November 30, 2021

Richard Stavneak, Director
Joint Legislative Budget Committee
1716 W. Adams
Phoenix, AZ 85007

Matthew Gress, Director
Governor's Office of Strategic Planning and Budgeting
1700 W. Washington St., 6th Floor
Phoenix, AZ 85007

Dear Mr. Stavneak and Mr. Gress:

Pursuant to A. R. S. §36-2903.11, please find enclosed the 2021 AHCCCS Report on Emergency Department Utilization. Please feel free to contact me if you have any questions about this report.

Sincerely,

Director

cc: Christina Corieri, Governor's Office, Senior Advisor to the Governor

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 2021

Jami Snyder, Director

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

BACKGROUND

A.R.S. § 36-2903.11 requires:

> On or before December 1, 2017, and on or before December 1 of 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, UnitedHealth Group reports that total unnecessary and avoidable ED use is as high as 66%[1] while the International Journal for Quality in Health Care classifies 3.3% of all ED visits as avoidable.[2] 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 (problems for which the resolution is expected to be fairly rapid, with minimal medical intervention), Levels II–III visits are low to moderate severity, and Levels IV and V visits are high severity and assumed to be emergency related. For purposes of this analysis, it is assumed that Levels I–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 visits could be associated with minor trauma, fevers which respond to antipyretics (fever

[1] "Study: The High Cost of Avoidable Hospital Emergency Department Visits." United Health Group. July 22, 2019. https://www.unitedhealthgroup.com/newsroom/posts/2019-07-22-high-cost-emergency-department-visits.html (accessed October 16, 2021).

[2] Hsia, Renee Y and Matthew Niedzwiecki. "Avoidable Emergency Department Visits: A Starting Point." Volume 29, Issue 5. https://academic.oup.com/intqhc/article/29/5/642/4085442 (accessed October 16, 2021).

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/administration/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 Levels I-III. Coding does not necessarily take into consideration mitigating circumstance such as age of the patient or the 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 of 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) 2012-2020 that are classified as Levels I-V, as well as the paid amount associated with those visits. The large increase in the number of visits and paid amount from SFY 2014 to SFY 2015 corresponds with Medicaid restoration and expansion. Payments decreased in SFY 2018 before increasing in SFY 2019, which can be attributed to three new level one trauma centers receiving a higher reimbursement rate for level three, four and five visits for those hospitals. SFY 2018 was the first year since expansion in which ED visits decreased, and that trend continued for ED visits through SFY 2019 and into SFY 2020. From SFY 2019 to SFY 2020, ED visits decreased by 7.6%, and payments decreased by 5.9%. The continued decline in SFY 2020 is believed to be attributable to the beginning of the COVID-19 pandemic.

