December 1, 2018

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

Matt Gress, Director
Governor's Office of Strategic Planning and Budgeting
1700 West Washington Street, 6th Floor
Phoenix, Arizona 85007

Dear Mr. Stavneak and Mr. Gress:

Pursuant to A. R. S. §36-2903.11, please find enclosed the 2018 AHCCCS Report on Emergency Department Utilization. Please feel free to contact me if you have any questions about this report.

Sincerely,

Jami Snyder
Deputy Director

cc: Christina Corieri, Governor's Office, Senior Policy Advisor

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 2018

Director, Tom Betlach

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, 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 (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 typically emergency related. Generally 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 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/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) 2012-2017 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 Medicaid restoration and expansion.

Table 1: AHCCCS ED Utilization – SFYs 2012-2017

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%**

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]

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[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 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 2012-2017**
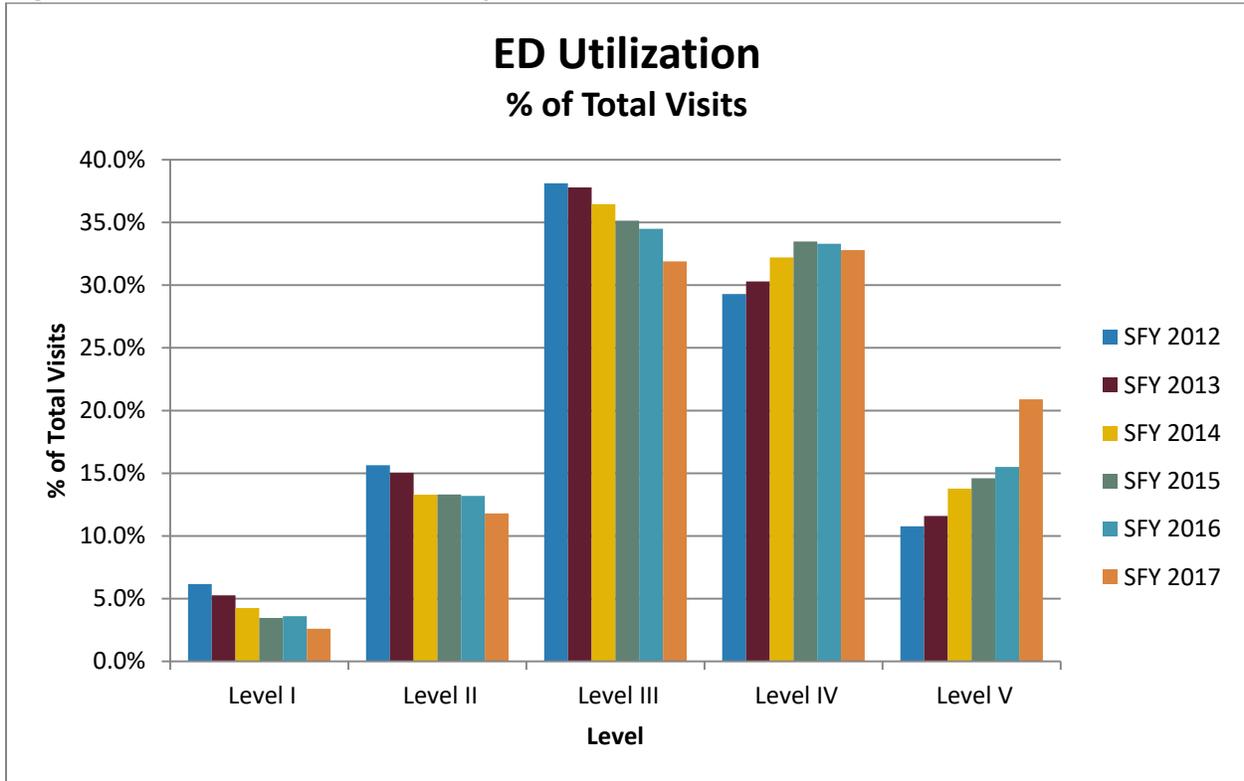
The six-year trend (shown above in Figure 1) shows a reduction of lower level ED visits (Levels I, II, and III) and a shift towards Level V visits.

