolled in the control group between February 1, 2015 – and April 30, 2017, and the associated time span (start and end dates) of each member's enrollment in the control group, as the control group repopulates on a quarterly basis to replace members that move out of the group.

4. *List of Members who met the Five-percent Threshold Cost Sharing Exemption During the Studied Period, August 1 – December 31, 2016*

Similar to the list of control group members, each MCE is responsible for maintaining records of members who meet the five-percent income threshold in each calendar quarter. Per federal regulation 42 CFR 447.78, members cannot pay more than five percent of their household income in a given benefit quarter towards cost sharing requirements. Therefore, these members would be exempt from all cost sharing requirements, including a co-pay for a non-emergent ER visit.

The purpose of this list was to flag members in the test and control groups who had met the five-percent threshold quarterly so that they could be excluded from the study sample as proposed in the original Protocol design. MCEs began tracking this information in August 2016. FSSA instructed MCEs to leave those who met the threshold in the control group. However, one MCE, MCE 1, removed those members and repopulated the control group on a monthly basis per the original Protocol.[13] Therefore, results presented in this assessment assume MCE 1 removed members who met the five-percent threshold from their control group.

The State agreed that members meeting the five-percent threshold would be included in the Urgent and Primary Care Services Utilization analysis. This is consistent with how the members are summarized in the MCE STC Reporting data.

Metrics

The HIP 2.0 ED Co-Pay Protocol included a list of metrics for examination. The following variables were selected for inclusion due to available data and the State's outcomes of interest to assess the effects of the policy. Due to the variability in MCE-reported data, the data is reported by individual MCE.

Demographic Characteristics

The control group was a random sample of approximately 5,000 HIP members across the three MCEs. Each MCE administered the selection and repopulation of their control group. The report reviews specific demographic characteristics of the test and control groups' membership to determine if they were comparable. After excluding specific criteria detailed in **Appendix D**, the enrollment data sample was reviewed for the following characteristics: age/gender, income, and plan/aid category enrollment.

Overall, Emergent, and Non-Emergent ER Utilization

The report summarizes overall ER utilization, by test and control groups, and emergent and non-emergent ER utilization. Specifically, it examines: 1) the number of members continuously enrolled in HIP 2.0 who use the ER within the test and control groups; 2) the number of non-emergent ER visits by members within the test and control groups; and 3) the number of emergent ER visits by members within the test and control groups.

The data was extracted from the individual MCE STC QR-GSU7 (Type of Emergency Room Utilization) and STC QR-GSU8 (Frequency of Emergency Room Utilization) reports submitted to

[13] A member crosscheck could not be performed because the following MCE data is not reported at the member level: MCE STC GSU7, GSU8, MO-CPAY2, and Nurse Hotline Calls.

IN OMPP. **Appendix E** provides additional detail into the calculation of the ER utilization metrics provided by the MCEs.

Members Who Incurred the ER Co-Payment and Whose Co-Payment was Waived

To examine the implementation of the graduated co-pay policy, MCE-reported data counts the number of members who incurred co-pays. Specifically, the MCE MO-CPAY2 report summarizes the number of members who incur the $8 co-pay for non-emergent use of the ER, the number of members who incur the $25 co-pay for non-emergent use of the ER, and the number of members whose co-pay was waived (reasons as to why co-pays may be waived are listed above in the **Background** section). Due to available data, the metrics are reported using each MCE's monthly report from May 2016 through December 2016.

Nurse Hotline Use

Data reported by MCE 1 and MCE 2 was used to summarize member utilization of the MCEs' 24-hour nurse hotlines prior to visiting the ER through the following metrics:

- Number of members who called their nurse hotline prior to visiting the ER
- Number of test and control groups members who called the nurse hotline prior to their first non-emergent ER visit and the number of members who called prior to their subsequent non-emergent visit

Data from MCE 3 was not available at the time of report development.

Urgent and Primary Care Services Utilization

To provide a broader view of utilization outside of the ER, primary and urgent care visits incurred in 2016 are reported.

The HIP 2.0 relies upon the national standard definition established by CMS to define urgent care locations and included providers with specialties as outlined in **Appendix F.** To evaluate the utilization in primary and urgent care settings, the encounter data was first linked to the enrollment data to limit the encounter data to the eligible sample, discussed in **Appendix D**. From there, primary and urgent care visits were identified using FSSA-determined logic. Utilization of primary care and urgent care visits per 1,000 member months was calculated by MCE, test and control groups, and experience period.

Descriptive Analysis

Metrics are reported for the test and control groups where data was available. Results are presented separately by MCE. In many cases, results are compared by experience period (*i.e.,* calendar quarter) to replicate the MCEs' reports to OMPP. Data submitted by the MCEs to the State did not support statistical testing.

Prior to presenting these descriptive analyses, the characteristics of the test and control groups are compared to confirm that the characteristics of members are similar across the two groups. As noted above, the control group was a random sample of approximately 5,000 HIP 2.0 members. MCE-reported data was used to identify control group members, which was then linked with FSSA enrollment data to summarize member demographics and eligibility categories.

IV. Results

This section presents the results included in this assessment. First, the demographic characteristics of the test and control groups are compared. Next, counts and distributions of the metrics defined above are shown by test and control groups, and experience period.

Demographic Characteristics

Exhibits 4 and **5** compare the demographic characteristics of the test group and the control group.

Exhibit 4 presents the number of members enrolled in HIP, as of December 31, 2016, age/gender and income distributions, and by test and control groups. Age/gender and income distributions are presented as percentages of enrollment by test and control groups.

Exhibit 4: Total Member Distribution by Age, Gender, and Income, for the Test and Control Groups (as of December 31, 2016)

Test or Control Group	Number and Percent of Members as of December 31, 2016	Age/Gender Distribution						Income Distribution			
		19 – 30 F	19 – 30 M	31 – 50 F	31 – 50 M	51 – 64 F	51 – 64 M	At or below 50% FPL	51% to 100% FPL	101% to 138% FPL	Above 138% FPL
Test (Graduated Co-pay)	382,699 99%	25%	11%	29%	16%	11%	8%	62%	23%	13%	1%
Control (Flat Co-pay)	4,669 1%	23%	11%	34%	15%	11%	8%	35%	35%	28%	2%

Source: MCE-reported data was used to identify test and control group members and was linked with FSSA enrollment data, which was used for the total count of members, age/gender distribution, and income distribution.

Notes:

- The counts exclude members 1) with non-open enrollment status; 2) outside 19-64 years of ages; 3) enrolled in HIPLink; and 4) who do not have an identified MCE in the enrollment data due to data issues known to the State.
- Due to rounding, totals may not sum to 100 percent.

Exhibit 4 shows that the control group represents one percent of the total HIP 2.0 population, 4,669 members as of December 31, 2016, which is lower than the 5,000 outlined in the Protocol. Consistent with the Protocol, the group was repopulated in January 2017.

The test and control groups are comparable in terms of the age/gender distribution. The income distributions show differences between the test and control groups.[14] Members with income at or below 50 percent of the FPL represent 62 percent of the test group. However, it is lower in the control group at 35 percent. Members with income between 51 and 100 percent of the FPL represent 23 percent of the test group and 35 percent of the control group. Members with income between 101 and 138 percent of the FPL represent 13 percent of the test group and 28 percent of the control group. Lastly, member with income above 138 percent of the FPL are comparable between the test and control groups at one and two percent, respectively.

Exhibit 5 displays the 2016 member months by aid category by the test and control groups.

Exhibit 5: Total Member Month (MM) Distribution by Enrollment Status, for the Test and Control Groups (January 1, 2016 – December 31, 2016)

Test or Control Group	CY 2016 Member Months	Plan/Aid Category Distribution				
		Regular Basic	Regular Plus	State Basic	State Plus	State Plus w/ Co-Pays
Test (Graduated Co-pay)	4,241,453	17%	43%	16%	23%	<1%
Control (Flat Co-pay)	53,008	17%	46%	10%	24%	3%

Source: MCE-reported data was used to identify test and control group members and was linked with FSSA enrollment data, which was used for the total count of member months and plan/aid category distribution.
Notes:
- The counts exclude members 1) with non-open enrollment status; 2) outside 19-64 years of ages; 3) enrolled in HIPLink; and 4) who do not have an identified MCE in the enrollment data due to data issues known to the State.
- The Aid Category Distribution section totals may not sum to 100 percent due to rounding.

Exhibit 5 shows that member month distributions by aid category are similar for the test and control groups. The test group has a higher proportion of State Basic members than the control group by six percentage points. This aid category, State Basic, has more vulnerable populations such as medically frail, lower income members, and pregnant women. The greatest proportion of the test and control groups are enrolled in Regular Plus.

Overall Emergency Room Utilization

Exhibits 6 and **7** show data on ER utilization for members who were continuously enrolled for 180 days. Specifically, they display the total number of continuously enrolled members for each quarter, the percent with zero ER visits, the percent with one ER visit, and the percent with two or more ER visits. **Exhibit 6** presents this data for the test and control groups by experience period and **Exhibit 7** displays this data for the test and control groups by MCE and experience period.

[14] Differences were not tested for statistical significance.

Exhibit 6: Total ER Visits per Member, by Test and Control Groups, by Experience Period (January 1, 2016 – September 30, 2016)

Test or Control Group	Experience Period	Members with 180 Days Continuous Enrollment	Percent of Continuously-Enrolled Members with Zero ER Visits	Percent of Continuously-Enrolled Members with 1 ER Visit	Percent of Continuously-Enrolled Members with 2 or More ER Visits
Test (Graduated Co-pay)	Q1 2016	276,449	80%	11%	9%
	Q2 2016	298,346	81%	11%	8%
	Q3 2016	323,263	81%	12%	8%
	Q4 2016	343,205	81%	11%	8%
Control (Flat Co-pay)	Q1 2016	4,004	80%	11%	9%
	Q2 2016	3,612	82%	10%	9%
	Q3 2016	2,115	86%	6%	9%
	Q4 2016	3,912	83%	9%	8%

Source: MCE STC-GSU 8 reporting. Restricted to members enrolled continuously for 180 days.
Notes:

- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans and the MCE 1 control group does not include members who met the five-percent cost sharing threshold.
- Due to rounding, totals may not sum to 100 percent.

Exhibit 7: ER Utilization by MCE and Experience Period, for the Test and Control Groups for Members with 180 days Continuous Enrollment (January 1, 2016 – December 31, 2016)

MCE	Experience Period	Members with 180 Days Continuous Enrollment		Percent of Members with Zero ER Visits		Percent of Members with 1 ER Visit		Percent of Members with 2 or More ER Visits	
		Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)
MCE 1	Q1 2016	79,361	876	82%	85%	13%	12%	5%	3%
	Q2 2016	86,137	952	82%	88%	13%	10%	5%	3%
	Q3 2016	94,124	318	81%	91%	14%	7%	6%	2%
	Q4 2016	96,100	930	84%	92%	12%	6%	4%	2%
MCE 2	Q1 2016	102,505	1,470	74%	73%	16%	16%	10%	11%
	Q2 2016	110,582	987	73%	72%	16%	17%	10%	10%
	Q3 2016	126,187	192	73%	70%	17%	17%	11%	13%
	Q4 2016	135,346	1,345	73%	78%	16%	14%	10%	8%
MCE 3	Q1 2016	94,583	1,658	86%	84%	3%	5%	11%	11%
	Q2 2016	101,627	1,676	88%	83%	4%	6%	8%	11%
	Q3 2016	102,952	1,605	90%	86%	3%	4%	6%	10%
	Q4 2016	111,759	1,637	88%	82%	4%	6%	8%	11%

Source: MCE STC-GSU 8 reporting. Restricted to members enrolled continuously for 180 days.
Notes:

- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans and the MCE 1 control group does not include members who met the five-percent cost sharing threshold.
- Due to rounding, totals may not sum to 100 percent.

