
State Demonstrations Group

February 4, 2016

Joseph Moser
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461
Indianapolis, IN 46204

Dear Mr. Moser:

The State of Indiana submitted its Emergency Department Copayment Protocol (Protocol) to the Centers for Medicare & Medicaid Services (CMS) on May 1, 2015 as required by special term and condition (STC) VIII.6, under its section 1115 demonstration, Healthy Indiana Plan 2.0 (HIP 2.0) (Project No. 11-W-00296/5). During the time subsequent to that submission, CMS and the state collaborated to reach approval of the Protocol.

At this time, we have no further questions about the Protocol. With this letter, CMS approves the state to move forward with implementation of the final version of the Protocol, which is attached to this letter. As required by the HIP 2.0 STCs, the attached Protocol will be inserted in the STCs as Attachment D.

We look forward to continuing to work with you and your staff on the HIP 2.0 demonstration. If you have any questions, please contact your project officer, Ms. Shanna Janu, at either 410-786-1370 or by email at Shanna.Janu@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Andrea J. Casart
Acting Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Ruth Hughes, Associate Regional Administrator, CMS Chicago Regional Office
Tannisse Joyce, CMS Chicago Regional Office

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.

Contents

Emergency Department Copayment Description.....	2
Member assignment methodology	3
Ambulatory care sensitive conditions	6
Process by which providers will identify test groups.....	6
Member education	7
Copay implementation	8
Grievance and appeals	8
Identification of members with emergency health conditions	9
Identification of members with non-emergency health conditions.....	10
Process to ensure hospitals meet the requirements at 447.54(d).....	11
Alternatives to the Emergency Department.....	12
Appeals	13
Estimated state savings	14

Emergency Department Copayment Description

Emergency care will be covered for all HIP Basic, HIP Plus, and HIP State Plan members; however, these members¹ 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;² 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)³ 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 disease management. The 24-hour Nurse Call Line must have a system in place to communicate

¹ 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.

² Providers can only require individuals with household income over 100% FPL to pay the copayment before services will be provided.

³ 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)

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 1 below.

Table 1. Emergency Department Copayment Monitoring and Evaluation

Monitoring and Evaluation Group	Indicators	Data Sources, Data Elements, and Data Analysis
<p>Test Group vs. Control Group</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p>Claims/encounter data:</p> <ul style="list-style-type: none"> • # of members who use the emergency department; • # of <i>emergent</i> ED visits by members within the control group; • # of <i>emergent</i> ED visits by members within the test group; • # of <i>non-emergent</i> ED visits by members within the control group; • # of <i>non-emergent</i> 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. <p>Survey data:</p> <ul style="list-style-type: none"> • # and/or % members who completed surveys, by test and control group • # and/or % of times hospital tried to collect for non-emergency visits to ED, by test and control group, by ability to collect (yes/no)

Monitoring and Evaluation Group	Indicators	Data Sources, Data Elements, and Data Analysis
		<ul style="list-style-type: none"> • # 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 • Reason(s) individual left the ED without care (when applicable) • Member and provider perceptions about the affordability of the copay <p>POWER account data:</p> <ul style="list-style-type: none"> • Outstanding debt due to ED visit <p>Call Center Records:</p> <ul style="list-style-type: none"> • Complaints made from members about the copayment, by reason code. • Complaints made from providers about the copayment, by reason code.
<p>“First Visit” versus “Subsequent Visit” Non-Emergent ED Visits</p>	<p>“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.</p> <p>“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.</p>	<p>Claims/encounter data:</p> <ul style="list-style-type: none"> • # of members who make “first visit” <i>non-emergent</i> ED visits, • # of members who make “subsequent visit” <i>non-emergent</i> ED visits. • # of members who call the 24-hour nurse hotline prior to “first visit” and “subsequent” <i>non-emergent</i> ED visits.
<p>Nurse Hotline “Call” versus “No Call”</p>	<p>“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.</p>	<p>Nurse Call Line data:</p> <ul style="list-style-type: none"> • # 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”).

Monitoring and Evaluation Group	Indicators	Data Sources, Data Elements, and Data Analysis
	<p>“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.</p>	
Emergent versus Non-Emergent Condition Determination	<p>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 <i>emergent</i> versus <i>non-emergent</i> medical conditions).</p> <p>Emergent: Emergent conditions are those defined as emergency 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.</p> <p>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.</p>	<p>The state will use claims/encounter data and data reported by the MCEs, to track and monitor data on <i>emergent</i> versus <i>non-emergent</i> 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.</p> <p>In addition, the state will use data from calls to the 24-hour nurse hotline, to collect, track, and monitor the number of members who called the nurse hotline before going to the ED.</p> <p>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.</p>

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 then 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 they 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 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.*

⁴ 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.”

- *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 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.⁵*

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.

⁵ 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.

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.

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

- 1. 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.