AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

February 6, 2017

Richard Stavneak, Director, Director
Joint Legislative Budget Committee
1716 West Adams
Phoenix, Arizona 85007

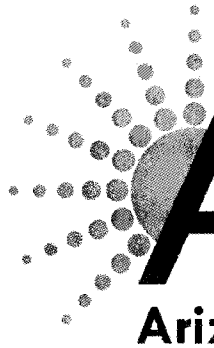
Dear Mr. Stavneak:

Pursuant to Laws 2016, Chapter 122, Section 30, please find enclosed the 2016 AHCCCS Report on Emergency Department Utilization. Please do not hesitate to contact me if I can answer any questions or provide additional information.

Sincerely,

Thomas J. Betlach
Director

cc: Lorenzo Romero, Director, Governor's Office of Strategic Planning and Budgeting



AHCCCS

Arizona Health Care Cost Containment System

Report to the Directors of the Governor's Office of Strategic Planning and Budgeting and the Joint Legislative Budget Committee Regarding Emergency Department Utilization

December 2016

Director, Tom Betlach

BACKGROUND

Laws 2016, Chapter 122, Section 30 requires:

> AHCCCS; emergency department use; report
> On or before December 1, 2016, the Arizona health care cost containment system administration shall report to the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting on the use of emergency departments for nonemergency purposes by Arizona health care cost containment system enrollees.

There is no national standard or code set that identifies whether the services provided in an Emergency Department (ED) were the result of an emergency or non-emergency situation, and coding may vary by hospital. This difficulty is best illustrated by the disparate reports regarding this topic. For example, the New England Healthcare Institute reports that total avoidable ED use is as high as 56% while the Center for Disease Control and Prevention reports a national average of non-emergency use of the emergency department for persons under 65 at about 10%. Both studies represent all payors and non-payors, not just the Medicaid population. Therefore, it is challenging to determine the number of emergency visits which are truly an emergency.

METHODOLOGY AND DATA

AHCCCS used the American College of Emergency Physicians' facility coding model to categorize the ED visit data for the State's Medicaid population. This is the same system of classification provided in prior reports on ED utilization. The model provides an easy-to-use methodology for assigning visit levels in an ED in one of five categories based on levels of care or intervention, with Level I representing a visit with the least amount of intervention and Level V visits representing the greatest amount of intervention.

In previous reports, AHCCCS used Level I ED visits as a proxy for non-emergency services, while stating that these varying levels do not precisely correspond to emergency and non-emergency uses of the ED. Perhaps a broader way to understand these levels is that Level I visits are usually self-limited or minor, Level II –III visits are low to moderate severity, and Level IV and V visits are typically emergency related. Levels I – Levels III are generally issues which could be addressed by a primary care physician in an office or an urgent care center if an individual is able to obtain timely services.

The American College of Emergency Physicians describes Level I visits as initial assessments where no medication or treatment is provided. Uncomplicated insect bites, providing a prescription refill only, the removal of uncomplicated sutures, or reading a TB test are examples. Treatment of sunburns, ear pain, minor viral infections, and simple traumas are generally coded as Level II visits. Level III coding is associated with minor trauma, fevers which respond to antipyretics (fever reducers such as aspirin and ibuprofen), and medical conditions requiring prescription drug management. Please refer to the following link for more information:

https://www.acep.org/physician-resources/practice-resources/administration/financial-issues-/-reimbursement/ed-facility-level-coding-guidelines/

Despite this, it is important to understand that there may be instances when ED utilization is appropriate for services coded as a Levels I-III. Coding does not necessarily take into consideration mitigating circumstance such as age of the patient or day or time of the health event leading to the visit. For example, fever and upper respiratory infections may be an appropriate use of the ED for an infant, but not for an adult in their 30s. Similarly, a relatively straightforward medical condition, such as a 2-inch laceration on the arm of an otherwise healthy 30-year-old late on a Friday night may be an appropriate use of the ED when nearby urgent care facilities are not open on the weekend. While not life-threatening, leaving the wound open until Monday morning when the patient might be able to see his or her physician would lead to a high probability of an infection. Moreover, whether a visit is truly an emergency may not be determined until the actual visit. A patient complaining of chest pain could be displaying early signs or a heart attack or may be suffering from heartburn. In this case, a visit to the emergency room would be appropriate even if the visit resulted in learning that the patient was merely suffering from heartburn.

Table 1 identifies total ED visits for State Fiscal Years (SFYs) 2012-2015 that are classified as Levels I-V, as well as the paid amount associated with those distributions. The large increase in the number of visits and paid amount in SFY 2015 corresponds with the Medicaid restoration and expansion.

