



HIP 2.0 ER Co-Payment Protocol

Healthy Indiana Plan

State of Indiana

Family and Social Services Administration

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EXECUTIVE SUMMARY

Milliman was retained by the State of Indiana, Family and Social Services Administration (FSSA) to support the submission of an Emergency Room (ER) co-payment protocol to CMS for the Healthy Indiana Plan 2.0 (HIP 2.0) program. As part of the HIP 2.0 demonstration, Indiana would like to test the impact of replacing the \$8 per non-emergency visit copay with a graduated amount: \$8 for the first visit then \$25 for each subsequent visit. The ER co-payment protocol addresses the analysis that will be performed to assess the impact of this provision on cost and quality of care.

FSSA requested assistance regarding the following two sections in the protocol submission:

- *Baseline data related to ambulatory care sensitive conditions and any other health outcomes the state proposes to examine* (section b of the draft protocol)
- *The estimated state savings with implementing this co-pay* (section m of the draft protocol).

This report documents responses to these two requests, as well as the methodology and assumptions used to develop them.

AMBULATORY CARE SENSITIVE CONDITION ADMISSIONS - BASELINE DATA

One goal of the study will be to demonstrate that a graduated co-pay does *not* cause members to forego necessary care, leading to adverse health outcomes. CMS has suggested that this may be tested by randomly assigning members to either the control group (\$8 per visit) or the intervention group (graduated copays). For each group, the state will measure the rate of hospitalization for ambulatory care sensitive (ACS) conditions. The Agency for Healthcare Research and Quality (AHRQ) defines these as hospitalizations for which “appropriate ambulatory care prevents or reduces the need for admission to the hospital”, and provides technical specifications which we have used to develop the values in this report.

For the actual demonstration, Indiana will compare the rate of ACS admissions in the intervention group with the rate in the control group. At the present time, CMS has asked that the state submit its proposed methodology and baseline historical data.

Tables 1a and 1b illustrate baseline data for ambulatory care sensitive conditions. Results were developed using SFY 2013 and SFY 2014 encounter claims for the HIP 1.0 and HHW Non-MA-U adult populations. The populations used to develop the baseline data are described below:

- **HIP 1.0:** This is the population covered under the prior 1115 waiver, and was comprised of non-pregnant adults aged 19 through 64 who were not otherwise eligible for Medicaid, primarily non-caretakers or caretakers with income above the mandatory income standard. These individuals have been transitioned to HIP 2.0, and are primarily enrolled in the new adult group.
- **HHW Non-MA-U adults:** These are Section 1931 caretakers, aged 19 through 64, with income under the mandatory income standard. The majority of these individuals, those not enrolled in transitional medical assistance (TMA), will be transitioned to HIP 2.0 and enrolled in the low income caretaker group.

For each population, we summarized the number of inpatient hospital admissions associated with each ACS condition, then converted this to the rate of admits per 100,000 life years.

Table 1a State of Indiana, Family and Social Services Administration Ambulatory Care Sensitive Conditions HIP 1.0 Population						
Measure Name	SFY 2013			SFY 2014		
	Admits	Member Months	Rate Per 100k Life Years	Admits	Member Months	Rate Per 100k Life Years
Congestive Heart Failure	22	472,885	55.83	33	464,231	85.30
COPD	85	277,160	368.02	64	274,281	280.00
Bacterial Pneumonia	80	472,885	203.01	74	464,231	191.28
Dehydration	37	472,885	93.89	32	464,231	82.72
Urinary Tract Infection	35	472,885	88.82	27	464,231	69.79
Asthma	8	195,725	49.05	11	189,936	69.50
Diabetes - Short Term Complications	49	472,885	124.34	60	464,231	155.10
Diabetes - Long Term Complications	55	472,885	139.57	48	464,231	124.08
Diabetes - Uncontrolled	5	472,885	12.69	3	464,231	7.75
Angina	4	472,885	10.15	1	464,231	2.58
Hypertension	22	472,885	55.83	15	464,231	38.77
Total	402	472,885	1,020.12	368	464,231	951.25