Table 1: AHCCCS ED Utilization – SFYs 2012-2020

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%**

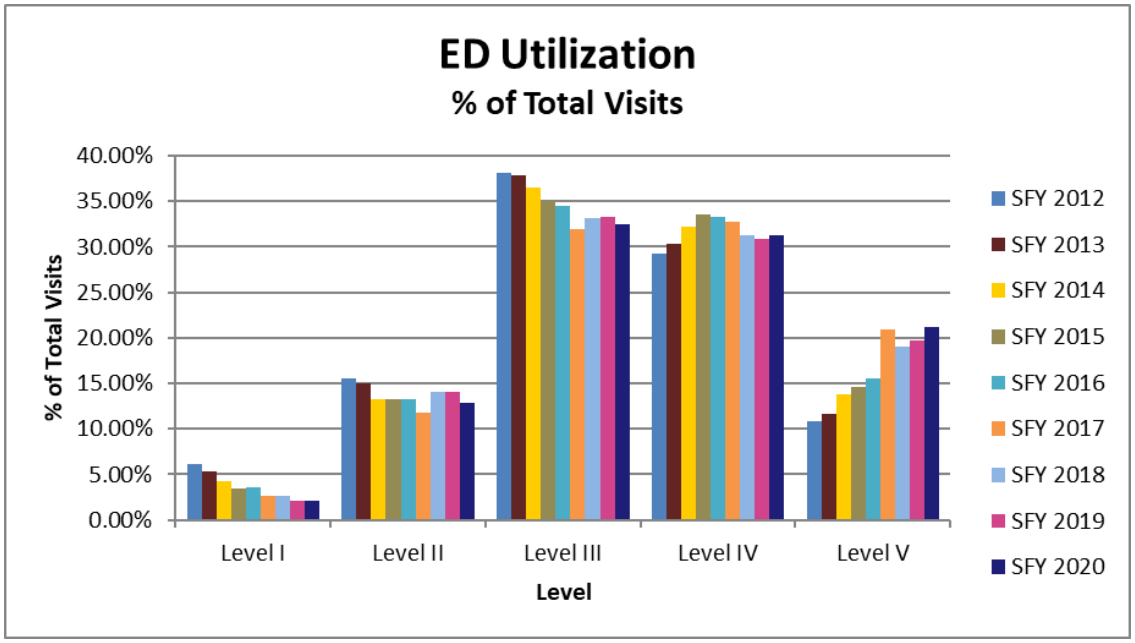
SFY 2013				
Level I	43,732	5.3%	$3,911,371	1.1%
Level II	124,721	15.0%	$20,735,580	6.0%
Level III	313,562	37.8%	$91,417,985	26.3%
Level IV	251,398	30.3%	$134,740,191	38.8%
Level V	96,221	11.6%	$96,387,515	27.8%
Overall- Summary	**829,634**	**100.0%**	**$347,192,641**	**100.0%**
SFY 2014				
Level I	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%**
SFY 2017				
Level I	30,759	2.6%	$2,988,739	0.5%
Level II	137,469	11.8%	$22,805,132	3.9%
Level III	371,520	31.9%	$110,142,037	18.9%
Level IV	381,219	32.8%	$203,934,319	35.0%
Level V	243,008	20.9%	$242,085,108	41.6%
Overall-Summary	**1,163,975**	**100.0%**	**$581,955,334**	**100.0%**

SFY 2018				
Level I	28,849	2.6%	$2,805,568	0.5%
Level II	156,726	14.0%	$25,264,227	4.4%
Level III	372,355	33.2%	$112,468,506	19.7%
Level IV	351,024	31.3%	$198,037,740	35.0%
Level V	213,350	19.0%	$231,119,972	41.6%
Overall-Summary	**1,122,304**	**100.0%**	**$569,696,013**	**100.0%**
SFY 2019				
Level I	22,594	2.1%	$2,195,192	0.4%
Level II	150,417	14.0%	$24,121,733	4.2%
Level III	356,593	33.3%	$112,808,133	19.5%
Level IV	330,799	30.9%	$196,641,909	34.0%
Level V	211,161	19.7%	$242,423,675	41.9%
Overall-Summary	**1,071,564**	**100.0%**	**$578,190,642**	**100.0%**
SFY 2020				
Level I	21,279	2.1%	$2,051,836	0.4%
Level II	127,447	12.9%	$21,536,442	4.0%
Level III	321,882	32.5%	$106,053,745	19.5%
Level IV	310,227	31.3%	$179,784,385	33.0%
Level V	209,558	21.2%	$234,911,817	43.2%
Overall-Summary	**990,393**	**100.0%**	**$544,338,225**	**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.[3]

[3] 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 Levels 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 2012-2020