As shown in **Exhibits 6** and **7**, the majority of members who were continuously enrolled in HIP 2.0 for 180 days did not visit the ER. There are similar percentages of test and control group members with zero ER visits, one visit, and two or more visits. Across MCEs and experience periods, 73 percent to 90 percent of test group members and 70 to 92 percent of control group members, did not visit the ER. There are differences in the proportion of members with zero or with one or more ER visits by MCE. However, overall, there are no stable patterns illustrating utilization in the test group was different from the control group.

Emergent and Non-Emergent Emergency Room Utilization

Exhibit 8 shows the number of emergent and non-emergent ER claims per 1,000 member months, and the percentage of ER visits that were deemed non-emergent, by MCE and experience period, for the test and control groups.

Exhibit 8: Total Emergent and Non-Emergent ER Claims per 1,000 Member Months, by MCE and Experience Period, for the Test and Control Groups (January 1, 2016 – December 31, 2016)

MCE	Experience Period	Total Member Months		Emergent ER Claims per 1,000 Member Months		Non-Emergent ER Claims per 1,000 Member Months		Percent of ER Visits Deemed Non-Emergent	
		Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)
MCE 1	Q1 2016	353,110	3,337	72	58	12	8	15%	12%
	Q2 2016	368,145	3,687	82	71	3	3	4%	4%
	Q3 2016	384,009	1,290	85	91	3	2	3%	3%
	Q4 2016	394,658	3,642	75	61	3	2	4%	3%
MCE 2	Q1 2016	435,725	4,621	62	60	19	24	23%	28%
	Q2 2016	456,897	3,833	68	63	17	23	20%	27%
	Q3 2016	482,674	5,308	78	47	11	22	12%	32%
	Q4 2016	508,934	4,307	67	44	15	16	18%	27%
MCE 3	Q1 2016	110,453	2,375	159	125	99	74	38%	37%
	Q2 2016	103,252	2,648	281	191	159	116	36%	38%
	Q3 2016	135,139	3,129	232	187	126	96	35%	34%
	Q4 2016	220,526	3,861	130	137	68	81	34%	37%

Source: MCE STC-GSU 7 reporting.
Notes:

- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans and the MCE 1 control group does not include members who met the five-percent cost sharing threshold.

The MCE-reported volume of ER claims per 1,000 member months varied by MCE. However, each MCE shows the test group has more emergent claims per 1,000 member months than the associated control group, except for MCE 1 in quarter three.

Non-emergent claims per 1,000 member months by test and control group also varied by MCE. MCE 2 reports more non-emergent ER claims for the control group than the test group; MCE 1 and MCE 3 report more non-emergent ER claims for the test group than the control group, except for MCE 3 in quarter four.

Further, the quantity of non-emergent claims differed by MCE; MCE 3 reported non-emergent ER claims per 1,000 member months ranging from 68 to 159, compared to MCE 1 and MCE 2, which ranged from two to 24.

The proportion of all ER claims that were non-emergent differed by MCE. MCE 3 reports the highest percentages of non-emergent use, ranging from 34 to 38 percent across the four quarters for the test and control groups, whereas MCE 1 reports the lowest percentages of non-emergent use, ranging from three to 15 percent of ER claims. MCE 2 non-emergent use ranges from 12 to 32 percent across time for the test and control groups.

Of the three MCEs, only MCE 2 members exhibit lower percentages of non-emergent ER utilization for the test group across all four quarters. The test and control groups within MCE 3 and within MCE 1 had similar proportions of visits that were non-emergent. While the proportions were quite similar, MCE 1 did report higher percentages of non-emergent ER utilization for the test group compared to the control group in all quarters. MCE 3 had a slightly higher proportion of non-emergent ER visits for the test group in two of the four quarters.

Members who Incurred the ER Co-Payment and Whose Co-Payment was Waived

To gain further insight into the implementation of the graduated ER co-pay policy, the assessment examined the number of HIP 2.0 members who used the ER and the associated co-pay amount: $8, $25, or waived. All test and control group members, except members who are exempt from cost-sharing, are charged $8 for the first non-emergent ER visit. Control group members are charged $8 for each subsequent non-emergent ER visit, while the test group members are charged $25 for each subsequent non-emergent visit. ER co-pays may be waived for a number of reasons, including:

- The visit was determined emergent by the provider at the point of service or by the MCE
- The member is exempt from cost-sharing (*e.g.,* met the five-percent cost sharing threshold, pregnant women and Native Americans)
- The member called their MCE’s nurse hotline prior to visiting the ER

Exhibits 9, 10, and **11** detail, by MCE, the number of members, by test and control groups, who had a non-emergent ER visit from May – December 2016 and the co-pay that was applied: $8, $25, or if the co-pay was waived. Members are counted once in each co-pay category but may be counted more than once each month. For example, a test group member may have one non-emergent visit in June and be counted once as incurring $8. The member may have a second non-emergent visit in June and be counted once as incurring $25. Available data does not provide insight into these counts at the member level.

Exhibit 9: Number of MCE 1 Members Who Incurred the $8 and $25 Co-Pay and Whose Co-Pay was Waived for Non-Emergent ER visits, by Month, for the Test and Control Groups (May 1, 2016 – December 31, 2016)

Month	Number of Members who Incurred an $8 Co-pay		Number of Members who Incurred a $25 Co-pay		Number of Members Whose Co-pay was Waived	
	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)
May	2,825	63	1,438	N/A	7,526	35
June	3,875	69	2,542	N/A	5,386	29
July	3,074	72	2,383	N/A	4,594	22
August	3,302	68	2,488	N/A	4,925	27
September	2,763	67	2,303	N/A	7,160	25
October	2,373	72	2,241	N/A	7,202	29
November	2,002	66	1,939	N/A	8,079	22
December	1,670	24	1,426	N/A	8,247	5

Source: MCE MO-CPAY2 reporting.
Notes:
- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans and the control group does not include members who met the five-percent cost sharing threshold.
- Percent of members with one non-emergent ER visit or with a subsequent non-emergent ER visit was not available at the time of report development.

Exhibit 10: Number of MCE 2 Members Who Incurred the $8 and $25 Co-Pay and Whose Co-Pay was Waived for Non-Emergent ER visits, by Month, for the Test and Control Groups (May 1, 2016 – December 31, 2016)

Month	Number of Members who Incurred an $8 Co-pay		Number of Members who Incurred a $25 Co-pay		Number of Members Whose Co-pay was Waived	
	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)
May	1,447	17	193	N/A	6,442	30
June	1,284	7	161	N/A	7,456	27
July	1,416	2	118	N/A	7,722	8
August	793	31	77	N/A	7,907	66
September	518	24	41	N/A	7,100	39
October	544	11	52	N/A	6,326	36
November	728	11	67	N/A	6,294	27
December	655	7	55	N/A	5,920	25

Source: MCE MO-CPAY2 reporting.
Notes:
- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans.
- Percent of members with one non-emergent ER visit or with a subsequent non-emergent ER visit was not available at the time of report development.

Exhibit 11: Number of MCE 3 Members Who Incurred the $8 and $25 Co-Pay and Whose Co-Pay was Waived for Non-Emergent ER visits, by Month, for the Test and Control Groups (May 1, 2016 – December 31, 2016)

Month	Number of Members who Incurred an $8 Co-pay		Number of Members who Incurred a $25 Co-pay		Number of Members Whose Co-pay was Waived	
	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)
May	2,034	63	1,865	N/A	4,660	80
June	1,220	30	168	N/A	1,702	38
July	2,544	83	845	N/A	4,045	103
August	1,956	43	871	N/A	3,302	61
September	1,387	25	598	N/A	2,810	34
October	1,408	10	746	N/A	2,736	10
November	2,428	22	1,422	N/A	4,578	26
December	2,062	30	1,358	N/A	4,180	36

Source: MCE MO-CPAY2 reporting.
Notes:
- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans.
- Percent of members with one non-emergent ER visit or with a subsequent non-emergent ER visit was not available at the time of report development.

The co-pay data allows for high-level observations regarding members who incurred the ER co-payment and whose co-payment was waived, but does not provide the level of detail that would allow for extensive analyses. First, the MCE reports do not include the number of members who had any non-emergent ER visit in a given month, which could be used to determine the proportion of members who incurred a co-pay. Second, the data reported the number of members who incurred the co-pay or had it waived, but it is not known how many of these members may have had multiple non-emergent ER visits and have been subject to the graduated co-pay. Therefore, it is not known what proportion of total non-emergent ER visits these co-pays represent. Control group members may have paid more than one $8 co-pay each month if they had multiple non-emergent visits and test group members may have paid more than one $25 co-pay but they would only be counted once in each category. Finally, the reports do not include the reason the member's co-pay was waived so it is not known if it was waived per cost-sharing exclusions or if the member called the nurse hotline or for other reasons.

Despite these restrictions, some observations can be made from the data. First, comparing the counts of members who incurred $8 or $25 and whose co-pay was waived illustrates that more members have their co-pay waived than those who incur the co-pay across all MCEs, with the exception of the MCE 1 control group, which excludes members who met the five-percent cost-sharing threshold. Second, the number of test group members who incurred the $25 co-pay was smaller than the number who incurred the $8 co-pay but the magnitude differed by MCE. Fewer MCE 2 test group members incurred the $25 co-pay than the number who incurred the $8 co-pay (approximately one tenth of the number who incurred the $8 co-pay). The number of MCE 3 test group members who incurred the $25 co-pay was approximately one half the count the number

who incurred the $8 co-pay. The number of MCE 1 test group members who incurred the $25 co-pay was approximately four-fifths the number who incurred the $8 co-pay.

Nurse Hotline Use

Each MCE is required to establish a 24-hour nurse hotline to participate in HIP 2.0. Members who call their MCE's nurse hotline prior to reporting to the ER have their co-pay waived, regardless of whether the nurse advised the member not to report to the ER. This policy applies to members in both the test and control groups. **Exhibit 12** shows the number of members who called the nurse hotline prior to reporting to the ER.

Exhibit 12: Number of Members Who Called the Nurse Hotline, by MCE and Experience Period, for the Test and Control Groups (January 1, 2016 – December 31, 2016)

MCE	Experience Period	Number of Members who Called the Nurse Hotline Prior to Reporting to the ER	
		Test (Graduated Co-pay)	Control (Flat Co-pay)
MCE 1	Q1 2016	134	2
	Q2 2016	237	3
	Q3 2016	211	0
	Q4 2016	145	0
	TOTAL	**727**	**5**
MCE 2	Q1 2016	68	0
	Q2 2016	59	0
	Q3 2016	45	0
	Q4 2016	34	0
	TOTAL	**206**	**0**
TOTAL ACROSS MCES	Q1 2016	202	2
	Q2 2016	296	3
	Q3 2016	256	0
	Q4 2016	179	0
	GRAND TOTAL	**933**	**5**

Source: MCE-reported nurse hotline data.
Notes:

- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans and the MCE 1 control group does not include members who met the five-percent cost sharing threshold.
- MCE 3 data was not available at the time of report development.

Nearly all members who reported to the ER did not call their MCE's nurse hotline prior to the visit. Although a small number of members (938) called the MCE nurse hotlines, more test group members called compared to control group members for both MCE 1 and MCE 2. **Exhibit 13** shows similar results for members with one non-emergent visit and for members with subsequent non-emergent visits.