As with the number of visits, the six-year trend for payments (shown in Figure 2 below) shows a decreasing percentage of payments are being spent on lower Level visits. In SFY 2017, the vast majority of the total amount paid ($446 million or 77%) falls within Levels IV and V. The percentage of total paid for Levels I-II visits is 3 percentage points below the percentage paid five years prior, while the percentage of total paid for Level V has increased by more than 12 percentage points over this five year period.

From SFY 2016 to SFY 2017, Level V visits increased by 68,084 visits, or 39%. Of that amount, 61,385, or 90%, were attributable to Banner hospitals. According to Banner Health, they adopted new software in March 2016 which assigns the charge code Level based on the hospital resources that were used to treat the ED patient instead of the acuity of the actual diagnosis. In SFY 2017, Banner Health hospitals accounted for 51% of Level V ED visits but only 30% of all AHCCCS ED visits.

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

Figure 2: AHCCCS ED Utilization by Paid Amount for SFYs 2012-2017
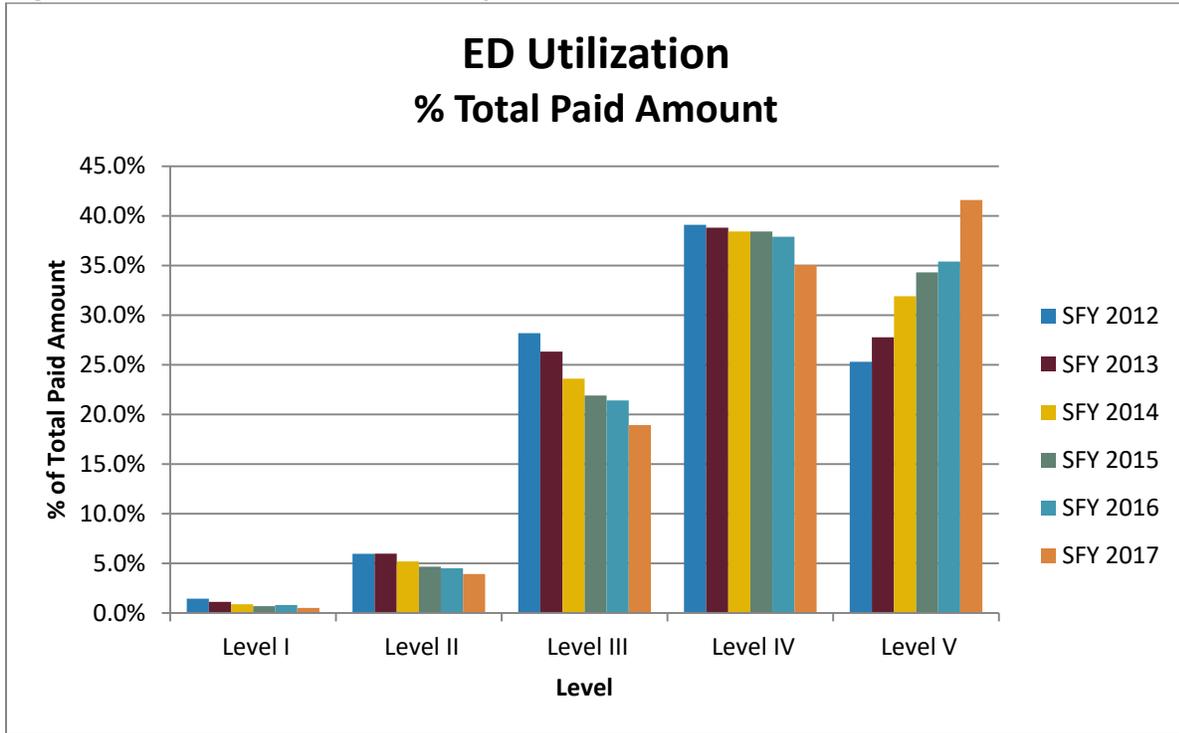
AHCCCS continues to drive innovation in the health care system to improve the delivery of care, improve the health of populations, and curb the upward trajectory of per capita spending. In particular, three recent initiatives have components which continue AHCCCS's aggressive efforts to ensure appropriate 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. Effective October 1, 2013, all physical and behavioral health services were integrated under one health plan for children with children's rehabilitative services (CRS) qualifying diagnoses. 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 behavioral health and substance abuse services, along with their physical health services, from an integrated plan. On October 1, 2018, AHCCCS integrated approximately 1.5 million Acute Care Program adults and children (excluding children in foster care who are enrolled in the Comprehensive Medical and Dental Program) into an integrated plan for physical and behavioral health services. 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, 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 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.