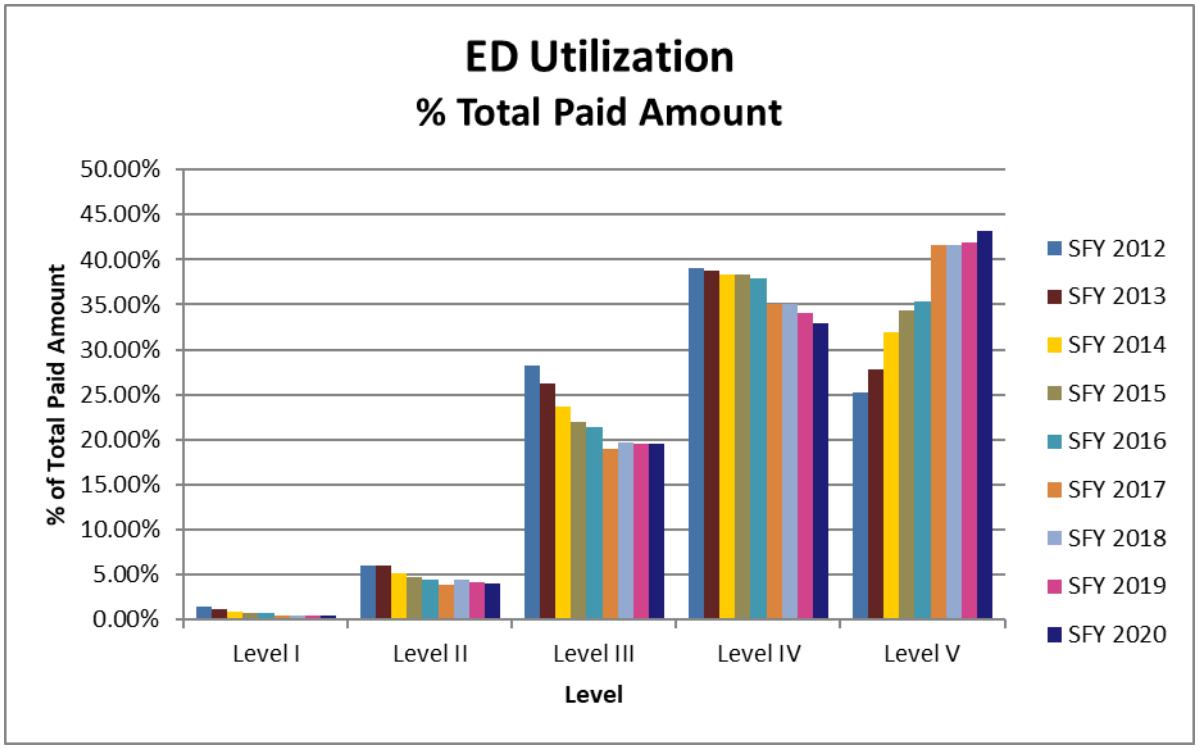


The nine-year trend (shown above in Figure 1) shows a reduction of lower level ED visits (Levels I, II, and III) and a shift towards Level IV and V visits. The Level V visit count has decreased slightly over the last several years through SFY 2018, SFY 2019 and SFY 2020. It's important to note that while volume of Level V visits decreased slightly from SFY 2019 - SFY 2020, it increased as a percentage of total visits to 21.2%. This means the distribution of visits has changed over time with a higher percentage of visits in Level V and less in Level 1.

As with the number of visits, the nine-year trend for payments (shown in Figure 2 below) shows a decreasing percentage of payments related to lower level visits. In SFY 2020, a clear majority of the total amount paid falls within Levels IV and V. These levels make up $415 million, or 76%, of total amount paid in SFY 2020. This is very similar to SFY 2019, where they also made up 76%. Meanwhile, the percentage of total paid for Levels I and II is 3.0 percentage points below the percentage paid in SFY 2012, while the percentage of total paid for Level V has increased by almost 18 percentage points over the time 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 2012-2020



The Public Health Emergency (PHE) that began in early 2020 with the outbreak of COVID-19 has had an impact on industries across the board, particularly on the healthcare industry. This report includes data from SFY 2020, which captures the first four months of the PHE. As such, the total impact of COVID-19 will need to be evaluated over time.

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 AHCCCS's aggressive efforts to ensure appropriate ED utilization: incentive payments, 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 in the most appropriate and least restrictive settings. AHCCCS began the integration focusing on targeted populations within the Medicaid system and continued with the implementation of the AHCCCS Complete Care (ACC) plan which integrated 1.5 million members' physical and behavioral health services. AHCCCS has taken a strategic and methodical approach over the last decade to achieve this integrated administration and continues to integrate when appropriate for the system. 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 contractors identify High Need/High Cost members and 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 the MCOs to ensure that these members are redirected to primary and specialty physical health providers and behavioral health providers, when appropriate.

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. Such evaluations led to the establishment of a separate fee schedule for Emergency Medical Services providers (Treat and Refer) and a separate fee schedule for hospital based free standing emergency departments which reimburse less than the Outpatient Hospital Fee Schedule for Levels I-III.