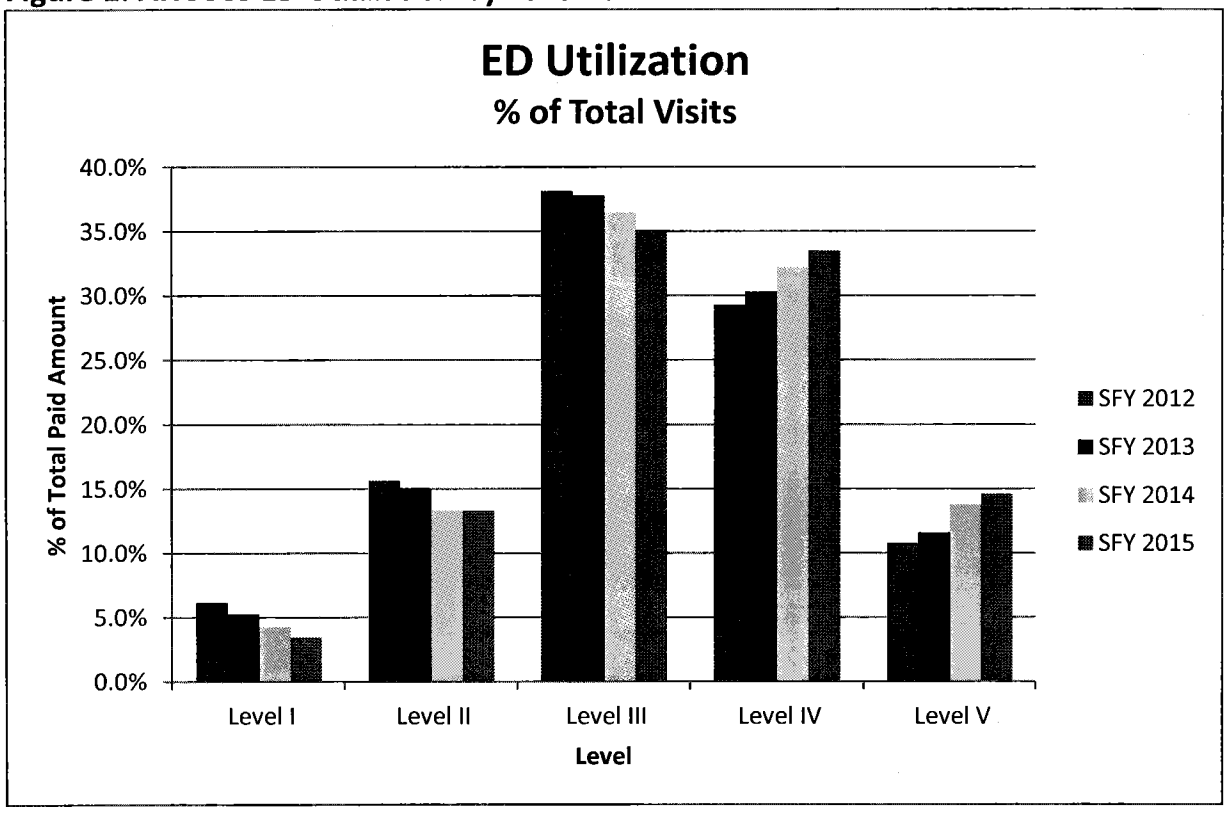
Table 1: AHCCCS ED Utilization – SFYs 2012-2015

Visit Level	# Visits	% Total Visits	Paid Amount	% Paid Amount
SFY 2012				
Level I	54,497	6.2%	$5,467,262	1.4%
Level II	138,274	15.6%	$22,526,590	6.0%
Level III	336,922	38.1%	$106,450,360	28.2%
Level IV	258,803	29.3%	$147,708,429	39.1%
Level V	95,134	10.8%	$95,571,459	25.3%
Overall-Summary	**883,630**	**100.0%**	**$377,724,099**	**100.0%**
SFY 2013				
Level I	43,732	5.3%	$3,911,371	1.1%
Level II	124,721	15.0%	$20,735,580	6.0%
Level III	313,562	37.8%	$91,417,985	26.3%
Level IV	251,398	30.3%	$134,740,191	38.8%
Level V	96,221	11.6%	$96,387,515	27.8%
Overall- Summary	**829,634**	**100.0%**	**$347,192,641**	**100.0%**
SFY 2014				
Level I	37,270	4.3%	$3,472,834	0.9%
Level II	116,455	13.3%	$20,509,576	5.2%
Level III	319,294	36.5%	$93,194,912	23.6%