Table 1b State of Indiana, Family and Social Services Administration Ambulatory Care Sensitive Conditions HFW Non-MA-U Adult Population						
Measure Name	SFY 2013			SFY 2014		
	Admits	Member Months	Rate Per 100k Life Years	Admits	Member Months	Rate Per 100k Life Years
Congestive Heart Failure	10	663,024	18.10	38	1,355,576	33.64
COPD	20	79,913	300.33	40	169,700	282.85
Bacterial Pneumonia	79	663,024	142.98	107	1,355,576	94.72
Dehydration	28	663,024	50.68	44	1,355,576	38.95
Urinary Tract Infection	62	663,024	112.21	147	1,355,576	130.13
Asthma	39	583,111	80.26	64	1,185,876	64.76
Diabetes - Short Term Complications	64	663,024	115.83	149	1,355,576	131.90
Diabetes - Long Term Complications	33	663,024	59.73	59	1,355,576	52.23
Diabetes - Uncontrolled	3	663,024	5.43	14	1,355,576	12.39
Angina	2	663,024	3.62	8	1,355,576	7.08
Hypertension	23	663,024	41.63	26	1,355,576	23.02
Total	363	663,024	656.99	696	1,355,576	616.12

Notes: COPD rates include only members aged 40 years or older.
Asthma rates include only members aged 18 to 39.

ESTIMATED STATE SAVINGS

The goal of the intervention is to encourage thoughtful ER utilization, which is expected to result in substitution of some ER visits with office visits, nurse helpline calls, or other alternative treatment.

Table 2 displays estimated state and federal savings for CY 2015.

Table 2 State of Indiana, Family and Social Services Administration Estimated Savings Impact of \$25 ER Co-payment	
Populations	CY 2015
HIP State Plan	\$ 1,242,000
HIP Plus/Basic	1,276,000
HIP Medically Frail	250,000
Total (State and Federal)	\$ 2,768,000
Federal Matching Assistance Percentage	66.52%
Total (Federal)	\$ 2,352,000
Total (State)	\$ 416,000

Note: HIP Plus/Basic and Medically Frail receive 100% Federal match.

The savings calculated are comprised of two components:

- Estimated 5% reduction in ER utilization and substitution with an alternative treatment at one third of the cost
- Savings related to higher member copayments (Repeat visits will be subject to a \$25 co-pay instead \$8)

Of the two components, the primary source of savings is due to lower ER utilization.

The methodology detail is provided in the following sections and Enclosure 1.

DATA AND METHODOLOGY

DATA

This report was developed using enrollment and encounter data as reported through the state of Indiana's Enterprise Data Warehouse (EDW), and originally provided by the fiscal agent. Enrollment and claims data was primarily from SFY 2013 and SFY 2014, as reported through February 2015. Milliman applied completion to the enrollment and claim estimates.

Enrollees in the HIP 1.0 and HHW Non-MA-U populations were identified using historical eligibility files from EDW. Individuals were considered to be enrolled in HIP 1.0 if they were assigned a subprogram code of 'H' and were enrolled in a health plan in a given month. HHW Adult members were identified if they were assigned a subprogram code of 'R' and were aged 19 years or older. Additionally, HHW members with an aid category of 'U' were excluded so as not to include MA-U members.

We also relied on data summarized for the 2015 HIP 2.0 capitation rate development. For additional details on the data and methodology underlying the rate certification, please refer to the certification report dated December 22, 2014, and signed by Rob Damler.

AMBULATORY CARE SENSITIVE CONDITION BASELINE DATA

Baseline data for ambulatory care sensitive conditions was developed using SFY 2013 and SFY 2014 enrollment and encounter inpatient claims data for the HIP 1.0 and HHW Non-MA-U adult populations.