The AHCCCS Administration highlights other efforts that AHCCCS, its contracted MCOs, and providers have undertaken in order to reduce inappropriate use of the ED, some of which have been highlighted in previous reports. Some initiatives are described below:

- The American Indian Medical Home (AIMH) program helps address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination. By enrolling in an AIMH, American Indian Health Program (AIHP) members are able to receive Primary Care Case Management, diabetes education, care coordination, and 24-hour access to their care team. By having anytime access to a care team, members are able to be appropriately triaged and assessed as to whether an ED visit is warranted. This care delivery model helps support members in learning to manage and organize their own health care. There are currently seven AIMHs across the state, with approximately 26.7% of AIHP members empaneled with an AIMH.
- Arizona Complete Health – Complete Care Plan (AZCH-CCP) has a number of programs designed to reduce the unnecessary ED utilization for its AHCCCS Complete Care (ACC) and Regional Behavioral Health (RBHA) lines of business. These programs include its Teladoc program, which provides members with 24/7 direct access to a provider. Members can call Teladoc directly or can be referred through the Nurse Advice Line, where a nurse performs an assessment and determines if a Teladoc visit is appropriate and offers the member this opportunity. This service was deployed in May 2019 and was designed to resolve health issues through a Teladoc provider rather than an ED visit.

AZCH-CCP noted that while overall ED visits have increased since 2019 for their health plan, preventable ED visits have decreased.

- Molina Healthcare reviews daily crisis contact reports received from the state's crisis response provider and crisis stabilization providers. Molina's care management staff follow up on all crisis notifications to ensure members are connected to needed services. For those members who have been identified as high risk or needing a higher level of care, a Molina Healthcare clinical team will initiate a follow up call to further explore cause of crisis, develop follow up intervention, and identify necessary services/supports to prevent a crisis from reoccurring. Molina Healthcare works closely with crisis stabilization units to identify members who have frequent admits, assisting with discharge planning to reduce the chance of another crisis episode. Preventing the reoccurrence of crisis episodes decreases member ED utilization, as problems are identified and treated before they can escalate to an ED visit.
- Health Choice Arizona, which serves the most sparsely populated area in the state, and an area with a high prevalence of tribal reservations, indicates their strategy for preventing unnecessary ED utilization is the development of Crisis Observation and Stabilization Centers. These Centers provide specialized short-term stabilization and serve as Behavioral Health Emergency Rooms for people in crisis and allow appropriate diversion from jail, EDs, and inpatient facilities. Health Choice Arizona notes these specialized crisis services have been well received by local first responders, hospitals, and Justice System partners and provide a more calm, appropriate, and specialized environment for someone experiencing a behavioral health crisis. Observation and Stabilization services divert people from hospital EDs and jails, and overall reduce the cost of community services and supports. In addition, Health Choice Arizona has also developed Substance Abuse Stabilization Facilities in smaller towns that border Tribal Nations. These facilities, known as (social model) detox facilities or safe shelters, provide a safe and supportive environment for an individual to recover from the effects of substance use. These facilities currently serve three towns in their service area.
- Banner University Family Care, in partnership with Banner Urgent Care Services and community behavioral health providers developed a pilot program to enhance the provision of complete care services for individuals with comorbid behavioral health and physical health conditions that present to EDs with symptoms of behavioral health or medical urgent needs. The program targets overutilization of Emergency Departments, other crisis settings and psychiatric as well as physical health hospitals. The goal of this pilot was to make urgent care services more accessible to individuals with such comorbidities and achieve higher quality, more cost effective, efficient, community based and person-centered care that reduces overutilization of EDs and other crisis settings. Strategies used include:
    - Coordination with and education to community behavioral health providers to help facilitate appropriate referrals to Banner Urgent Care Services.
    - Specialized training for providers and support staff in the selected Banner Urgent Care Services locations to increase competency and comfort level in meeting the behavioral health needs of members.

- Access to behavioral health consultation.
- Expedited coordination between Banner University Family Care, Banner Urgent Care Services, and community behavioral health providers to obtain information related to a member's diagnosis, treatment and support care and follow up services.

