December 1, 2017

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

Dear Mr. Stavneak:

Pursuant to A.R.S. § 36-2903.11, please find enclosed the 2017 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: Matt Gess, Director, Governor's Office of Strategic Planning and Budgeting

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 2017

Director, Tom Betlach

BACKGROUND

A.R.S. § 36-2903.11 requires:

> On or before December 1, 2017, and on or after each year thereafter, the 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 members.

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 payers and non-payers, 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. 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. Generally Levels I – Levels III are 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) 2012-2016 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 from SFY 2014 to SFY 2015 corresponds with the Medicaid restoration and expansion.

Table 1: AHCCCS ED Utilization – SFYs 2012-2016

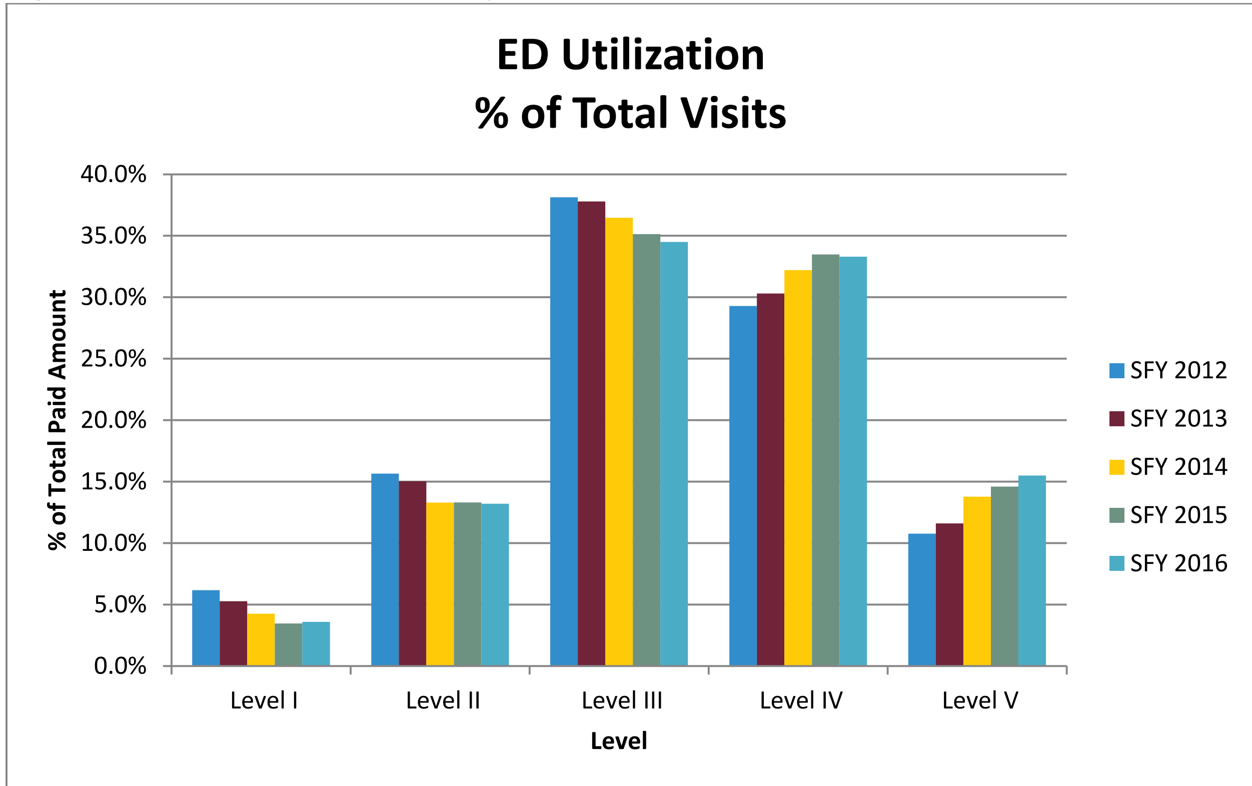
Visit Level	# Visits	% Total Visits	Paid Amount	% Paid Amount
SFY 2012				
Level I	54,497	6.2%	$5,467,262	1.4%
Level II	138,274	15.6%	$22,526,590	6.0%
Level III	336,922	38.1%	$106,450,360	28.2%
Level IV	258,803	29.3%	$147,708,429	39.1%
Level V	95,134	10.8%	$95,571,459	25.3%
Overall-Summary	**883,630**	**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%**
SFY 2016				
Level I	40,106	3.6%	$4,237,969	0.8%
Level II	148,109	13.2%	$24,712,886	4.5%
Level III	388,003	34.5%	$116,722,853	21.4%
Level IV	374,985	33.3%	$206,221,222	37.9%
Level V	174,924	15.5%	$192,706,131	35.4%
Overall- Summary	**1,126,127**	**100.0%**	**$544,601,060**	**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]