To identify the number of hospital admissions associated with each condition, we used the definitions provided in the technical specifications for the AHRQ prevention quality indicators. In accordance with the definitions, admissions and life years related COPD and Asthma were calculated using subsets of the data: COPD admission rates were calculated only for members aged 40 or years or older, while asthma rates were included only for members aged 18 to 39. The SQL syntax used to query the inpatient claims and assign conditions is included in Enclosure 1.

The number of admissions was divided by the number of member months in the base data, then multiplied by 1,200,000 to calculate rates of admission per 100,000 life years for each condition, which are presented in Tables 1a and 1b.

ESTIMATED SAVINGS TO STATE

The estimated savings to the state due to the \$25 co-pay for non-emergency ER visits was calculated based on two components: the extra cost sharing collected from the member, and an anticipated reduction in ER utilization induced by the higher co-pay. Both of these components were developed on a per member per month basis, and then multiplied by forecasted enrollment to produce an overall savings estimate.

As part of the development of the CY 2015 capitation rates for HIP 2.0, the value of the \$25 co-pay collected for non-emergency ER visits was calculated for each rate group on a per member per month basis. These values, reduced by 32% (to reflect that an \$8 co-pay could instead be collected in a standard Medicaid program), were used as the basis for the first component of the savings estimate in this report.

The CY 2015 capitation rate development also included projections of ER utilization and expenditures on per member per month basis. For the savings estimate in this report, it was assumed that these ER expenditures would be reduced by 5% due to the higher co-pay required for non-emergency use of the ER, and that these claims would be substituted with alternative treatment at one third of the cost. As with the first savings component, this value was calculated on a per member per month basis.

Finally, the estimates for the two savings components were multiplied by the anticipated program member months for CY 2015 in order to project total savings. Details of this calculation are displayed in Table 3, and the savings are split into state and federal shares in Table 2 in the Executive Summary.

Table 3 State of Indiana, Family and Social Services Administration Estimated Savings Impact of \$25 ER Co-payment Calendar Year 2015				
	State Plan	HIP Expansion	HIP Medically Frail	Total
Copay PMPM	\$ 0.06	\$ 0.08	\$ 0.14	\$ 0.08
Utilization Savings PMPM	1.14	0.53	1.17	0.76
Total Savings PMPM	\$ 1.20	\$ 0.61	\$ 1.31	\$ 0.84
Member Months	1,032,066	2,086,790	190,489	3,309,345
Total Savings (State and Federal)	\$ 1,242,000	\$ 1,276,000	\$ 250,000	\$ 2,768,000

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration (FSSA), to support the submission of an Emergency Room co-payment protocol to CMS for the Healthy Indiana Plan 2.0 program. The data and information presented may not be appropriate for any other purpose.

The letter may be shared with the health plan to which it relates, but is not to be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration, the health plans, and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and FSSA approved May 14, 2010, and last amended December 24, 2014.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The actuaries preparing this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

ENCLOSURE 1

```

drop table Date_Ranges;
CREATE MULTISET VOLATILE TABLE Date_Ranges AS
(
SELECT
                                cast('2015-03-31' as date) AS HP_PDDTE

)WITH DATA
ON COMMIT PRESERVE ROWS;

```

```
DROP TABLE ALT_RIDs;
```

```

CREATE MULTISET VOLATILE table ALT_RIDs as (
select
    T1.Recipient_Legacy_ID, max(T1.Recipient_ID) as Final_ID
FROM
    Recipient_Legacy_ID T1 join (select Recipient_Legacy_ID, max(Date_Eff) as Most_Recent from
Recipient_Legacy_ID group by 1) T2
    on T1.Recipient_Legacy_ID=T2.Recipient_Legacy_ID and Most_Recent=T1.Date_Eff
    left outer join (select distinct Elig_Recipient_ID from FSSAWORK.MIL_HHW_CRCS_ELIG_DAYS) T3 on
T1.Recipient_Legacy_ID = T3.Elig_Recipient_ID
    left outer join (select distinct Elig_Recipient_ID from FSSAWORK.MIL_HHW_CRCS_ELIG_DAYS) T4 on
T1.Recipient_ID eq T4.Elig_Recipient_ID
    left outer join Date_Ranges on 1=1
where date_exp >= (HP_PDDTE - INTERVAL '3' YEAR) and (T3.Elig_Recipient_ID is not null or
T4.Elig_Recipient_ID is not null)
group by 1
) with data
on commit preserve rows;