Exhibit 13: Number of Members Who Called the Nurse Hotline Prior to Their First and Subsequent Non-Emergent ER Visit, by MCE and Experience Period, for the Test and Control Groups (January 1, 2016 – December 31, 2016)

MCE	Experience Period	Number of Unique Individuals who Called the Nurse Hotline Prior to their First Non-Emergent Visit to the ER		Number of Unique Individuals who Called the Nurse Hotline Prior to their Subsequent Non-Emergent Visit to the ER	
		Test (Graduated Co-pay)	**Control** (Flat Co-pay)	**Test** (Graduated Co-pay)	**Control** (Flat Co-pay)
MCE 1	Q1 2016	20	0	6	0
	Q2 2016	41	1	2	1
	Q3 2016	42	0	6	0
	Q4 2016	26	0	5	0
	TOTAL	**129**	**1**	**19**	**1**
MCE 2	Q1 2016	68	0	12	0
	Q2 2016	59	0	12	0
	Q3 2016	45	0	13	0
	Q4 2016	34	0	5	0
	TOTAL	**206**	**0**	**42**	**0**
TOTAL ACROSS MCES	Q1 2016	88	0	18	0
	Q2 2016	100	1	14	1
	Q3 2016	87	0	19	0
	Q4 2016	60	0	10	0
	GRAND TOTAL	**335**	**1**	**61**	**1**

Source: MCE-reported data.
Notes:
- The composition of the test and control groups differ. The test group includes pregnant women, Native Americans, and members who met the five-percent cost sharing threshold. The control group does not include pregnant women or Native Americans and the MCE 1 control group does not include members who met the five-percent cost sharing threshold.
- MCE 3 data was not available at the time of report development.

Urgent and Primary Care Services Utilization

The graduated co-pay policy was intended to reduce inappropriate use of the ER by decreasing non-emergent ER visits. To examine utilization of services outside of the ER, FSSA encounter data was summarized by number of visits for urgent and primary care.

Exhibit 14 shows the number of urgent care visits and visits per 1,000 member months by MCE and quarter, and by test and control groups for 2016 incurred dates.[15] It displays similar urgent care utilization across the test and control groups and experience periods. There is no consistent pattern in the differences in urgent care visit utilization between test and control groups for all three MCEs. MCE 2 and MCE 3 test and control group members had 14 to 20 urgent care visits per 1,000 member months across calendar year 2016. MCE 1 test and control groups show six to nine urgent care visits per 1,000 member months for quarters one through three, and 11 to 13 visits per 1,000 member months for quarter four.

Exhibit 15 presents the number of primary care visits and visits per 1,000 member months by quarter, by MCE, and by test and control groups. There is no consistent pattern in the differences in the number of primary care visits per 1,000 member months by test and control groups. The MCE 2 test group has more visits per 1,000 member months than the control group across all four quarters. Conversely, the MCE 1 test group has a lower number of visits per 1,000 member months than the control group across all time periods. The comparison differs by quarter for MCE 3; the test group has a lower number of visits per 1,000 member months in three of the four quarters. In addition, there are decreases for all MCEs from quarter one to quarter four in both the test and control groups, except for MCE 3 quarter three 2016.

[15] The member month counts included in **Exhibit 14** will be different from the member month counts reported in the 2017 POWER Account Contribution Assessment due to the exclusion of members without an identified MCE in this report (2016 ER Co-payment Assessment). The observations were included in the member month counts in the POWER Account Contribution Assessment. Source: The Lewin Group. (2017). *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment.*

Exhibit 14: Total Urgent Care Visits and Visits per 1,000 Member Months, by MCE and Experience Period, for the Test and Control Groups (January 1, 2016 – December 31, 2016)

MCE	Experience Period	Eligible Member Months		Total Number of Urgent Care Visits		Urgent Care Visits per 1,000 Member Months	
		Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)
MCE 1	Q1 2016	328,629	2,928	2,900	22	9	8
	Q2 2016	346,858	3,188	2,957	19	9	6
	Q3 2016	358,482	3,633	3,197	23	9	6
	Q4 2016	373,938	3,972	3,928	52	11	13
	TOTAL	**1,407,907**	**13,721**	**12,982**	**116**	**9**	**8**
MCE 2	Q1 2016	405,264	4,410	6,753	64	17	15
	Q2 2016	432,008	3,647	7,305	55	17	15
	Q3 2016	455,439	5,344	8,458	105	19	20
	Q4 2016	486,444	4,857	8,201	85	17	18
	TOTAL	**1,779,155**	**18,258**	**30,717**	**309**	**17**	**17**
MCE 3	Q1 2016	226,719	4,407	3,471	60	15	14
	Q2 2016	231,113	4,776	3,288	71	14	15
	Q3 2016	235,995	5,393	3,611	93	15	17
	Q4 2016	245,163	5,699	4,026	95	16	17
	TOTAL	**938,990**	**20,275**	**14,396**	**319**	**15**	**16**
TOTAL ACROSS MCES	Q1 2016	960,612	11,745	13,124	146	14	12
	Q2 2016	1,009,979	11,611	13,550	145	13	12
	Q3 2016	1,049,916	14,370	15,266	221	15	15
	Q4 2016	1,105,545	14,528	16,155	232	15	16
	GRAND TOTAL	**4,126,052**	**52,254**	**58,095**	**744**	**14**	**14**

Source: MCE-reported data was used to identify test and control group members. The MCE-reported data was linked with FSSA enrollment data, which was used for the total eligible member months. FSSA encounter data was used to identify urgent care visits for the sample identified.

Notes:

- The counts exclude members 1) with non-open enrollment status; 2) outside 19-64 years of ages; 3) enrolled in HIPLink; 4) who do not have an identified MCE in the enrollment data due to data issues known to the State; and 5) pregnant women and Native Americans. In addition, the MCE 1 control group does not include members who met the five-percent cost sharing threshold.

Exhibit 15: Total Primary Care Visits and Visits per 1,000 Member Months, by MCE and Experience Period, for the Test and Control Groups (January 1, 2016 – December 31, 2016)

MCE	Experience Period	Eligible Member Months		Number of Primary Care Visits		Primary Care Visits per 1,000 Member Months	
		Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)	Test (Graduated Co-pay)	Control (Flat Co-pay)
MCE 1	Q1 2016	328,629	2,928	19,759	215	60	73
	Q2 2016	346,858	3,188	20,048	231	58	72
	Q3 2016	358,482	3,633	18,384	235	51	65
	Q4 2016	373,938	3,972	16,221	224	43	56
	TOTAL	**1,407,907**	**13,721**	**74,412**	**905**	**53**	**66**
MCE 2	Q1 2016	405,264	4,410	25,703	260	63	59
	Q2 2016	432,008	3,647	25,188	196	58	54
	Q3 2016	455,439	5,344	24,770	281	54	53
	Q4 2016	486,444	4,857	20,646	186	42	38
	TOTAL	**1,779,155**	**18,258**	**96,307**	**923**	**54**	**51**
MCE 3	Q1 2016	226,719	4,407	15,416	356	68	81
	Q2 2016	231,113	4,776	15,167	291	66	61
	Q3 2016	235,995	5,393	14,363	353	61	65
	Q4 2016	245,163	5,699	12,642	308	52	54
	TOTAL	**938,990**	**20,275**	**57,588**	**1,308**	**61**	**65**
TOTAL ACROSS MCES	Q1 2016	960,612	11,745	60,878	831	63	71
	Q2 2016	1,009,979	11,611	60,403	718	60	62
	Q3 2016	1,049,916	14,370	57,517	869	55	60
	Q4 2016	1,105,545	14,528	49,509	718	45	49
	GRAND TOTAL	**4,126,052**	**52,254**	**228,307**	**3,136**	**55**	**60**

Source: MCE-reported data was used to identify test and control group members. The MCE-reported data was linked with FSSA enrollment data, which was used for the total eligible member months. FSSA encounter data was used to identify primary care visits for the sample identified.

Notes:

- The counts exclude members 1) with non-open enrollment status; 2) outside 19-64 years of ages; 3) enrolled in HIPLink; 4) who do not have an identified MCE in the enrollment data due to data issues known to the State; and 5) pregnant women and Native Americans. In addition, the MCE 1 control group does not include members who met the five-percent cost sharing threshold.

V. Limitations and Summary

Limitations

There are a number of limitations examining the impact of the graduated ER co-pay policy, as assessed in this report. These limitations can be summarized into three different categories: data available for analysis, reliability of MCE-reported data, differences in sample characteristics and the association of those characteristics with ER utilization.

Available Data

This assessment spans a limited timeframe in that it reviews data from January 1 – December 31, 2016 but the graduated co-pay policy began February 4, 2016 and runs through January 31, 2018. Eleven months is a limited amount of time for members to understand the graduated ER co-pay policy and to influence their behavior.

MCE reports do not contain details about the implementation of the policy at the member or hospital levels, so this analysis cannot provide insight into the degree of provider and member understanding of the ER co-payment policies.

Another limitation of the MCE-reported data is that the inclusion criteria and denominator definitions are not consistent across data sources limiting the comparisons that can be made across metrics, *e.g.,* some metrics are by member while others are by ER visit. In addition, there are some key metrics that were not included in the MCE-reported data. For example, the MCE reports do not include data on how many test group members had more than one *non-emergent* ER visit during their benefit period; therefore, it is difficult to ascertain to what extent the graduated co-pay policy is beginning to affect test group members.

Additionally, there are limitations related to internal consistency between different reports and data sources. For instance, the number of waived co-pays is high given the low volume of nurse hotline calls.

Finally, urgent care locations are defined by their place of service as listed in the encounter data. However, the data does not allow for inclusion of alternative places of service, such as drug store or supermarket walk-in clinics. Additionally, the definition for primary care visits excluded any claim record where the referring provider's National Provider Identifier is populated. Therefore, these estimates may under-report use of urgent and primary care visits.

MCE-Reported Data

This assessment utilized MCE-reported data that is part of FSSA's and OMPP's existing operational processes. Independent validation of MCE reports was outside the scope of this assessment.

Test and Control Group Differences

The test and control groups by data source are composed differently. For example, MCE-reported data excludes pregnant women and Native Americans from the control group but not from the test group. MCE-reported data also includes members who are exempt from cost sharing in the test group and includes members who met the five-percent threshold in the control group (except for

MCE 1). These members may be more likely to use the ER because they are not charged a co-pay for non-emergent use of the ER.

Finally, there were differences in the test and control groups in many characteristics that could be correlated with ER utilization. This includes differences in the income distributions and the enrollment by plan/aid category. These differences greatly limit comparisons between the test and control groups.

Summary

This report reviews data related to the HIP 2.0 ER Co-payment Policy, which was implemented on February 4, 2016. The assessment examined enrollment, encounter, and MCE-reported data for calendar year 2016 to compare ER utilization, payment of the ER co-pay, use of the nurse hotline, and urgent and primary care visits.

The majority of members (80 to 86 percent across the MCEs) did not visit the ER in calendar year 2016. The number of non-emergent ER visits between the test and control groups varied by MCE and quarter, with no discernable patterns. For MCE 2, the number of non-emergent ER visits per 1,000 member months ranges from 11 to 19 for the test group and from 17 to 24 for the control group across the experience periods; MCE 1 reports three to 12 visits for the test group and two to eight for the control; and MCE 3 reports 68 to 159 for the test group and 74 to 116 for the control group.

Very few members incurred the ER co-pay for non-emergent visits between August and December 2016. For example, in December 2016, 7,287 members incurred either an $8 or $25 co-pay, while 18,413 had their co-pay waived. Overall, more members have their co-pay waived than those who incur the co-pay across all MCEs, with the exception of the MCE 1 control group.

Few members called the nurse hotline prior to a non-emergent ER visit; in total, 933 test group members and five control group members called in 2016 prior to a non-emergent ER visit.

There was no consistent pattern in the differences in primary care and urgent care visits between the test and control groups.

Appendix A: Emergency Department Copayment Protocol

HEALTHY INDIANA PLAN

Emergency Department Copayment Protocol

2/4/2016

The Emergency Department Copay Protocol describes the process to be used under the state plan for collecting non-emergency use of emergency department copayments from beneficiaries. This protocol also describes how the state plans to test a graduated copay for non-emergency use of the emergency room. Specifically, the test shall examine whether use of a $25 copay for recurrent non- emergent use of the emergency department reduces unnecessary emergency department use without any meaningful harm to beneficiary health.