[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 percentage of Level I and Level II ED visits, demonstrating an even lower total percentage of non-emergency visits than is displayed in Figure 1.

Figure 1: AHCCCS ED Utilization by Level for SFYs 2012-2016

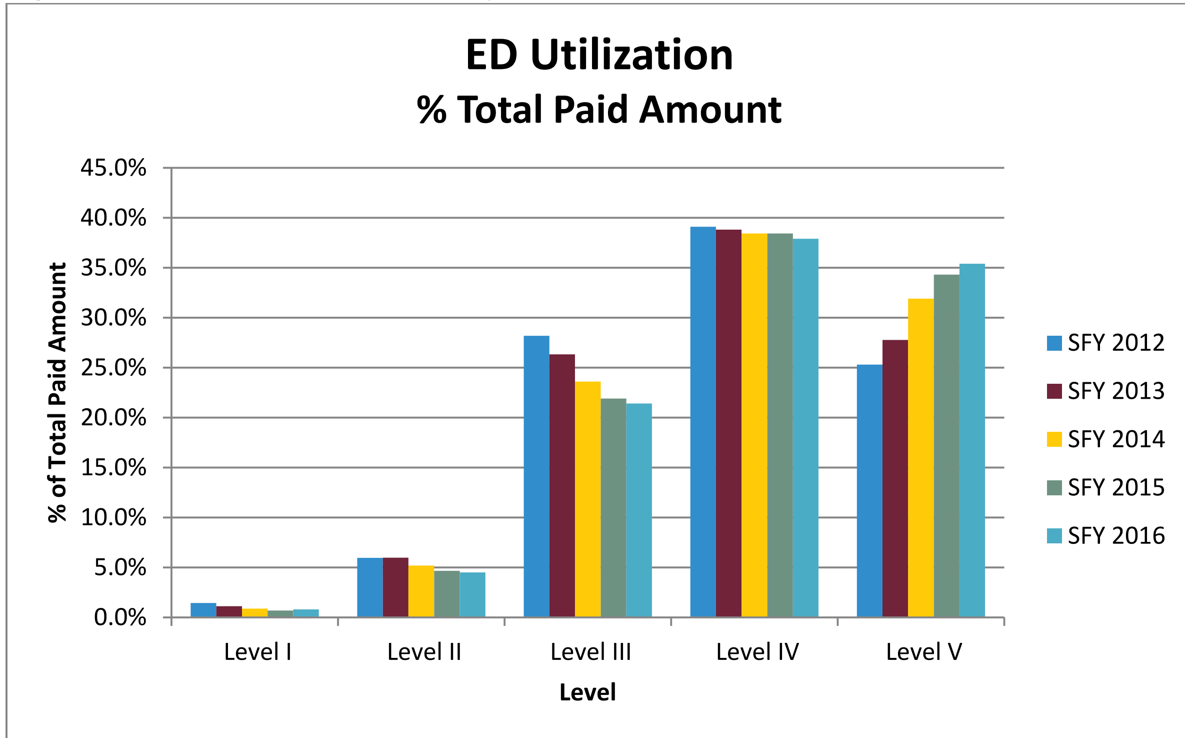


The five-year trend (shown above in Figure 1) shows positive results with a reduction of lower level ED visits (Levels I, II, and III) and a shift towards visits most appropriate for the ED (Levels IV and V).

As with the number of visits, the five-year trend for payments (shown in Figure 2 below) shows a decreasing percentage of payments are being spent on lower Level visits. In SFY 2016, the vast majority of the total amount paid ($398.9 million or 73.3%) fall within Levels IV and V. The percentage of total paid for Level I visits is 0.6 percentage points below the percentage paid four years prior while the percentage of total paid for Level V has increased by more than ten percentage points over this four year period.