```

```
DROP TABLE ALT_HHW_CRCS_ELIG_DAYS;
```

```

CREATE MULTISET VOLATILE table ALT_HHW_CRCS_ELIG_DAYS as (
select T1.*, T2.Recipient_Legacy_ID
from FSSAWork.MIL_HHW_CRCS_ELIG_DAYS T1
    join ALT_RIDs T2 on T1.Recipient_ID= T2.Final_ID
) with data
on commit preserve rows;

```

-- Get SFY 2013 and 2014 IP encounter claims. Limit HHW claims to Non-MA-U adults

```

DROP TABLE ENC_CLM_TARGETS;
CREATE MULTISET VOLATILE table ENC_CLM_TARGETS as
(
SELECT Claim_Numb, Claim_Line, Date_of_Service_YYYYMM, Recipient_ID, IP_OP, admits, days_units,
category_sortkey, Amt_Paid_Prorted as Raw_Dollars,
    case
        when ind_zero_paid = 'Y' then Repriced - Amt_TPL_Detail
        else Amt_Paid_Prorted
    end as Repriced_Dollars,
    'HHW' as claim_source, coalesce(T3.New_Age,T4.New_Age) as Age
From FSSAWork.MIL_CRCS_UB_HHW_EVAL T1
    left outer join ALT_RIDs T2 on T1.Recipient_ID eq T2.Recipient_Legacy_ID
    left outer join (select distinct elig_recipient_ID, year_and_month, new_age from
FSSAWork.MIL_HHW_CRCS_ELIG_DAYS where age_band in ('Adult Male','Adult Female') and Package = 'AB-
Non-U') T3
    on T1.Recipient_ID=T3.elig_recipient_ID and T1.Date_of_Service_YYYYMM=T3.year_and_month

```

```

left outer join (select distinct elig_recipient_ID, year_and_month, new_age from
FSSAWork.MIL_HHW_CRCS_ELIG_DAYS where age_band in ('Adult Male','Adult Female') and Package = 'AB-
Non-U') T4
on T2.Final_ID=T4.elig_recipient_ID and T1.Date_of_Service_YYYYMM=T4.year_and_month
WHERE Date_of_Service_YYYYMM between '201207' and '201406' and IP_OP = 'IP' and (T3.Year_And_Month is
not null or T4.Year_And_Month is not null)
UNION
SELECT Claim_Numb, Claim_Line, Date_of_Service_YYYYMM, T1.Recipient_ID, IP_OP, admits, days_units,
category_sortkey, Amt_Paid_Prorated as Raw_Dollars,
Amt_Paid_Prorated as Repriced_Dollars, 'HIP' as claim_source, New_Age as Age
From FSSAWork.MIL_CRCS_UB_HIP_EVAL T1
join (select distinct Recipient_ID, year_and_month, new_age from
FSSAWork.MIL_HIP_CRCS_ELIG_DAYS) T2
on T1.Recipient_ID=T2.Recipient_ID and T1.Date_of_Service_YYYYMM=T2.year_and_month
WHERE Date_of_Service_YYYYMM between '201207' and '201406' and IP_OP = 'IP'
) with data
ON COMMIT PRESERVE ROWS
;