Level IV	282,037	32.2%	$151,789,518	38.4%
Level V	120,654	13.8%	$125,991,580	31.9%
Overall- Summary	**875,710**	**100.0%**	**$394,958,419**	**100.0%**
		SFY 2015		
Level I	36,964	3.5%	$3,471,645	0.7%
Level II	141,885	13.3%	$23,555,864	4.7%
Level III	374,660	35.1%	$110,664,203	21.9%
Level IV	357,061	33.5%	$194,065,020	38.4%
Level V	155,721	14.6%	$173,294,103	34.3%
Overall- Summary	**1,066,291**	**100.0%**	**$505,050,836**	**100.0%**

Figures 1 and 2 display these statistics graphically. The data represents outpatient ED visits and does not include ED visits that resulted in admission to the hospital.[1]

Figure 1: AHCCCS ED Utilization by Level for SFYs 2012-2015

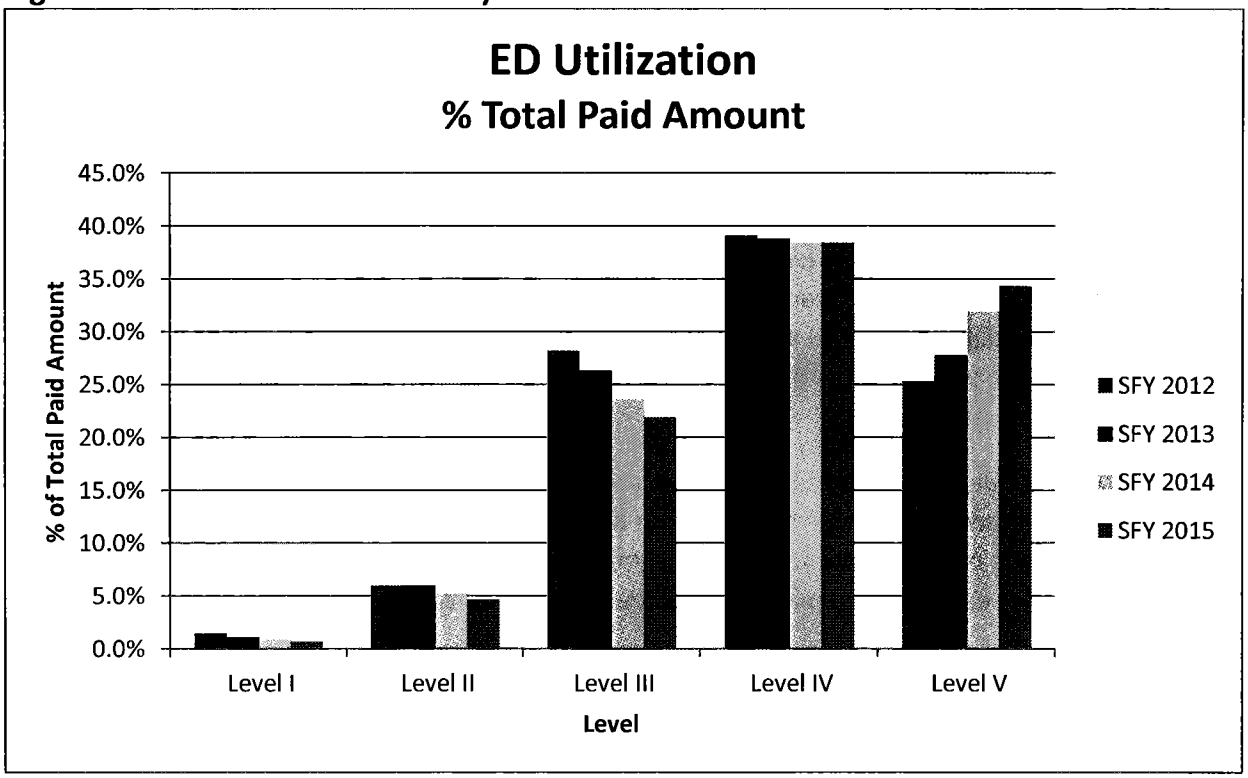


[1] An ED visit that results in an inpatient admission is not captured in AHCCCS data as an ED visit; the ED services are paid as part of the inpatient stay. If AHCCCS were able to capture such data, this would result in a higher percentage of Level III-V ED visits and a lower level of Level I and Level II ED visits, demonstrating an even lower total percentage of non-emergency visits than is displayed in Figure 1.