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Emergency Department Copayment Description

Emergency care will be covered for all HIP Basic, HIP Plus, and HIP State Plan members; however, these members[16] will be subject to a copayment if they use the emergency department (ED) for non-emergency care. In an effort to reduce inappropriate use of the ED and encourage the appropriate use of primary and urgent care centers, HIP 2.0 is testing a graduated copayment. An $8 copayment will be incurred for their first inappropriate emergency department visit, while any subsequent inappropriate emergency department utilization within the same 12 month benefit period would require a $25 copayment. Providers will collect the copayment directly from members;[17] and member POWER account funds cannot be used by the member to pay the copayment. Provider payments will be reduced by the applicable copayment amount.

In contrast to the graduated copayment structure of the "test" group, the state will establish a random selection of individuals—named the "control" group—that will only have an $8 copayment applied to subsequent visits.

To determine if "test" and "control" members are subject to any copayment, the hospital will verify if the member meets any of the qualifications.

Copayments will be waived if the member is found to have an emergency condition, as defined in section 1867(e) (1) (A)[18] of the Emergency Medical Treatment and Active Labor Act, or if the person is admitted to the hospital within twenty-four (24) hours of the original visit. All emergency department visits where a copayment may be applied are subject to prudent layperson review to determine whether an emergency medical condition exists for purposes of applying the copayment. Members of the same family will all be a part of the same group and will have the same copay.

In addition, the member copayment must be waived for any member who contacts the 24-hour Nurse Call Line prior to utilizing a hospital emergency department to obtain advice on their medical conditions and the appropriate setting to receive care. As indicated in Section 6 of the HIP 2.0 Scope of Work (SOW), managed care entities are required to operate a Nurse Call Line 24 hours a day, 7 days a week:

The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty four (24)-hour Nurse Call Line should be well publicized and designed as a resource to members to help discourage inappropriate emergency room use, particularly for members in

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16 HIP members that will not be subject to the non-emergency ED use copayment include HIP Link members and Basic, Plus, and State Plan members exempt from cost sharing (*i.e.*, members who are pregnant or members identified as an American Indian/Alaska Native (AI/AN), pursuant to 42 CFR 136.12). Link cost sharing will be detailed in the HIP Link protocol.

17 Providers can only require individuals with household income over 100% FPL to pay the copayment before services will be provided.

18 Section 1867(e)(1)(A) describes an emergency condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." (Retrieved from http://www.ssa.gov/OP_Home/ssact/title18/1867.htm)

disease management. The 24-hour Nurse Call Line must have a system in place to communicate all issues with the member's PMCP. In addition, as set forth in Section 6.6.3, the 24-Hour Nurse Call Line must be equipped to provide advice for HIP members seeking services from hospital emergency departments. (HIP 2.0 SOW; p. 99)

If a member calls the Nurse Call Line prior to seeking emergency care, the member will not be subject to a copayment.

Member assignment methodology

a. *The method by which beneficiaries will be assigned to participate in the emergency department copay structure test group as described in paragraph 2 of this section ($8 for the first visit and $25 for each subsequent visit) and control group as described in paragraph 3 of this section ($8 for each visit);*

To test if applying a $25 copayment for subsequent ED visits impacts member utilization when compared to a flat rate $8 copayment the state will select a control group that is not subject to the

$25 ED copayment. The control group will be selected as a random sample of at least 5,000 HIP members, in accordance with Section VIII, Paragraph 3 of the STCs. The random sample methodology will be based on two digits of the HIP member identification number.

The state will assign members to the control group using the same formula that the Centers for Medicare and Medicaid Services (CMS) uses to select its five percent (5%) samples from standard analytical files using health insurance claims. Specifically, the state will create a control group from selecting records with five random two-digit numbers (e.g., 05, 20, 45, 70 or 95) in positions 7 and 8 of the HIP member identification number. Thus, if these two digits of the member identification number equals one of those five numbers, then the person is included in the control group of at least 5,000 members.

Members who are exempt from cost sharing, including American Indian/Alaska Native (AI/AN) and pregnant members, will be excluded from the sample. Women who are selected and become pregnant will be removed from the sample as they will have no copayments applied for the remainder of their pregnancy. On a quarterly basis, the sample will be repopulated with new members who have the randomly selected numbers in positions 7 and 8 of the member RID to assure a control group sample of at least 5,000 members. Members who leave the sample will still have their ED use while a member of the sample considered for the purpose of the study.

The state will monitor the ED utilization and utilization of primary and urgent care services of members in the general HIP population and the control group. ED visits per quarter for each group will be examined for significance, as will the incidence of ambulatory sensitive conditions, including mortality. To distinguish between true emergency and non-emergency visits, the state will use the listed copayment as the primary indicator for all populations subject to cost sharing. Data collected will be stratified according to member income (e.g., 100 to 138% FPL, below 100% FPL, etc.); member benefit plan (i.e., HIP Basic, HIP Plus, HIP State Plan); and other related categories. Additional monitoring and evaluation is detailed in Table 1below.

Table 1. Emergency Department Copayment Monitoring and Evaluation

Monitoring and Evaluation Group	Indicators	Data Sources, Data Elements and Data Analysis
Test Group vs. Control Group	**Control Group:** Random sample of at least 5,000 HIP members, selected using the same formula that the Centers for Medicare and Medicaid Assistance (CMS) uses to select its five percent (5%) samples from standard analytical files using health insurance claims. The control group will not include members exempt from cost sharing. Control group selection will be shared with the MCEs so they can add the necessary indicators to the member account information. **Test Group:** The test group will consist of all HIP members who are not within the control group, also excluding those exempt from cost sharing. **Identifying Member Status:** When a HIP member enters the ED, the provider will verify the member's eligibility as is routine. The Indiana eligibility verification (EVS) step will confirm eligibility, and will also indicate if the member has a copayment. To confirm the copayment amount, the provider will call the MCE provider help line to confirm. Training materials advise providers that verification with the MCE over the phone is the most accurate way of assessing if the member owes a copayment and what copayment amount is due.	**Claims/encounter data**: ▪ # of members who use the emergency department; ▪ # of *emergent* ED visits by members within the control group; ▪ # of *emergent* ED visits by members within the test group; ▪ # of *non-emergent* ED visits by members within the control group; ▪ # of *non-emergent* ED visits by members within the test group; ▪ # of members within the control group who called the 24-hour nurse hotline prior to reporting to the ED; ▪ # of members within the test group who called the 24-hour nurse hotline prior to reporting to the ED; ▪ # of members who utilize urgent care instead of the ED; ▪ Types of providers members are seeing for services related to non-emergency ED visit, within 1 month and 3 months of ED visit ▪ # of members with claims/service codes [related to reason for non-emergency ED visit] more complex, less complex, or same complexity within 1 month, 3 months of non-emergency ED visit; ▪ # of members admitted to hospital for condition related to non-emergency ED visit within 1 month, 3 months; ▪ # of members receiving ED emergency condition assessment and having service(s) performed at urgent care or other non-emergency setting; and ▪ Other related data. **Survey data**: ▪ # and/or % members who completed surveys, by test and control group ▪ # and/or % of times members paid copayment for non-emergency visits to ED, by test and control group ▪ # and/or % of times member tried to contact Nurse Hotline in advance of ED visit, by ability to contact, by test and control group ▪ # and/or % of times went to urgent after visiting ED (for non-emergency visits), by test and control group

Monitoring and Evaluation Group	Indicators	Data Sources, Data Elements and Data Analysis
		▪ Reason(s) individual left the ED without care (when applicable) ▪ Member and provider perceptions about the affordability of the copay **POWER account data**: ▪ Outstanding debt due to ED visit **Call Center Records:** ▪ Complaints made from members about the copayment, by reason code. ▪ Complaints made from providers about the copayment, by reason code.
"First Visit" versus "Subsequent Visit" Non-Emergent ED Visits	"**First visit**": Member's first visit to the ED that results in paid claims for which the MCE made a determination of non-emergent status for making the appropriate payment to the hospital. "**Subsequent visit**": Any visit to the ED—other than the member's first visit—that results in paid claims for which the MCE made a determination of non-emergent status for making the appropriate payment to the hospital.	**Claims/encounter data:** ▪ # of members who make "first visit" non-emergent ED visits, ▪ # of members who make "subsequent visit" ▪ non-emergent ED visits. ▪ # of members who call the 24-hour nurse hotline prior to "first visit" and "subsequent" non-emergent ED visits.
Nurse Hotline "Call" versus "No Call"	**"Calls":** Member calls (or calls made on member's behalf) received by the 24-hour nurse hotline up to 24-hours before the member reports to the emergency room. **"No calls":** Calls which a) did not occur or b) which were not received by the 24-hour nurse hotline from the member (or on the member's behalf) up to 24-hours before the member reported to the emergency room.	**Nurse Call Line data:** ▪ # of members who make Nurse Call Line "calls" prior to using the ED; and ▪ # of member who do not call Nurse Call Line in advance of presenting at ED ("no calls")
Emergent versus Non-Emergent Condition Determination	As indicated within the Section 6.6 of the HIP 2.0 Scope of Work (SOW), the MCEs are responsible for determining emergency medical conditions (i.e., determining emergent versus non-emergent medical conditions). ***Emergent:*** Emergent conditions are those defined as emergency	The state will use claims/encounter data and data reported by the MCEs, to track and monitor data on emergent versus non-emergent medical condition determination. Specifically, the state will use claim/encounter data to identify how many members have qualifying emergency claims and qualifying non-emergency claims. In addition, the state will use data from calls to the 24-hour nurse hotline, to collect, track, and

Monitoring and Evaluation Group	Indicators	Data Sources, Data Elements and Data Analysis
	medical conditions in 42 CFR 438.114, as well as those which meet the "prudent layperson" standard as defined in IC 12- 15-12 and result in paid claims for which the MCE made a determination of emergent status for making the appropriate payment to the hospital. The state will use "Codes to Identify ED Visits" as specified by the HEDIS 2014 Technical Specifications in identifying emergency conditions. ***Non-emergent:*** Non-emergent conditions are those which result in paid claims for which the MCE made a determination of non-emergent status for making the appropriate payment to the hospital.	monitor the number of members who called the nurse hotline before going to the ED. Data collected will be stratified according to member income (e.g., 100 to 138% FPL, below 100% FPL, etc.); member benefit plan (i.e., HIP Basic, HIP Plus, HIP State Plan); and other related categories.

Ambulatory care sensitive conditions

b. *Baseline data related to ambulatory care sensitive conditions and any other health outcomes the state proposes to examine;*

Baseline ambulatory care sensitive conditions are detailed in the attached document provided by Milliman Inc.

Process by which providers will identify test groups

c. *The method by which providers will identify those in the test and control groups;*

When a HIP member enters the ED the provider will verify member eligibility as is routine. The Indiana eligibility verification (EVS) step will confirm eligibility and also indicate if the member has a copayment. To confirm the copayment amount the provider utilizes the MCE's online verification system, MCE training material, and/or can call the MCE provider help line to confirm. Training material advises providers that verification with the MCE online or over the phone is the most accurate way of assessing if the member owes a copayment and what copayment amount is due. If the Emergency Department provider completes the initial assessment of the HIP member's condition, and meets the requirements of 447.54(d), the provider may assess the copayment. The following charges may be assessed to the member for the non-emergency ED visit:

- If the visit is the member's first visit to the ED, and they are not otherwise exempt and did not call the Nurse Hotline in advance then the member will owe an $8 copayment.

- If the member has visited the ED more than once in the benefit period, is not otherwise exempt, did not call the nurse hotline in advance of the visit, and is not a member of the control group them the member will owe a $25 copayment
  - Members of the control group will owe a $8 copayment for subsequent ED visits, and copayment amount will be verified by calling the MCE or using the MCE online verification system
- If the member is otherwise exempt from cost sharing, or called the Nurse Call Line in advance of the visit, no copayment will be owed.