```

--Get a list of diagnosis codes by claim

```

DROP TABLE ENC_DIAG_LIST;
CREATE MULTISET VOLATILE table ENC_DIAG_LIST as
(
SELECT
DISTINCT
T1.Claim_Numb,
Diag_Code,
I_Primary_Diag
FROM (select distinct claim_num from ENC_CLM_TARGETS) T1 join claim_diagnosis T3 on T1.Claim_num =
T3.Claim_num
WHERE I_Primary_Diag = 'Y'
UNION
SELECT
DISTINCT
T1.Claim_Numb,
Diag_Code,
I_Primary_Diag
FROM (select distinct claim_num from ENC_CLM_TARGETS) T1 join denied_claim_diagnosis T3 on
T1.Claim_num = T3.Claim_num
WHERE I_Primary_Diag = 'Y'
) with data
ON COMMIT PRESERVE ROWS
;

```

*/*Create secondary diagnosis groupings*/*

```

DROP TABLE SECOND_DIAG_GROUPS;
CREATE MULTISET VOLATILE table SECOND_DIAG_GROUPS as
(
SELECT
DISTINCT
T1.Claim_Numb,
sum(case when Diag_Code in
('4910','4911','49120','49121','4918','4919','4920','4928','494','4940','4941','496') then 1 else 0 end) as COPD,
sum(case when Diag_Code in
('27700','27701','27702','27703','27709','51661','51662','51663','51664','51669','74721','7483','7484','7485','74860',
'74861','74869','7488','7489','7503','7593','7707') then 1 else 0 end) as Cys_Fib,
sum(case when Diag_Code in ('28241','28242','28260','28261','28262','28263','28264','28268','28269') then
1 else 0 end) as Sickle_Cell,
sum(case when Diag_Code in ('2765','27650','27651','27652') then 1 else 0 end) as Dehydration,
sum(case when Diag_Code in ('40300','40301','40310','40311','40390','40391','40400','40401','40402',

```

```

        '40403','40410','40411','40412','40413','40490','40491','40492','40493','585','5855','5856') then 1 else 0
end) as Chron_Renal,
    sum(case when Diag_Code in
('59000','59001','59370','59371','59372','59373','7530','75310','75311','75312','75313','75314','75315','75316','7531
7',
        '75319','75320','75321','75322','75323','75329','7533','7534','7535','7536','7538','7539) then 1 else 0 end)
as Kidney_Disorder,
    sum(case when Diag_Code in ('40300','40310','40390','40400','40410','40490') then 1 else 0 end) as
Kidney_Disease
FROM (select distinct claim_num from ENC_CLM_TARGETS) T1 join claim_diagnosis T3 on T1.Claim_num =
T3.Claim_num
GROUP BY 1
WHERE I_Primary_Diag = 'N'
) with data
ON COMMIT PRESERVE ROWS
;

```

```

DROP TABLE CARDIAC_PROC_CLAIMS;
CREATE MULTISET VOLATILE table CARDIAC_PROC_CLAIMS as

```

```

(
select distinct claim_num
from claim_procedure_ub
where proc_icd_code = 'I9' and proc_code in (
'0050', '375', '3506', '3521', '3533', '3554', '3584', '3601', '3612', '3634', '3737', '3763', '3772', '3777',
'0051', '1751', '3507', '3522', '3534', '3555', '3591', '3602', '3613', '3639', '3741', '3764', '3773', '3778',
'0052', '1752', '3508', '3523', '3535', '3560', '3592', '3603', '3614', '3691', '3751', '3584', '3785', '3796',
'0053', '1755', '3509', '3524', '3539', '3561', '3593', '3604', '3615', '3699', '3752', '3582', '3786', '3797',
'0054', '3500', '3510', '3525', '3541', '3562', '3594', '3605', '3616', '3731', '3753', '3583', '3787', '3779',
'0056', '3501', '3511', '3526', '3542', '3563', '3595', '3606', '3617', '3732', '3754', '3766', '3774', '3780',
'0057', '3502', '3512', '3527', '3550', '3570', '3596', '3607', '3619', '3733', '3755', '3770', '3775', '3781',
'0066', '3503', '3513', '3528', '3551', '3571', '3597', '3609', '3631', '3734', '3760', '3782', '3776', '3798',
'362', '3504', '3514', '3531', '3552', '3572', '3598', '3610', '3632', '3735', '3761', '3783', '3794', '3826',
'363', '3505', '3520', '3532', '3553', '3573', '3599', '3611', '3633', '3736', '3762', '3771', '3795', '3798',
'3581'
)
) with data
ON COMMIT PRESERVE ROWS
;