- AHCCCS' Targeted Investment Program, which provides incentives for AHCCCS providers to develop systems of integrated care, has a number of initiatives including:
  - Participating program providers must receive admission/discharge/transfer alerts from hospitals including emergency departments through the health information exchange, Health Current. This enables primary care and/or behavioral health providers to follow up with members at high risk of readmission. The recent years of TI reinforced these efforts through performance-measure-based incentives for Hospital, primary care physician (PCP) and behavioral health (BH) participants to increase follow-up after hospitalization within 7 and 30 days to decrease ED utilization and rehospitalization.
  - Participating hospitals connect with the patient's community behavioral health provider or PCP regarding the patient's behavioral and medical health history upon admission to help ensure the member's needs are met without requiring readmission.
  - Participating behavioral health practices identify physical health conditions and connect members to primary care services. This has resulted in members with frequent ED utilization transitioning to primary care and reducing or eliminating ED utilization. This effort was reinforced through TI performance-measure-based incentives for PCP and BH participants. Incentivizing coordination of medical screenings for members with exacerbating behavioral health needs decreases ED utilization by addressing underlying conditions before they become emergent.
  - Participating co-located justice clinics identify justice-involved individuals with high-risk physical or behavioral health conditions and connect members to services. This has resulted in members with frequent ED utilization transitioning to preventative primary care and reducing or eliminating ED utilization. This focus was refined for members with substance use conditions in the recent years of TI, where performance-measure-based incentives require Justice clinic providers to initiate and continue engaging referred members for alcohol and other drug abuse dependence treatment. These services directly reduce the number of ED visits which are common among individuals with substance use disorder and other behavioral health conditions.
  - All TI provider organizations are incentivized to participate in the TI Program Quality Improvement Collaborative (TIPQIC). In association with ASU, TI providers share best practices and are supported to perform root cause

analysis to achieve improved results on the coordination processes described in the bullet points above.

CONCLUSION

Since SFY 2014, the percentage of Levels I-III ED visits has fallen by over six percentage points, demonstrating, in part, the continued success of AHCCCS, its MCOs, and AHCCCS providers. Overall, AHCCCS members demonstrate a relatively low rate of non-emergency ED utilization, at less than 20% of all ED visits (based on Level I-II utilization, some of which may be true emergencies as noted previously). Despite the low percentage of Level I and Level II ED utilization, AHCCCS continues to work with its contracted MCOs, hospitals, and other providers to further reduce ED utilization for non-emergency care.

APPENDIX A

Top ten diagnoses for each visit level (categorized by volume)

Level I

- Acute upper respiratory infection, unspecified
- Encounter for issue of repeat prescription
- Procedure/treatment not carried out due to patient leaving prior to being seen by health care provider
- Encounter for removal of sutures
- Unspecified injury of head, initial encounter
- Viral infection, unspecified
- Cough
- Unspecified abdominal pain
- Toxic effect of venom of scorpion, accidental (unintentional), initial encounter
- Rash and other nonspecific skin eruption

Level II

- Acute upper respiratory infection, unspecified
- Other specified disorders of teeth and supporting structures
- Acute pharyngitis, unspecified
- Viral infection, unspecified
- Otitis media, unspecified, right ear
- Periapical abscess without sinus
- Streptococcal pharyngitis
- Rash and other nonspecific skin eruption
- Otitis media, unspecified, left ear
- Acute obstructive laryngitis [croup]

Level III

- Acute upper respiratory infection, unspecified
- Flu due to other identified influenza virus with other respiratory manifestations
- Viral infection, unspecified
- Urinary tract infection, site not specified
- Acute pharyngitis, unspecified
- Streptococcal pharyngitis
- Fever, unspecified
- Headache

- Cough
- Low back pain

Level IV

- Unspecified abdominal pain
- Headache
- Urinary tract infection, site not specified
- Acute upper respiratory infection, unspecified
- Nausea with vomiting, unspecified
- Constipation, unspecified
- Epigastric pain
- Alcohol abuse with intoxication, unspecified
- Other chest pain
- Noninfective gastroenteritis and colitis, unspecified

Level V

- Other chest pain
- Chest pain, unspecified
- Suicidal ideations
- Unspecified abdominal pain
- Urinary tract infection, site not specified
- Alcohol abuse with intoxication, unspecified
- Syncope and collapse
- Pneumonia, unspecified organism
- Headache
- Epigastric pain