Member education

d. *The strategy for educating beneficiaries on their assigned group including any beneficiary materials such as member handbooks;*

Beneficiaries are educated about the copayment responsibilities associated with visiting the Emergency Department through member notices and outreach materials, member handbooks, and online materials provided by both the state and MCEs. Members can also receive education about the ED copayment requirements when the call the MCEs call center or the Nurse Hotline.

For members selected for the control group, MCEs will develop state-approved notices which will be sent to selected members to inform them of their placement within the non-graduated $8 ED copay group. General member materials including handbooks, will reference the $25 copayment schedule; but members in the $8 group will receive special targeted communication from the MCEs informing them of their placement in the control group.

Members within the control group ($8/non-graduated ER co-payment) will receive the following standard language from MCEs in their notices:

> *If you choose to use the emergency room when you do not have an emergency health condition you will have to pay a copayment. Your copayment for use non-emergency use of the emergency room will be $8 for each visit. If you are unsure of whether you have an emergency health condition, you should call the 24hour nurse helpline for advice on the best place to seek care. If you contact the nurse helpline, you will not be responsible for making any copayment if you go to the emergency room. To contact the nurse line for questions about health conditions please call [insert MCE specific nurse hotline#].*
>
> *Your member handbook and member materials mention a $25 copayment for non- emergency use of the ER when you visit more than once a year. This $25 copayment will not apply to you. Your copayment for using the ER for non-emergency care will always be $8. If your visit to the ER is a true emergency you will not have to pay a copayment.*

MCEs will be able to indicate to these members when the members call in that they are part of the control group and that their copayment remains $8 for non-emergency visits to the emergency department after the initial visit. Providers and other emergency department staff will be able to verify all members' copayments owed for the ED visit when calling to check the member copayment responsibility with the MCE when it has been determined that the member does not have an emergency health condition.

Copay implementation

e. *The strategy for working with health plans on implementing the copay structure;*

The state has worked closely with the MCEs on all HIP operational policies since the beginning of the original HIP program in 2007. Currently, the state holds meetings at least twice a week that include the MCEs. The implementation of the graduated copayment structure and the control group has been discussed during these meetings. For example, discussions around the design of the HIP member card accommodated the ED copayment policy, determining that to reduce provider confusion HIP member cards will not list the amount of the graduated ED copayments, but will instruct the provider to contact the MCE by phone to verify the copayment amount when a member owes a copayment for non-emergency use of the emergency department. The provider will not use the member card to determine if an $8 or $25 copayment amount applies, but will verify the actual amount with the MCE. This same strategy will be used for the members who are in the control group with the $8 copayment applied regardless of the number of non-emergency visits to the emergency department, to reduce administrative complexities for providers. Providers will check with the MCEs, and for the control group, regardless of it is the member's first or fifth visit to the ED during the benefit period, the MCE verification will provide the $8 copayment amount. MCE and stated education to providers also includes content concerning the fact that the provider may not require collection of copayments for members below 100% FPL before service.

Another example of how the state has worked with the health plans in implementing the copayment structure is the group assignment of members within the same household.

Specifically, members within the same household and/or family will be assigned to the same group (test or control), and will have the same co-payment amount structure (graduated or non-graduated/flat).

Grievance and appeals

f. *The strategy for a grievance and appeals process for beneficiaries;*

Initial dispute of ED copayments amounts initiate with the MCE grievance and appeals process. All MCEs are contractually required to maintain a process that meets all applicable federal requirements. These requirements are detailed in Section 7 of the HIP 2.0 Scope of Work.

Members that disagree with the assessment of the ED copayment amount for any reason can file a grievance with the applicable MCE. If the member is unable to resolve their concern through the MCE grievance process then they may appeal through the state's appeal process. Member handbooks detail the member grievance process.

Member handbooks are available at:

Anthem: http://www.anthem.com/inmedicaid/

MHS: http://www.mhsindiana.com/

MDwise: http://www.mdwise.org/for-members/healthy-indiana-plan/

Identification of members with emergency health conditions

g. The number of individuals who were determined to have an emergent condition;

The state will use a series of mechanisms to determine whether or not an individual presenting to an emergency department has an emergency condition. According to HIP 2.0 Scope of Work Section 6.2, all MCE designation and treatment of emergency medical conditions must comply with 1876(e)(1)(A), 42 CFR 438.114, and IC 12-15-12.4[19] These federal and state requirements define an emergency medical condition as:

> *A medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) serious jeopardy to the health of: (A) the individual; or (B) in the case of a pregnant woman, the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.*

All MCEs will also consider a condition an "emergency condition" if the individual is admitted to the hospital within 24 hours of the original visit or if an MCE-provided layperson review determines that the medical condition could meet the emergency medical condition definition above. A layperson reviewer must be provided by each MCE and may not have more than a high school education and must not have training in a medical, nursing, or social work-related field.

Each MCE provides information to help individuals identify emergency conditions within their member handbook and related materials. Example language is listed below:

> ***Emergency care***
>
> *An emergency is a medical condition with such severe symptoms (including severe pain or active labor) that you reasonably believe that not getting medical attention right away may:*
>
> - *Place your mental or physical health (or the health of your unborn child) in jeopardy.*
> - *Cause impairment to a body function.*
> - *Cause disfigurement.*
> - *Cause dysfunction of a body organ or part.*

In addition, a member visit to the ED may be considered an emergency if it was authorized by a nurse on the Nurse Call Line—a 24-hour call line operated by each MCE to triage member calls. If the Nurse Call Line determines that a visit to an ED is appropriate, the MCE-run call line will be responsible for coordinating with the member, ED provider/hospital, and MCE to ensure the member will not be responsible for a copayment when he or she presents at the ED.

Emergency visits will be monitored through claims/encounter data; and the assessment of the applied $0 copay will consider different reasons for the lack of copay, including member groups exempt from cost sharing, calls to the Nurse Call Line, emergency medical conditions identified by

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[19] Section 6.6 of the Scope of Work states that MCEs "may not determine what constitutes an emergency on the basis of lists of diagnoses or symptoms."

the medical provider upon screening, prudent layperson reviews, and other reasons. The assessment of this population will be stratified according to member income (e.g., 100 to 138% FPL, below 100% FPL, etc.); member benefit plan (i.e., HIP Basic, HIP Plus, HIP State Plan); and other related categories.

Individuals will only have a copayment applied if there is a non-emergent condition and they do not call the Nurse hotline and obtain a waiver in advance of the visit. Total ED visits are available through encounter data, and MCEs are required to report the total ED copayments applied at the $8 or $25 level for each HIP Plan option. The difference between these two values will represent the number of individuals determined to have an emergent condition on an ongoing basis. Members who are exempt from cost sharing (i.e., pregnant women and AI/AN members) will be excluded from the sample.

Identification of members with non-emergency health conditions

h. *How the state/MCOs defines non-emergency services for purposes of imposing cost sharing;*

i. *Any MCO guidelines for ED staff in determining what is and is not a condition that requires emergency treatment;*

At the point of service Emergency Department providers must assess if the member has an emergency medical condition. A condition will be considered a non-emergency health condition if it does not meet the definition of "emergency medical condition" established in 1876(e) (1) (A), 42 CFR 438.114, and IC 12-15-12.

If a member's health condition does not qualify as emergent, the provider will inform the member of his or her cost sharing responsibility and must provide an appropriate referral to services where the member will not be subject to the Emergency Department copayment.

Members will not be charged for the assessment to identify whether their condition qualifies as emergent. If the member decides to continue with the service at the ED, after a) being informed that his/her condition is non-emergent, and b) that proceeding with non-emergent treatment at the ED will require a copay, the provider may collect the copayment at the point of service or charge a copayment to the member.

All ED claims are subject to additional review by the MCEs. Claims that are non-emergency due to failure to fulfill the four reasons listed above will be paid to the provider less the applicable copayment amount. If the provider did not collect the copayment at the time of the visit and the ED visit is determined to be non-emergency, the provider may bill the member for the balance. If the provider did collect a copayment and the visit is later determined to be an emergency, the provider is obligated to refund the member for any copayment the member paid at the point of service.

All MCEs are required to operate an internal grievance process. Members may file a grievance if they disagree with the application of the ED copayment. After the member exhausts the MCE grievance process, they may appeal to the state.

Process to ensure hospitals meet the requirements at 447.54(d)

j. The plan to operationalize a process to ensure hospitals meet the requirements at 447.54(d);

In accordance with federal regulation 42 CFR § 447.54(d), hospitals and ED providers are required to meet the following requirements before they may impose cost sharing:

a. *Conduct an appropriate medical screening under §489.24 subpart G to determine that the individual does not need emergency services;*
b. *Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;*
c. *Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;*
d. *Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and*
e. *Provide a referral to coordinate scheduling for treatment by the alternative provider.*[20]

If a member has an available and accessible alternate non-emergency services provider, does not have an emergency medical condition and did not receive a waiver from the 24-hour Nurse Call Line, and the provider has met the requirements in accordance with 42 CFR § 447.54(d), the member will owe a copayment to the provider.

Available and accessible refers to 42 CFR §447.54 (cost sharing for services furnished in a hospital emergency department) which places the requirement on hospitals to provide an alternate non-emergency services provider to patients before providing non-emergency services which might impose cost sharing for such services.

In addition, the draft State of Indiana Quality Strategy Plan 2015 includes provisions to require MCEs to develop networks that will provide "a sufficient number and geographic distribution of primary care and urgent care facilities to serve the expected enrollment." To ensure these expectations are met, the state proposes a requirement for MCEs to submit quarterly network adequacy reports to the state for the first year of the HIP 2.0 demonstration.

Both the state and the MCEs have communications to providers detailing the requirements on hospitals prior to assessing the ED copayment. The state's initial HIP Provider bulletin addressed the requirements hospitals must meet to apply and collect the copayment for a non- emergency visit to the emergency department. The state's provider bulletins can be viewed at: http://provider.indianamedicaid.com/ihcp/Publications/bulletin_results.asp.

The requirements of 42 CFR 447.54 (d) are included in the HIP 2.0 Scope of Work and MCEs are contractually obligated to ensure that providers appropriately assess the ED copayments.

[20] Source: U.S. Government Publishing Office. (2015). Part 445—Payments for Services. Retrieved from http://www.ecfr.gov/cgi-bin/text-idx?node=pt42.4.447&rgn=div5#se42.4.447_154.

MCE provider materials, including provider manuals and internal policy and procedure documents, detail the requirements for providers prior to assessing the ED copayment. Example language from an MCE provider manual is provided below:

> *Prior to assessing the copayment, the member must be screened to ensure they do not have an emergency health condition. The requirements for a medical screening examination and stabilizing treatment when an individual presents at the emergency room department remain in place regardless of the member's ability to pay. Members that do not have an emergency health condition must be informed of other options for treatment of their non-emergency condition and of the cost sharing associated with seeking treatment in the ED. Per federal requirements, the ED provider may require payment of the co-payment before the non-emergency service is provided, however the provider must also:*
>
> - *Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;*
> - *Provide the name and location of an alternate non-emergency services provider that is available and accessible;*
> - *Verify that an alternate provider can provide the services without the imposition of the co-payment; and*
> - *Provide a referral* to coordinate scheduling of this treatment.
>
> *Additionally, if copay is collected and later waived it must be refunded to member.*

Alternatives to the Emergency Department

k. *A description of the network of providers available to accommodate after hours and next day appointments as an alternative to the ED;*

MCEs are required to develop urgent care networks and are encouraged to include non- traditional urgent care providers, like retail clinics, in their networks. Members in need of urgent care may self-refer to an urgent care provider. The MCE contract does not require that this self- referral extend to out-of-network providers, however, at least one MCE includes self-referral to out-of-network urgent care providers. Types of urgent care providers in MCE networks include urgent care, immediate care, walk-in clinics and retail clinics such as CVS Minute Clinics.