The four-year trend (shown above in Figure 1) shows positive results with a reduction of lower level ED visits and a shift towards visits most appropriate for the ED. The percentage of Level I, II, and III visits either decreased or remained the same from the previous year's percentage of 4.3%, 13.3%, and 36.5%, respectively, with the higher acuity visits (Levels IV and V) in SFY 2015 both showing increases over SFY 2014.

As with the number of visits, the four-year trend for payments (shown in Figure 2 below) shows a decreasing percentage of payments are being spent on lower Level visits. In SFY 2015, the vast majority of the total amount paid ($367.4 million or 72.7%) fall within Levels IV and V. The percentage of total paid for Level I visits is slightly less than the percentage paid in SFYs 2012-2014, while the percentage of total paid for Level V increased slightly from 31.9% to 34.3%.

Figure 2: AHCCCS ED Utilization by Paid Amount for SFYs 2012-2015



The top ten diagnoses for each visit level can be found in Appendix A.

AHCCCS continues to drive innovation in the health care system to improve the delivery of care, improve the health of populations, and curb the upward trajectory of per capita spending. In particular, three recent initiatives have components which continue our aggressive effort to ensure appropriate ED utilization: value based purchasing, integration, and High Needs/High Cost intervention. AHCCCS also continues to re-examine reimbursement methodologies to ensure that they do not encourage inappropriate use of the ED.

Beginning October 1, 2013, AHCCCS amended its Acute Care managed care contracts to include value based purchasing (VBP) initiatives and has since expanded VBP initiatives to all of its contracts. One such VBP initiative focuses specifically on reducing ED utilization. To encourage this effort, managed care organizations (MCOs) may allow providers to share in savings incurred through reducing unnecessary use of the ED, or otherwise reward providers for meeting pre-established performance metrics related to this utilization.

AHCCCS also continues its integration efforts. Among other benefits, integration should reduce costs by ensuring members receive the most appropriate care. One example of integration is the recently enacted integrated Regional Behavioral Health Authority (RBHA) contracts. On April 1, 2014, Mercy Maricopa Integrated Care became the entity responsible for administering both behavioral health and physical health services to individuals with Serious Mental Illness (SMI) in Maricopa County. On October 1, 2015, all persons statewide with SMI became part of an integrated health plan with Health Choice Integrated Care serving AHCCCS recipients in northern Arizona and Cenpatico Integrated Care serving AHCCCS recipients in southern Arizona. Since integration, all health plans have engaged in aggressive efforts to lower unnecessary ED usage.

The High Needs/High Cost initiative mandates that AHCCCS Acute Care MCOs and RBHAs identify High Need/High Cost members and, for those members that are not already part of an integrated contract, work together to plan interventions for addressing appropriate and timely care. All MCOs use frequent visits to the ED as part of the High Needs/High Cost member identification process. Intensive care coordination efforts are employed by both the MCOs and the RBHAs to ensure that these members are redirected to primary and specialty physical health providers, and behavioral health providers, as needed.

AHCCCS also continues to evaluate its payment methodologies to ensure that reimbursement does not incentivize unnecessary use of the ED when less costly care would be more appropriate. This has led to reviewing reimbursements for Emergency Medical Services (EMS) providers and hospital based free standing emergency departments as describe in more detail below.

Through VBP, integration, High Needs/High Cost, reimbursement changes, and other efforts, AHCCCS, its contracted MCOs, and AHCCCS providers are continuing efforts to reduce inappropriate ED usage.

In the last two reports, the AHCCCS Administration highlighted a number of initiatives that AHCCCS, its contracted MCOs, and providers have undertaken in order to reduce inappropriate use of the ED. Some more recent initiatives are described below:

- Building on the prior efforts of a number of Arizona fire departments, AHCCCS collaborated with EMS stakeholders and the Arizona Department of Health Services (ADHS), Bureau of EMS and Trauma System to launch the Arizona Treat and Refer Recognition Program. The Treat and Refer program gives EMS providers the opportunity to address non-emergent health needs through an assessment and referral to a more appropriate level of care (e.g. primary care provider, urgent care, behavioral health clinic) in lieu of transporting individuals to an ED. Beginning October 1, 2016,

EMS providers who have been recognized by ADHS through the Arizona Treat and Refer Recognition Program and are registered with AHCCCS may be reimbursed by AHCCCS for their service.