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

Figure 2: AHCCCS ED Utilization by Paid Amount for SFYs 2012-2016



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 efforts to integrate administration for both physical and behavioral health services. Among other benefits, integration should reduce costs by ensuring members receive the most appropriate care. Between April 1, 2014 and October 1, 2015, AHCCCS members determined to have a Serious Mental Illness (SMI) became part of an integrated health plan. Effective October 1, 2015, approximately 80,000 dual eligible members (those enrolled in both Medicaid and Medicare) began receiving their mental health and substance abuse services from an

integrated plan. In November 2017, AHCCCS released an RFP to integrate all other Acute Care Program adults and children (excluding children in foster care who are enrolled in the Comprehensive Medical and Dental Program) into a single-plan for physical and behavioral health care service delivery with start date of October 1, 2018. Since the start of AHCCCS' integration efforts, 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 Regional Behavioral Health Authorities (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. The evaluation led to the establishment of a separate fee schedule for Emergency Medical Services (EMS) providers (Treat and Refer) and a separate fee schedule for hospital based free standing emergency departments which reimburses less than the Outpatient Hospital Fee Schedule for Levels I-III.

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

- Health Net Access (an Acute Care Program MCO) uses a medical respite care provider for homeless members who are in a course of treatment to encourage the completion of the treatment, decreasing ED visits which are in effect used as a source of ongoing care following hospital discharge.
- Cenpatico Integrated Care (a RBHA) works closely with local system partners such as law enforcement, County Attorney's offices, hospitals, jails and courts to educate the system partners on the problems associated with taking members experiencing a behavioral health crisis to an ED. The Contractor is also expanding its rural Arizona facility based crisis services as an effective alternative to taking members to an ED.
- Care1st (an Acute Care Program MCO) has an ED Diversion Program, which identifies members with high, moderate and low ED utilization within 6 months, or frequent use of the ED for non-emergent services or chronic care situations. The program provides alternate resources for urgent issues such as urgent care or providers with extended hours.
- Mercy Care Plan (an Acute Care Program and ALTCS MCO) identifies physician groups with assigned members that have high utilization of EDs. Groups whose members have statistically significant ED usage are visited by the plan's medical director to discuss specific patient usage and offer education on preventable ED usage, including alternatives such as office scheduling for non-emergent care and use of urgent care or after hour clinics.
- University Family Care (an Acute Care Program MCO) identifies members with four or more ED visits in a 6 month period, and determines if staff need to reach out to the member for

education or assistance. Additionally, members with 2 or more ED visits in two months are given access to a vendor who assists the member in reaching a case manager for assistance. They can create an alert for the case manager when they have difficulty obtaining care from their PCP or have questions about their care. The Contractor's Value Based Purchasing program includes an ED initiative that helps identify members receiving multiple opioid prescriptions though the ED.

CONCLUSION

Since SFY 2012, the percentage of Level I, II, and III ED visits has fallen by 8.6 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_032610finaledits.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
- Encounter for issue of repeat prescription
- Encounter for removal of sutures
- Cough
- Fever
- Unspecified injury of head, initial encounter
- Viral infection
- Other specified disorders of teeth and supporting structures
- Vomiting
- Headache

Level II

- Acute upper respiratory infections of unspecified site
- Other specified disorders of teeth and supporting structures
- Acute pharyngitis
- Viral infection
- Otitis media, right ear
- Dental caries
- Otitis media, left ear
- Fever
- Periapical abscess without sinus
- Rash and other nonspecific skin eruption

Level III

- Acute upper respiratory infections of unspecified site
- Acute bronchitis
- Acute pharyngitis
- Fever
- Urinary tract infection
- Low back pain
- Headache
- Viral infection
- Streptococcal pharyngitis
- Cough

Level IV

- Unspecified abdominal pain
- Headache
- Urinary tract infection
- Acute upper respiratory infection
- Nausea with vomiting
- Noninfective gastroenteritis and colitis
- Chest pain, unspecified
- Epigastric pain
- Constipation
- Other chest pain

Level V

- Other chest pain
- Chest pain, unspecified
- Suicidal ideations
- Unspecified chest pain
- Unspecified abdominal pain
- Urinary tract infection
- Syncope and collapse
- Alcohol abuse with intoxication
- Asthma, unspecified, with (acute) exacerbation
- Major depressive disorder, single episode