MCEs may also leverage primary care providers to direct members to the appropriate care location. Members who need to be seen after-hours or "next day" always have the option to seek care from an Urgent Care Center/Provider. Additionally, primary care providers are required to provide after-hours instructions to members to help determine the appropriate level of care needed by the member. Most PMPs provide an on-call service to address immediate questions from members. If a practitioner determines the member needs to be seen during an after-hours call, the practitioner will direct the member to seek the appropriate level of care as determined by the conversation with the member (which may include instructing the member to call the office first thing in the morning to schedule an appointment). Additionally, most FQHCs have open access scheduling that allows for same day scheduling. Members who cannot contact their primary care provider have access to his or her MCE's Nurse Call Line.

In addition, one MCE is developing a pilot program to reduce ER utilization in three (3) counties; Monroe, Delaware and Vanderburgh. Claim analysis has shown that these counties had the highest utilization of ED claims per capita for 2014. The program will be developed and launched to members in these counties who utilized the emergency department (ED) in 2014.

This campaign will notify them of alternatives to the ED like CVS Minute Clinics and will include education on the proper usage of these clinics and where they are located. The MCE will also include education about the relationship value and proper use of their assigned primary medical provider. The pilot launch is expected in the second quarter of 2015. The MCE will review the claim utilization after six months to determine if the pilot resulted in a decrease in ED utilization in these counties and an increase in utilization with the CVS Minute Clinic or the member's assigned primary medical providers. After reviewing the claim results for the targeted counties, the pilot may be expanded to other counties in 2015 with high ED utilization and eventually statewide in 2016.

Appeals

l. *Description of appeal rights, how those are made available and including in member education, if an individual feels as though it was indeed an emergency, and shouldn't have been charged cost sharing;*

Initial dispute of ED copayments amounts initiate with the MCE grievance and appeals process. All MCEs are contractually required to maintain a process that meets all applicable federal requirements. These requirements are detailed in Section 7 of the HIP 2.0 Scope of Work.

Members who disagree with the assessment of the ED copayment amount for any reason can file a grievance with the applicable MCE. If the member is unable to resolve their concern through the MCE grievance process, then they may appeal through the state's appeal process. Member handbooks detail the member grievance process for both the plan and state level appeals.

Member handbooks are available at:

Anthem: http://www.anthem.com/inmedicaid/

MHS: http://www.mhsindiana.com/

MDwise: http://www.mdwise.org/for-members/healthy-indiana-plan/

Estimated state savings

m. *The estimated state savings with implementing this copay*

The estimated savings with implementing this copay are detailed in the attached document prepared by Milliman Inc.

Appendix B: Sample MCE Notice Informing Members of Selection into Control Group

<insert Date>

***********3-DIGIT 479
John Sample
Sample House
1234 Main Street
West Lafayette IN 47906-1448

9-1
1009

Dear MDwise HIP Member,

You have been randomly selected to take part in a pilot program to evaluate emergency room use.

HIP encourages you to make wise health care decisions. This includes responsible use of the emergency room (ER). If a HIP member goes to the ER for a non-emergency, they pay an $8 copay the first time and $25 every time after.

Beginning <start_date>, you will only be charged $8 for all non-emergency visits to the ER. You will no longer be charged a $25 copayment when you visit the emergency room for a non-emergency service. Your copayment for non-emergency visits to the ER will be $8 during the pilot program.

Other information we have sent you will still talk about the $25 copayment. You can ignore this. The $25 copayment will not apply to you as long as you are on HIP with MDwise. See your primary medical provider (PMP) for non-emergency medical needs. You should use the ER for emergencies only.

If you have any questions, please call customer service at **1-800-356-1204 or 317-630-2831 if you are in the Indianapolis area.**

Wishing you good health,
MDwise customer service

HIPM0202 (9/15)

MDwise Healthy Indiana Plan (HIP) • P.O. Box 44236 • Indianapolis, IN 46244-0236
p: 317.630.2831/1.800.356.1204 • f: 317.822.7192/1.877.822.7192 • MDwise.org

Appendix C: Relevant MCE Reporting Manuals

STC QR-GSU 7: Type of Emergency Room Utilization

General Report Description	
STC QR-GSU7 Type of Emergency Room Utilization for HIP Basic Members	
Purpose	To summarize utilization of emergency room services.
Format	Excel template
Qualifications/ Definitions	This is quarterly report. The MCE must submit the report to OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting period. Information is to be reported for HIP by two age cohorts: ▪ 19 years ▪ Age 20 years and older **Each age cohort is to be separated by Test versus Control group.** The top row adds up information for all poverty levels within the age cohorts. These fields are automatically calculated. The category "ALL" is the sum of the two age cohorts entered by the MCE. These fields are automatically calculated.
STC QR-GSU7 HIP Basic Data Elements	
Item 1	**Updated data from a Previous Submission**
Description	Mark an X on any row for which the data reported for a previous quarter has been updated on this submission of the report.
Item 2	**Experience Period**
Description	Enter the experience period corresponding to this reporting period (e.g. 2015Q1).
Item 3	**STC HIP Basic Member Months by Age Cohort**
Description	Report the total member months in the reporting period for each age cohort. **Separate the age cohort by Test versus Control group members**.
Item 4	**Number of ER Visits Adjudicated for the Experience Period**
Description	Report the total number of paid claims for which the MCE made a determination of emergent or non-emergent status for making the appropriate payment to the hospital.
Item 5	**Number of ER Visits Adjudicated that the MCE Deemed Emergent**
Description	Report the total number of paid claims for which the MCE made a determination of emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**

General Report Description	
Item 6	**Number of ER Visits Adjudicated that the MCE Deemed Non-Emergent**
Description	Report the total number of paid claims for which the MCE made a determination of non-emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**
Item 7	**ER Adjudicated Claims Per 1,000 Members**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated for the Experience Period) divided by (Total Member Months for Age Cohort in the Reporting Period) * 1,000 **Separate the total number and enter by Test and Control members.**
Item 8	**Percent of Adjudicated ER Claims Emergent**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated that the MCE Deemed Emergent) divided by (Number of ER Visits Adjudicated for the Experience Period) **Separate the total number and enter by Test and Control members.**
Item 9	**Percent of Adjudicated ER Claims Non-Emergent**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated that the MCE Deemed Non-Emergent) divided by (Number of ER Visits Adjudicated for the Experience Period) **Separate the total number and enter by Test and Control members.**
Item 10	**Check that Column 8+9 equals 100%**
Description	Verify that columns 8 and 9 add up to 100%.
STC QR-GSU7 Type of Emergency Room Utilization for HIP Plus Members	
Purpose	To summarize utilization of emergency room services by HIP Plus members.
Format	Excel template
Qualifications/ Definitions	This is quarterly report. The MCE must submit the report to OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting period. Information is to be reported for HIP Plus by two age cohorts: ▪ 19 years ▪ Age 20 years and older **Each age cohort is to be separated by Test versus Control group.**

General Report Description	
	The top row adds up information for all poverty levels within the age cohorts. These fields are automatically calculated. The category "ALL" is the sum of the two age cohorts entered by the MCE. These fields are automatically calculated.
STC QR-GSU7 HIP Plus Data Elements	
Item 1	**Updated data from a Previous Submission**
Description	Mark an X on any row for which the data reported for a previous quarter has been updated on this submission of the report.
Item 2	**Experience Period**
Description	Enter the experience period corresponding to this reporting period (e.g. 2015Q1).
Item 3	**STC HIP Plus Member Months by Age Cohort**
Description	Report the total member months in the reporting period for each age cohort.
Item 4	**Number of ER Visits Adjudicated for the Experience Period**
Description	Report the total number of paid claims for which the MCE made a determination of emergent or non-emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**
Item 5	**Number of ER Visits Adjudicated that the MCE Deemed Emergent**
Description	Report the total number of paid claims for which the MCE made a determination of emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**
Item 6	**Number of ER Visits Adjudicated that the MCE Deemed Non-Emergent**
Description	Report the total number of paid claims for which the MCE made a determination of non-emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**
Item 7	**ER Adjudicated Claims Per 1,000 Members**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated for the Experience Period) divided by (Total Member Months for Age Cohort in the Reporting Period) * 1,000 **Separate the total number and enter by Test and Control members.**

General Report Description	
Item 8	**Percent of Adjudicated ER Claims Emergent**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated that the MCE Deemed Emergent) divided by (Number of ER Visits Adjudicated for the Experience Period) **Separate the total number and enter by Test and Control members.**
Item 9	**Percent of Adjudicated ER Claims Non-Emergent**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated that the MCE Deemed Non-Emergent) divided by (Number of ER Visits Adjudicated for the Experience Period) **Separate the total number and enter by Test and Control members.**
Item 10	**Check that Column 8+9 equals 100%**
Description	Verify that columns 8 and 9 add up to 100%.
STC QR-GSU7 Type of Emergency Room Utilization for HIP State Plan Members	
Purpose	To summarize utilization of emergency room services by HIP State Plan members.
Format	Excel template
Qualifications/ Definitions	This is quarterly report. The MCE must submit the report to OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting period. Information is to be reported for HIP Plus by two age cohorts: ▪ 19 years ▪ Age 20 years and older **Each age cohort is to be separated by Test versus Control group.** The top row adds up information for all poverty levels within the age cohorts. These fields are automatically calculated. The category "ALL" is the sum of the two age cohorts entered by the MCE. These fields are automatically calculated.
STC QR-GSU7 HIP State Plan Data Elements	
Item 1	**Updated data from a Previous Submission**
Description	Mark an X on any row for which the data reported for a previous quarter has been updated on this submission of the report.
Item 2	**Experience Period**
Description	Enter the experience period corresponding to this reporting period (e.g. 2015Q1).
Item 3	**STC State Plan Member Months by Age Cohort**

General Report Description	
Description	Report the total member months in the reporting period for each age cohort. **Separate the total number and enter by Test and Control members.**
Item 4	**Number of ER Visits Adjudicated for the Experience Period**
Description	Report the total number of paid claims for which the MCE made a determination of emergent or non-emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**
Item 5	**Number of ER Visits Adjudicated that the MCE Deemed Emergent**
Description	Report the total number of paid claims for which the MCE made a determination of emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**
Item 6	**Number of ER Visits Adjudicated that the MCE Deemed Non-Emergent**
Description	Report the total number of paid claims for which the MCE made a determination of non-emergent status for making the appropriate payment to the hospital. **Separate the total number and enter by Test and Control members.**
Item 7	**ER Adjudicated Claims Per 1,000 Members**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated for the Experience Period) divided by (Total Member Months for Age Cohort in the Reporting Period) * 1,000 **Separate the total number and enter by Test and Control members.**
Item 8	**Percent of Adjudicated ER Claims Emergent**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated that the MCE Deemed Emergent) divided by (Number of ER Visits Adjudicated for the Experience Period) **Separate the total number and enter by Test and Control members.**
Item 9	**Percent of Adjudicated ER Claims Non-Emergent**
Description	This is a calculated field that uses the data reported in previous items. The formula is: (Number of ER Visits Adjudicated that the MCE Deemed Non-Emergent) divided by (Number of ER Visits Adjudicated for the Experience Period) **Separate the total number and enter by Test and Control members.**
Item 10	**Check that Column 8+9 equals 100% for Test and Control groups**
Description	Verify that columns 8 and 9 add up to 100%.