```

```

DROP TABLE IMMUNOCOMP_PROC_CLAIMS;
CREATE MULTISET VOLATILE table IMMUNOCOMP_PROC_CLAIMS as

```

```

(
select distinct claim_num
from claim_procedure_ub
where proc_icd_code = 'I9' and proc_code in (
'0018', '4101', '5282',
'335', '4102', '5283',
'336', '5051', '5285',
'375', '5059', '4107',
'3350', '5280', '4108',
'3351', '4103', '4109',
'3352', '4104', '5285',
'3751', '4105', '5569',
'410', '4106',
'4100', '5281'
)
) with data
ON COMMIT PRESERVE ROWS

```

```

;
DROP TABLE DIALYSIS_PROC_CLAIMS;
CREATE MULTISET VOLATILE table DIALYSIS_PROC_CLAIMS as
(
select distinct claim_num
from claim_procedure_ub
where proc_icd_code = 'I9' and proc_code in (
'3895','3927','3929','3942','3943','3993','3994'
)
) with data
ON COMMIT PRESERVE ROWS
;

```

*/*Add diags and assign to ACS categories*/*

```

DROP TABLE IP_CLMS_W_DIAGS;
CREATE MULTISET VOLATILE table IP_CLMS_W_DIAGS as
(
SELECT T1.*, Diag_Code,
       case
         when Diag_Code in
('39891','4280','4281','42820','42821','42822','42823','42830','42831','42832','42833','42840','42841','42842','42843',
'4289') and T4.Claim_Numb is NULL then 'CHF'
         when (Diag_Code in
('4910','4911','49120','49121','4918','4919','4920','4928','494','4940','4941','496') or
              (Diag_Code in ('4660','490') and COPD > 0)) and not Cys_Fib > 0 and
Age >= 40 then 'COPD'
         when Diag_Code in
('481','4822','48230','48231','48232','48239','48241','48242','4829','4830','4831','4838','485','486') and not
Sickle_Cell > 0 and T5.Claim_Numb is NULL then 'Bacterial Pneumonia'
         when (Diag_Code in ('2765','27650','27651','27652') or (Dehydration > 0 and
Diag_Code in
('2760','00861','00862','00863','00864','00865','00866','00867','00869','0088','0090','0091','0092','0093','5589','5845',
'5846','5847','5848','5849','586','9975'))))
              and not Chron_Renal > 0 then 'Dehydration'
         when Diag_Code in ('59010','59011','5902','5903','59080','59081','5909','5950','5959','5990') and
not Kidney_Disorder > 0 and T5.Claim_Numb is NULL then 'UTI'
         when Diag_Code in ('49300','49301','49302','49310','49311','49312','49320',
'49321','49322','49381','49382','49390','49391','49392')
              and not Cys_Fib > 0 and age between 18 and 39 then 'Asthma'
         when Diag_Code in
('25010','25011','25012','25013','25020','25021','25022','25023','25030','25031','25032','25033') then 'Diabetes -
Short Term'
         when Diag_Code in
('25040','25041','25042','25043','25050','25051','25052','25053','25060','25061','25062','25063','25070','25071','250
72','25073','25080','25081','25082','25083','25090','25091','25092','25093') then 'Diabetes - Long Term'
         when Diag_Code in ('25002','25003') then 'Diabetes - Uncontrolled'
         when Diag_Code in ('4111','41181','41189','4130','4131','4139') and T4.Claim_Numb is NULL then
'Angina'
         when Diag_Code in
('4010','4019','40200','40210','40290','40300','40310','40390','40400','40410','40490') and T4.Claim_Numb is NULL
and not ( Kidney_Disease > 0 and T6.Claim_Numb is not NULL) then 'Hypertension'
         else 'Other'
       end as ACS_Group
From ENC_CLM_TARGETS T1 left join ENC_DIAG_LIST T2 on T1.Claim_Numb=T2.Claim_Numb
left join SECOND_DIAG_GROUPS T3 on T1.Claim_Numb=T3.Claim_Numb
left join CARDIAC_PROC_CLAIMS T4 on T1.Claim_Numb=T4.Claim_Numb