- Since 2010, at least 12 hospital-based freestanding emergency departments (FrEDs) have opened in Arizona. Unlike on-site hospital emergency departments, hospital-based FrEDs do not offer on-site inpatient admissions and lack the intensive care capabilities of on-site emergency departments. For patients who must be admitted to a hospital, transportation to the hospital will be necessary, delaying care and incurring additional charges. Overhead costs associated with hospital-based freestanding emergency departments are less than those of on-site emergency departments. Payments to hospital-based FrEDs are currently equivalent to those provided at on-site hospital EDs. With concerns that the growing presence of hospital-based FrEDs will contribute to excessive emergency department utilization, AHCCCS has proposed a new rate schedule which will reimburse most FrEDs at a percentage of the current outpatient hospital rate for Levels I, II, and III visits and 100% for Level IV and V visits.
- As one if its VBP initiatives, Mercy Care Plan (MCP) contracts with provider groups who manage high-risk populations by providing 24/7 coverage and home visits. MCP continues to grow its VPB initiatives and makes incentive payments that use measures of ED utilization. After using its predictive modeling capabilities to identify those at risk of ED utilization, MCP performs outreach activities and, when appropriate, engages the member in a care management process appropriate for his/her needs.
- Most of United Community Plan's Accountable Care Organizations have VPB contracts which track ED visits as a goal for improvement. United makes incentive payments for decreasing unnecessary use of the ED and rewards practices which proactively identity and engage high-risk patients into appropriate care. This has led to more extended hours of care on weekdays and weekends, increasing the availability of same day appointments, and adding additional providers.
- Centpatico Integrated Care (CIC) has worked to ensure that crisis mobile teams are located in all communities in which they serve so that individuals may be served in a more appropriate community setting as opposed to the ED. For example, in 2016, CIC opened two 23-hour crisis centers, one in Yuma and one in Pima County. Law enforcement officers may drop off individuals at these centers instead of the ED and are able to quickly return to work. Facilities in these communities also take recipients who walk-in or have been dropped off by other individuals.
- Health Choice Integrated Care (HCIC) contracts with urgent care facilities near EDs in order to steer members to a more appropriate and less costly setting when appropriate. Like CIC, HCIC also has also established crisis mobile teams.

CONCLUSION

Since SFY 2012, the percentage of Level I, II, and III ED visits has fallen by eight percentage points, demonstrating the continued success of AHCCCS, its MCOs, and AHCCCS providers. Overall, AHCCCS members demonstrate a relatively low rate of non-emergency ED utilization,

particularly when compared to national averages. Despite the low percentage of improper ED utilization, AHCCCS continues to work with its contracted MCOs, hospitals, and other providers to further reduce ED utilization for non-emergency use.

REFERENCES

http://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues-/-Reimbursement/ED-Facility-Level-Coding-Guidelines/

http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610final edits.pdf

http://www.cdc.gov/nchs/data/databriefs/db38.htm

APPENDIX A

Top ten diagnoses for each visit level

Level I

- Acute upper respiratory infections of unspecified site
- Issue of repeat prescriptions
- Encounter for removal of sutures
- Head injury, unspecified
- Fever, unspecified
- Cough
- Abdominal pain, unspecified site
- Other current conditions classifiable elsewhere of mother, antepartum condition or Complication
- Vomiting alone
- Pain in limb

Level II

- Acute upper respiratory infections of unspecified site
- Unspecified otitis media
- Unspecified disorder of the teeth and supporting
- Acute pharyngitis
- Unspecified dental caries
- Rash and other nonspecific skin eruption
- Fever, unspecified
- Conjunctivitis, unspecified
- Unspecified viral infection
- Head injury, unspecified

Level III

- Acute upper respiratory infections of unspecified site
- Unspecified otitis media
- Fever, unspecified
- Urinary tract infection, site not specified
- Lumbago
- Acute pharyngitis
- Headache
- Unspecified site of ankle sprain and strain
- Acute bronchitis
- Vomiting alone

Level IV

- Abdominal pain, unspecified site
- Headache
- Urinary tract infection, site not specified
- Abdominal pain, other specified site
- Unspecified chest pain
- Other current conditions classifiable
- Abdominal pain, epigastric
- Nausea with vomiting
- Acute upper respiratory infections of unspecified site
- Other and unspecified noninfectious gastroenteritis and colitis

Level V

- Unspecified chest pain
- Other chest pain
- Suicidal ideation
- Abdominal pain, unspecified site
- Syncope and collapse
- Alcohol abuse, unspecified
- Abdominal pain, other specified site
- Urinary tract infection, site not specified
- Asthma, unspecified, with (acute) exacerbation
- Headache