STC QR-GSU 8: Frequency of Emergency Room Utilization

General Report Description	
STC QR-GSU8 Frequency of Emergency Room Utilization by HIP Basic members	
Purpose	To summarize utilization of emergency room services by HIP Basic members and to identify opportunities for participation in case or care management.
Format	Excel template
Qualifications/ Definitions	This is quarterly report. The MCE must submit the report to OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting period. Information is to be reported for all ages, 19-64. **Each age cohort is to be separated by Test versus Control group.** The top row of each quarter adds up information for all age cohorts combined. These fields are automatically calculated. Test Group is defined as all HIP members not in the Control Group, also excluding those exempt from cost sharing. Control group is defined as a random sample of at least 5,000 (total of all MCEs combined, approximately 1,700 per MCE) HIP members not in the Test Group, also excluding those exempt from cost sharing. ▪ Members in the Test Group will pay $8 for the 1st inappropriate use of the ER then $25 for each subsequent inappropriate use of the ER within the same 12 month benefit period. ▪ Members in the Control Group will only have a flat rate copayment of $8 applied to subsequent visits.
STC QR-GSU8 HIP Basic Data Elements	
Item 1	**Updated data from a Previous Submission**
Description	Mark an X on any row for which the data reported for a previous quarter has been updated on this submission of the report.
Item 2	**Experience Period**
Description	Enter the experience period corresponding to this reporting period (e.g. 2015Q1).
Item 3	**Total Unique HIP Basic Members Enrolled with 180 Days of Continuous Enrollment**
Description	Report the total unique number of HIP Basic members within each age cohort that had at least 180 days of continuous enrollment using the ending anchor date as the last day of the reporting period. For example, if the last day of the reporting period is March 31, 2015, then only count members who have had continuous enrollment for at least the period October 1, 2014 through March 31, 2015. **Separate the total number and enter by Test and Control members.**

General Report Description	
Item 4	**HIP Basic Members with Zero or One ER Visit in the 180 Day Period**
Description	Report the total number of unique HIP Basic members identified in Item #3 that had zero or one hospital ER visits in the 180 day period up to the end of the reporting period. For example, if the last day of the reporting period is March 31, 2013, then count any ER visits that occurred between October 1, 2012 and March 31, 2013. **Separate the total number and enter by Test and Control members.**
Item 5	**HIP Basic Members with Two ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP Basic members identified in Item #3 that had two hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 6	**HIP Basic Members with Three to Nine ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP Basic members identified in Item #3 that had three to nine hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 7	**HIP Basic Members with 10 or More ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP Basic members identified in Item #3 that had ten or more hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 8	**Percent of HIP Basic Members with Zero or One ER Visit**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Basic members with Zero or One ER Visit in 180 Day Period divided by Total Unique HIP Basic Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 9	**Percent of HIP Basic Members with Two ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Basic members with Two ER Visits in 180 Day Period divided by Total Unique HIP Basic Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**

General Report Description	
Item 10	**Percent of HIP Basic Members with Three to Nine ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Basic members with Three to Nine ER Visits in 180 Day Period divided by Total Unique HIP Basic Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 11	**Percent of HIP Basic Members with Ten or More ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Basic members with Ten or More ER Visits in 180 Day Period divided by Total Unique HIP Basic Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 12	**Check that Columns 8-11 equal 100% for Test and Control groups**
Description	Auto calculations to assure all members are accounted for in the experience period.
STC QR-GSU8 Frequency of Emergency Room Utilization by HIP Plus members	
Purpose	To summarize utilization of emergency room services by HIP Plus members and to identify opportunities for participation in case or care management.
Format	Excel template
Qualifications/ Definitions	This is quarterly report. The MCE must submit the report to OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting period. Information is to be reported for all ages, 19-64. **Each age cohort is to be separated by Test versus Control group.** The top row of each quarter adds up information for all age cohorts combined. These fields are automatically calculated. Test Group is defined as all HIP members not in the Control Group, also excluding those exempt from cost sharing. Control group is defined as a random sample of at least 5,000 (total of all MCEs combined, approximately 1,700 per MCE) HIP members not in the Test Group, also excluding those exempt from cost sharing. ▪ Members in the Test Group will pay $8 for the 1st inappropriate use of the ER then $25 for each subsequent inappropriate use of the ER within the same 12 month benefit period. ▪ Members in the Control Group will only have a flat rate copayment of $8 applied to subsequent visits.

General Report Description	
STC QR-GSU8 HIP Plus Data Elements	
Item 1	**Updated data from a Previous Submission**
Description	Mark an X on any row for which the data reported for a previous quarter has been updated on this submission of the report.
Item 2	**Experience Period**
Description	Enter the experience period corresponding to this reporting period (e.g. 2015Q1).
Item 3	**Total Unique HIP Plus Members Enrolled with 180 Days of Continuous Enrollment**
Description	Report the total unique number of HIP Plus members within each age cohort that had at least 180 days of continuous enrollment using the ending anchor date as the last day of the reporting period. For example, if the last day of the reporting period is March 31, 2015, then only count members who have had continuous enrollment for at least the period October 1, 2014 through March 31, 2015. **Separate the total number and enter by Test and Control members.**
Item 4	**HIP Plus Members with Zero or One ER Visit in the 180 Day Period**
Description	Report the total number of unique HIP Plus members identified in Item #3 that had zero or one hospital ER visits in the 180 day period up to the end of the reporting period. For example, if the last day of the reporting period is March 31, 2015, then count any ER visits that occurred between October 1, 2014 and March 31, 2015. **Separate the total number and enter by Test and Control members.**
Item 5	**HIP Plus Members with Two ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP Plus members identified in Item #3 that had two hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 6	**HIP Plus Members with Three to Nine ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP Plus members identified in Item #3 that had three to nine hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 7	**HIP Plus Members with 10 or More ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP Plus members identified in Item #3 that had ten or more hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**

General Report Description	
Item 8	**Percent of HIP Plus Members with Zero or One ER Visit**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Plus members with Zero or One ER Visit in 180 Day Period divided by Total Unique HIP Plus Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 9	**Percent of HIP Plus Members with Two ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Plus members with Two ER Visits in 180 Day Period divided by Total Unique HIP Plus Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 10	**Percent of HIP Plus Members with Three to Nine ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Plus members with Three to Nine ER Visits in 180 Day Period divided by Total Unique HIP Plus Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 11	**Percent of HIP Plus Members with Ten or More ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: HIP Plus members with Ten or More ER Visits in 180 Day Period divided by Total Unique HIP Plus Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 12	**Check that Columns 8-11 equal 100% for Test and Control groups**
Description	Auto calculations to assure all members are accounted for in the experience period.
STC QR-GSU8 Frequency of Emergency Room Utilization by HIP State Plan members	
Purpose	To summarize utilization of emergency room services by HIP State Plan members and to identify opportunities for participation in case or care management.
Format	Excel template
Qualifications/ Definitions	This is quarterly report. The MCE must submit the report to OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting period. Information is to be reported for all ages, 19-64.

<table>
<tr><th colspan="2">General Report Description</th></tr>
<tr><td></td><td>The top row of each quarter adds up information for all age cohorts combined. These fields are automatically calculated.

Each age cohort is to be separated by Test versus Control group.

Test Group is defined as all HIP members not in the Control Group, also excluding those exempt from cost sharing.

Control group is defined as a random sample of at least 5,000 (total of all MCEs combined, approximately 1,700 per MCE) HIP members not in the Test Group, also excluding those exempt from cost sharing.
▪ Members in the Test Group will pay $8 for the 1st inappropriate use of the ER then $25 for each subsequent inappropriate use of the ER within the same 12 month benefit period.
▪ Members in the Control Group will only have a flat rate copayment of $8 applied to subsequent visits.</td></tr>
<tr><td colspan="2">STC QR-GSU8 HIP State Plan Data Elements</td></tr>
<tr><td>Item 1</td><td>Updated data from a Previous Submission</td></tr>
<tr><td>Description</td><td>Mark an X on any row for which the data reported for a previous quarter has been updated on this submission of the report.</td></tr>
<tr><td>Item 2</td><td>Experience Period</td></tr>
<tr><td>Description</td><td>Enter the experience period corresponding to this reporting period (e.g. 2015Q1).</td></tr>
<tr><td>Item 3</td><td>Total Unique HIP State Plan Members Enrolled with 180 Days of Continuous Enrollment</td></tr>
<tr><td>Description</td><td>Report the total unique number of HIP State Plan members within each age cohort that had at least 180 days of continuous enrollment using the ending anchor date as the last day of the reporting period.

For example, if the last day of the reporting period is March 31, 2015, then only count members who have had continuous enrollment for at least the period October 1, 2014 through March 31, 2015.

Separate the total number and enter by Test and Control members.</td></tr>
<tr><td>Item 4</td><td>HIP State Plan Members with Zero or One ER Visit in the 180 Day Period</td></tr>
<tr><td>Description</td><td>Report the total number of unique HIP State Plan members identified in Item #3 that had zero or one hospital ER visits in the 180 day period up to the end of the reporting period. For example, if the last day of the reporting period is March 31, 2015, then count any ER visits that occurred between October 1, 2014 and March 31, 2015.

Separate the total number and enter by Test and Control members.</td></tr>
<tr><td>Item 5</td><td>HIP State Plan Members with Two ER Visits in the 180 Day Period</td></tr>
</table>

General Report Description	
Description	Report the total number of unique HIP State Plan members identified in Item #3 that had two hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 6	**HIP State Plan Members with Three to Nine ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP State Plan members identified in Item #3 that had three to nine hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 7	**HIP State Plan Members with 10 or More ER Visits in the 180 Day Period**
Description	Report the total number of unique HIP State Plan members identified in Item #3 that had ten or more hospital ER visits in the 180 day period up to the end of the reporting period. **Separate the total number and enter by Test and Control members.**
Item 8	**Percent of HIP State Plan Members with Zero or One ER Visit**
Description	This is a calculated field that uses the data reported in previous items. The formula is: ▪ HIP State Plan members with Zero or One ER Visit in 180 Day Period divided by ▪ Total Unique HIP Plus Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 9	**Percent of HIP State Plan Members with Two ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: ▪ HIP State Plan members with Two ER Visits in 180 Day Period divided by ▪ Total Unique HIP State Plan Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**
Item 10	**Percent of HIP State Plan Members with Three to Nine ER Visits**
Description	This is a calculated field that uses the data reported in previous items. The formula is: ▪ HIP State Plan members with Three to Nine ER Visits in 180 Day Period divided by ▪ Total Unique HIP State Plan Members Enrolled that had 180 Days Continuous Enrollment **Separate the total number and enter by Test and Control members.**

<table>
<tr><th colspan="2">General Report Description</th></tr>
<tr><td>Item 11</td><td>Percent of HIP State Plan Members with Ten or More ER Visits</td></tr>
<tr><td>Description</td><td>This is a calculated field that uses the data reported in previous items. The formula is:
▪ HIP State Plan members with Ten or More ER Visits in 180 Day Period divided by
▪ Total Unique HIP State Plan Members Enrolled that had 180 Days Continuous Enrollment
Separate the total number and enter by Test and Control members.</td></tr>
<tr><td>Item 12</td><td>Check that Columns 8-11 equal 100% for Test and Control groups</td></tr>
<tr><td>Description</td><td>Auto calculations to assure all members are accounted for in the experience period.</td></tr>
</table>

STC MO-CPAY 2: ER Co-Payment Report

General Report Description	
MO-CPAY2 ER Co-Payment Report	
Purpose	To monitor members' co-payment expenditures by Test Group and Control Group and HIP Program.
Format	Excel template
Qualifications/Definitions	This is a monthly and year-to-date report to be submitted to OMPP by the 6th day of the month following the end of the experience period to ensure timely delivery to CMS. Indicate the number (or percent) of members who had an ER visit during the reporting period, and the resulting ER co-payment applied to that encounter. The data collected for this report is separated into the following HIP Program and Group distributions:

Test Group	
Basic	Waived
	$8 for first visit
	$25 thereafter
Plus	Waived
	$8 for first visit
	$25 thereafter
State Plan	Waived
	$8 for the first visit
	$25 thereafter

Control Group	
Basic	Waived
	$8 for first visit
Plus	Waived
	$8 for first visit
State Plan	Waived
	$8 for the first visit

	Note: For the populations listed with **waived** co-pay, this indicates that the visit was considered to meet the prudent layperson definition of an emergency visit, and the co-pay was waived or reimbursed. **Co-pays are also waived for** **members in specific populations including Native Americans and pregnant women.**
MO-CPAY2 Data Elements	
Column 1 Items 1-9	**Number of Test Members (Monthly Data)**

<table>
<tr><td>Description</td><td>Number of members in the Test Group who used the ER that month. Data are based on the amount of co-pay for each of the HIP Programs. Enter monthly data for items 1-9.