```

```

left join IMMUNOCOMP_PROC_CLAIMS T5 on
T1.Claim_Numb=T5.Claim_Numb
left join DIALYSIS_PROC_CLAIMS T6 on T1.Claim_Numb=T6.Claim_Numb
) with data
ON COMMIT PRESERVE ROWS
;

```

```

select
claim_source,
case
when date_of_service_YYYYMM between '201207' and '201306' then 'SFY 2013'
when date_of_service_YYYYMM between '201307' and '201406' then 'SFY 2014'
end as SFY,
ACS_GROUP,
count(*) as admits
from IP_CLMS_W_DIAGS
group by 1,2,3
;

```

```

select
'HHW' as program,
case
when year_and_month between '201207' and '201306' then 'SFY 2013'
when year_and_month between '201307' and '201406' then 'SFY 2014'
end as SFY,
case
when New_Age between 18 and 39 then '18 to 39'
when New_Age >=40 then 'Over 40'
end as Age_Bucket,
sum(member_months) as member_months
from FSSAWork.MIL_HHW_CRCS_ELIG_DAYS
where age_band in ('Adult Male','Adult Female') and Package = 'AB-Non-U' and year_and_month between
'201207' and '201406'
group by 1,2,3
UNION
select

```

```

'HIP' as program,
case
when year_and_month between '201207' and '201306' then 'SFY 2013'
when year_and_month between '201307' and '201406' then 'SFY 2014'
end as SFY,
case
when New_Age between 18 and 39 then '18 to 39'
when New_Age >=40 then 'Over 40'
end as Age_Bucket,
sum(member_months) as member_months
from FSSAWork.MIL_HIP_CRCS_ELIG_DAYS
where year_and_month between '201207' and '201406'
group by 1,2,3
;

```

Emergency Room Copayment Protocol

4/30/2015

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

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Emergency room co-payment description

A co-payment will apply to non-emergency use of an emergency room by members enrolled in HIP Basic, HIP Plus, and HIP State Plan options. Members enrolled in HIP Link are not subject to the HIP copayments for the non-emergency use of the ER. Link cost sharing will be detailed in the HIP Link protocol.

Excluding those 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), these HIP members will be subject to a graduated co-payment for all non-emergent use of hospital emergency department services.

An \$8 co-payment 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 co-payment. Providers will collect the co-payment directly from members and member POWER Account funds cannot be used by the member to pay the co-payment. A random selection of individuals will only have a \$8 copayment applied to subsequent visits. Provider payments will be reduced by the applicable copayment amount.

Co-payments will be waived if the member is found to have an emergency condition, as defined in section 1867(e)(1)(A) 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 room 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 co-payment.

In addition, the member co-payment 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. 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 room co-pay 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 5,000 HIP members. The random sample methodology will be based on the 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 Assistance (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, up to a total of 5,000 members.

Native American members who do not have copayments 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, up to a total of 5,000 members. Members that 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 adverse health outcomes.

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 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 ER, 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 test group then the member will owe a \$25 copayment

- Members of the test 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 hotline 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 ER copayment requirements when they call the MCEs call center or the Nurse Hotline.