Enter whole numbers.</td></tr>
<tr><td>Column 2 Items 1-9</td><td>Percent of Test Members (Monthly Data)</td></tr>
<tr><td>Description</td><td>Percent of members in the Test Group who used the ER that month. Data are based on the amount of co-pay for each of the HIP Programs. Enter monthly data for items 1-9.

For Column 2:
Item 1 Numerator = Column 1 Item 1 (HIP Plus members in the Test group for whom the co-pay was waived)
Denominator = Total number of HIP Plus members in the Test Group
Item 2 Numerator = Column 1 Item 2 (HIP Basic members in the Test Group for whom the co-pay was waived)
Denominator = Total number of HIP Basic members in the Test Group
Continue this pattern for Items 3-9.

Enter percentages with 1 decimal space.</td></tr>
<tr><td>Column 3 Items 1-9</td><td>Number of Test Members (Year-to-Date Data)</td></tr>
<tr><td>Description</td><td>Number of members in the Test Group who used the ER for the Year-to-Date. Data are based on the amount of co-pay for each of the HIP Programs. Enter YTD data for items 1-9.

Enter whole numbers.</td></tr>
<tr><td>Column 4 Items 1-9</td><td>Percent of Test Members (Year-to-Date Data)</td></tr>
<tr><td>Description</td><td>Percent of members in the Test Group who used the ER for the Year-to-Date. Data are based on the amount of co-pay for each of the HIP Programs. Enter YTD data for items 1-9.

For Column 4:
Item 1 Numerator = Column 3 Item 1 (HIP Plus members in the Test Group for whom the co-pay was waived)
Denominator = Total number of HIP Plus members in the Test Group
Item 2 Numerator = Column 3 Item 2 (HIP Basic members in the Test Group for whom the co-pay was waived)
Denominator = Total number of HIP Basic members in the Test Group
Continue this pattern for lines 3-9.

Enter percentages with 1 decimal space.</td></tr>
<tr><td>Column 1 Items 10-15</td><td>Number of Control Members (for the Monthly Data)</td></tr>
</table>

<table>
<tr><td>Description</td><td>Number of members in the Control Group who used the ER that month. Data are based on the amount of co-pay for each of the HIP Programs. Enter monthly data for items 1-9.

Enter whole numbers.</td></tr>
<tr><td>Column 2 Items 10-15</td><td>Percent of Control Members (for the Monthly Data)</td></tr>
<tr><td>Description</td><td>Percent of members in the Control Group who used the ER for the Year-to-Date. Data are based on the amount of co-pay for each of the HIP Programs. Enter YTD data for items 1-9.

For Column 2:
▪ Item 10 Numerator = Column 1 Item 10 (HIP Plus members in the Control Group for whom the co-pay was waived)
▪ Denominator = Total number of HIP Plus members in the Control Group
▪ Item 11 Numerator = Column 1, Item 11 (HIP Basic members in the Control Group for whom the co-pay was waived)
▪ Denominator = Total number of HIP Basic members in the Control Group
Continue this pattern, as above, for Items 12-15.

Enter percentages with 1 decimal space.</td></tr>
<tr><td>Column 3 Items 10-15</td><td>Number of Control Members (for the Year-to-Date Data)</td></tr>
<tr><td>Description</td><td>Number of members in the Control Group who used the ER that month. Data are based on the amount of co-pay for each of the HIP Programs. Enter monthly data for items 1-9.

Enter whole numbers.</td></tr>
<tr><td>Column 4 Items 10-15</td><td>Percent of Control Members (for the Year-to-Date Data)</td></tr>
<tr><td>Description</td><td>Percent of members in the Control Group who used the ER for the Year-to-Date. Data are based on the amount of co-pay for each of the HIP Programs. Enter YTD data for items 1-9.

For Column 4:
▪ Item 10 Numerator = Column 3 Item 10 (HIP Plus members in the Control Group for whom the co-pay was waived)
▪ Denominator = Total number of HIP Plus members in the Control Group
▪ Item 11 Numerator = Column 3 Item 11 (HIP Basic members in the Control Group for whom the co-pay was waived)
▪ Denominator = Total number of HIP Basic members in the Control Group
Continue this pattern for lines 3-9.

Enter percentages with 1 decimal space.</td></tr>
</table>

Additional MCE Data Requests

Nurse Hotline Calls and ER Use by Plan

Plan	Time Period	Number of unique individuals who called the Nurse hotline prior to reporting to the ER		Number of unique individuals who DID NOT call the Nurse hotline prior to reporting to the ER		Number of unique individuals who called the Nurse hotline prior to their first non-emergent visit to the ER		Number of unique individuals who called the Nurse hotline prior to subsequent non-emergent visits to the ER	
		Test	Control	Test	Control	Test	Control	Test	Control
Basic	Jan – March 2016								
	April – June 2016								
	July – September 2016								
	October – December 2016								
	January – December 2016								
Plus	Jan – March 2016								
	April – June 2016								
	July – September 2016								
	October – December 2016								
	January – December 2016								
State	Jan – March 2016								
	April – June 2016								
	July – September 2016								
	October – December 2016								
	January – December 2016								

Members Ever Enrolled in the Control Group (February 1, 2015 – April 30, 2017)

Recipient ID	Start Date	End Date

Members Meeting the 5% Threshold in CY 2016 (January 1, 2016 – December 31, 2016)*

Recipient ID	Start Date for First Span	End Date for First Span	Start Date for Second Span	End Date for Second Span	Start Date for Third Span	End Date for Third Span	Start Date for Fourth Span	End Date for Fourth Span

*Members could meet the 5% threshold up to 4 times in CY 2016; if member met the 5% threshold more than once during CY 2016, please provide a date range for each time the member met the threshold.

Appendix D: Exclusion Criteria and Results

The exclusion process followed these steps:

1. Starting from the total HIP 2.0 enrollment extract, members outside ages 19-64, eligible HIP 2.0 population, were first excluded.
2. The second criterion excluded members with a "closed" enrollment status who have not paid a PAC and do not have full HIP coverage.
3. Next, members with a conditional flag of not "Y" were excluded, as they would be fully enrolled due to their "Open" status, per the second criterion. Members with an "Open" status and conditional flag equal to "Y" were retained as the member receives full benefits with conditional status until their application is fully processed and they pay PAC.
4. Next, members enrolled in HIP Link were excluded as they are not subject to HIP 2.0 co-pays.
5. Members were excluded from the data because the data did not identify which of the three HIP MCEs they were enrolled. The State confirmed this was a known data issue and had been corrected in May 2017 but not to historical data. The State also confirmed these member months should be excluded for the purposes of this analysis as the members may have been related to those transitioning in or out of the HIP program.[21]
6. Lastly, the duplicated member in a month identified and their latest coverage eligibility date was retained.

Exhibit D.1 lists the study sample exclusion criteria and the remaining number of member months included.

[21] State feedback received on July 25, 2017.

Exhibit D.1: Enrollment Data Exclusions Leading to Final Member Month (MM) Sample

Enrollment Logic Step	2016 Member Months	Percent Excluded From Previous Exclusion Step
Raw HIP 2.0 Enrollment	**5,514,947**	
1. Exclude member months outside the ages of 19-64		
Excluded	22,809	
Remaining	5,492,138	<1%
2. Exclude member months with status code of "Closed"		
Excluded	688,512	
Remaining	4,803,626	13%
3. Exclude member months with conditional flag of not "Y"		
Excluded	232,759	
Remaining	4,570,867	5%
4. Exclude member months with enrolled in HIP Link		
Excluded	399	
Remaining	4,570,468	<1%
5. Exclude member months with no identified MCE assignment		
Excluded	276,006	
Remaining	4,294,462	6%
6. Exclude duplicate member months		
Excluded	1	
Remaining	4,294,461	<1%
Final Eligible MMs	**4,294,461**	**22%**

Note: This sample was also used for the Urgent and Primary Care Services Utilization metrics discussed below.

Appendix E: Identification of Emergency Room Services

Below is the logic developed by Indiana FSSA and MCEs to determine which services are to be placed into what categories of service for the HIP STC service utilization reports.[22]

General Guidelines:

1. Each claim should only be listed once; the dollars, claim volume and members involved are summed at the bottom of the page.
2. The ER Claims, both emergent and non-emergent, should be counted only once on the report, either in the Emergency Room category of service or the category of service which best fits. Consideration should be given to the primary procedure code and/or diagnosis code for inclusion with ER Claims.

Categories of Service:

- **Emergency Room**
  - **Total ER Claims - To identify all ER claims, start with UB-04 claims (facility, aka institutional) that use revenue codes 450-459 and 981 and are for Outpatient services.** Note that the other CMS-1500 claims associated with these ER visits will be captured in other categories such as Physician Services in the ER and Lab Services.
  - **Emergency -** PROCEDURE Codes = [99281 – 99285] These are the Emergency Department visit E&M codes (Given that these are E&M codes they will include both physical and behavioral health diagnoses).
  - **Non-emergency**
    - Type of Bill code = 131
      - Remove PROCEDURE Codes = [99281-99285] Emergency (accounted for above)
      - Remove PROCEDURE Codes = [10021 – 69990] All surgery codes (accounted for in Other Outpatient and in Inpatient Hospital).
      - Remove any PROCEDURE Code starting with "J" All injectables (accounted for in Family Planning and Physician – Other Professional Services)
      - Remove PROCEDURE Codes = [99217-99220; 99224-99226] Initial Observation Care and Subsequent Observation Care. (Accounted for in the Total of Outpatient Hospital Claims, below).
      - Remove PROCEDURE Codes = [99201-99215] Office visits (Accounted for in Physician)
      - Remove PROCEDURE Codes = [90785-90899] Behavioral Health (Accounted for in Outpatient Hospital – Behavioral Health, below).
  - **Top 20 Reasons for Emergency Room Visit (pull DX1 code and DX1 code**

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[22] FSSA Office of Medicaid Policy and Planning. (2016). MCE STC Reporting Manual Version 2.0*: VIII. vii Appendix III.G.1 – HHW, HIP, and HIP STC, and HCC Service Utilization Codes Logic.*

description)

- Emergency - PROCEDURE Codes = [99281 – 99285]
  - For each claim found in this group take primary DX and sort descending by the number of members (rather than number of claims) having a similar DX

Appendix F: Identification of Primary and Urgent Care Services

To effectively evaluate the type of service outcomes, Lewin utilized consistent definitions for primary care and urgent care. For both, primary care and urgent care, a visit was identified using the combination of member and date of service. Visits were identified for both primary care and urgent care using claims that were paid and non-voided professional medical claims. Additional criteria were specific to primary care.

For additional criteria specific to primary care, Lewin used the national standard definition established by the Centers for Medicare & Medicaid Services (CMS) for Medicare claims processing for primary care claims under the Affordable Care Act as indicated in the *CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 2161, Change Request 7060*. CMS specifies a limited set of services eligible to be counted as primary care, based on evaluation and management (E&M) current procedural terminology (CPT) codes. CMS also specifies a set of providers to identify as delivering primary care; including, family practitioners, general practitioners, geriatric practitioners, internists, general internists, pediatricians, general pediatricians, pediatric nurse practitioners, family nurse practitioners, nurse practitioners (other), and physician assistants. Because of the nature of working with a Medicaid population, Lewin also included providers with specialties of obstetrics/gynecology, obstetric nurse practitioner, rural health clinic (RHC), and federally qualified health clinic (FQHC). Additionally, by definition primary care is not referral or specialty care, so claims with referring providers were excluded from consideration as primary care.

Urgent care locations are defined by their place of service listed in the claims data equal to twenty.