For members selected for the test 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 test group. MCEs will be able to indicate to these members when they call in that they are part of the test group and that their copayment remains \$8 for non-emergency visits to the emergency department after the initial visit. Providers and other emergency room staff will be able to verify all member's copayments owed for the ED visit when checking the member's 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 weekly that include the MCEs. The implementation of the graduated copayment structure and the test group has been discussed during these meetings. For example, during discussions on the design of the HIP member card, due to the ER copayment policy it was determined that to reduce provider confusion HIP member cards will not list the amount of the graduated ER copayments, but will instruct the provider to check with the MCE through the MCEs online system or over the 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 test group with the \$8 copayment applied regardless of the number of non-emergency visits to the emergency room, to reduce

administrative complexities for providers. Providers will check with the MCEs, and for the test group, regardless of it is the member's first or fifth visit to the ED, 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 refuse service if a copayment is not made for members below 100% FPL.

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;

Identification of emergent conditions is discussed below. Individuals will only have a copayment applied if there is a non-emergent condition and they do not call the Nurse hotline 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.

Identification of members with non-emergency health conditions

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

Identification of emergency and non-emergency conditions is a responsibility of the MCEs, as described in Section 6 of the HIP 2.0 Scope of Work. All MCEs operate a Nurse hotline, and any member that calls the nurse line in advance of going to the ED will have their copayment waived. If the member did not call the Nurse hotline and was not admitted to the hospital,

Managed Care Entities use various processes to identify if a condition is a non-emergency and requires a copayment be applied. These processes include:

- Verifying the member reason for the ED visit indicated on the claim against a the MCE's list of emergency health conditions. Conditions that are on the MCE's emergency health condition list will be paid in full and will not have the copayment applied.
- If an ED visit claim is not on the emergency health condition list, then it is subject to prudent lay-person review. ED visits that are considered to be an emergency as a result of this review will be paid in full and will not have a copayment applied.
- All MCEs are also 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.

All ED claims are subject to additional review by the MCEs. Claims that are non-emergency based on the MCEs list of emergency conditions and prudent lay-person review 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 claim is determined to be emergency, and paid in full, the provider is obligated to refund the member any remaining balance.

Process to identify non-emergency health conditions

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

MCE provider manuals and educational material provide guidelines for providers in assessing emergency health conditions. For example an excerpt of the MCE manual indicates that an emergency condition is:

Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- *Place the Member's health or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy*
- *Cause serious impairment to bodily functions*
- *Cause serious dysfunction to any bodily organ or part*

At the point of service Emergency Department providers must assess if the member has an emergency condition meeting the prudent layperson standard. If the Emergency Department provider determines that the condition is not an emergency and in accordance with the following section informs the member of their cost-sharing responsibility and provides the appropriate referral to services where they will not be subject to the Emergency Department copayment then they may collect the copayment at the point of service. During claims payment processes MCEs have additional review processes that include both claims review for emergency conditions based

on diagnoses and prudent layperson review. If during these processes it is determined that the condition is an emergency, the provider will be required to refund the payment to the HIP member.

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);*

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 C.F.R. § 447.54(d) the member will owe a copayment to the provider.

- a) The hospital may require payment of the co-payment before the service can be provided;
- b) The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible;
- c) An alternate provider can provide the services without the imposition of the co-payment; and
- d) The hospital provides a referral to coordinate scheduling of this treatment.

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 MCE's are contractually obligated to ensure that providers appropriately assess the ER copayments. MCE provider materials, including provider manuals and internal policy and procedure documents detail the requirements for providers prior to assessing the ER 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 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 ER. Per federal requirements, the ER provider may require payment of the co-payment before the non-emergency service is provided, however the provider must also:

- *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 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 each MCE’s Nurse Hotline.

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 ER claims per capita for 2014. The program will be developed and launched to members in these counties who have utilized the emergency room (ER) in 2014. This campaign will notify them of alternatives to the ER 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 ER 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 ER 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 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 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 co-pay*

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