In prior reports the AHCCCS Administration highlighted other efforts 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:

- At least twenty-six hospitals are currently participating in the Targeted Investment (TI) Program which provides incentives for AHCCCS providers to develop systems of integrated care. For members discharged from a hospital with a primary diagnosis of mental health, TI-participating hospitals must:
  - Make a direct connection to a community behavioral health provider to discuss the member's clinical and discharge disposition prior to discharge and to obtain input into the discharge planning process;
  - With input from the patient, schedule a follow-up appointment with the patient's community behavioral health provider to occur within seven days of discharge; and
  - Conduct a community-based, post-discharge medication review within 48 hours of discharge for members with complex medication regimens.
- Health Choice Integrated Care, a Regional Behavioral Health Authority (RBHA), has a program that identifies members who may be inappropriately utilizing an ED. Once identified in the program, the member is placed in a high needs/high cost program for focused outreach and case management. This outreach may come from a 'Healthcare Buddy' who provides regular calls to the member for assistance in accessing services from appropriate providers. In the first six months in contract year 2017, 256 members were identified for this program based upon their utilization. The number of members eligible based upon the same utilization criteria dropped by nearly 10% in the second six months of the year.

- United Health Care (an Acute Care Program MCO) has a hospital to home nurse program which completes an onsite visit with a member within two days of discharge to review the hospital's discharge instructions, reconcile new medications, facilitate follow up with the member's primary care practitioner (PCP) and specialist, and provide education on the members' needs and symptom management.
- Cenpatico Integrated Care (a RBHA) monitors members in an ED to ensure they are transitioned to a community placement as soon as possible; it trains local hospitals to contact their nursing call line when a member is in the ED. The call line can then send a crisis mobile team to assess the appropriate placement of the member, and to reassess the member if necessary. The staff at the nursing line also reaches out to the ED every 3-4 hours to check the status of the member. At 16 hours, the health plan contacts the ED and the crisis team to discuss the current placement. The nursing line then sends alerts to the health plan about any members in the ED over 24 hours.
- Health Net Access' (an Acute Care Program MCO) quality management program monitors for members leaving the inpatient and ED settings against medical advice. These events are referred to case management and behavioral health departments for follow up and intervention. If the same member has 2 or more events, their PCP is notified. The health plan also identifies the top 1% of ED utilizers and places them into a case management program.

CONCLUSION

Since SFY 2012, the percentage of Levels I-III ED visits has fallen by 8.6 percentage points, demonstrating, in part, the continued success of AHCCCS, its MCOs, and AHCCCS providers. From SFY 2016 to SFY 2017, some of the reduction in Levels I-IV visits were driven by a change in coding methodology by Banner Health hospitals which account for 30% of all Arizona AHCCCS ED visits. AHCCCS is looking further into the Banner ED visit data.

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

https://www.acep.org/administration/reimbursement/ed-facility-level-coding-guidelines/

https://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 infection
- Encounter for issue of repeat prescription
- Encounter for removal of sutures
- Procedure/treatment not carried out due to patient leaving prior to being seen by health care provider
- Unspecified injury of head, initial encounter
- Fever
- Cough
- Rash and other nonspecific skin eruption
- Viral infection
- Unspecified abdominal Pain

Level II
- Acute upper respiratory infection
- Other specified disorders of teeth and supporting structures
- Acute pharyngitis
- Otitis media, right ear
- Dental caries
- Rash and other nonspecific skin eruption
- Periapical abscess without sinus
- Otitis media, left ear
- Fever
- Laceration without foreign body of other part of the head, initial encounter

Level III
- Acute upper respiratory infection
- Acute pharyngitis
- Urinary tract infection
- Low back pain
- Headache
- Fever
- Streptococcal pharyngitis
- Viral infection
- Cough
- Acute bronchitis

Level IV
- Abdominal pain
- Headache
- Urinary tract infection
- Acute upper respiratory infection
- Nausea with vomiting
- Constipation
- Noninfective gastroenteritis and colitis
- Epigastric pain
- Asthma, with (acute) exacerbation
- Low back pain

Level V
- Chest pain, unspecified
- Other chest pain
- Abdominal pain
- Suicidal ideations
- Urinary tract infection
- Epigastric pain
- Syncope and collapse
- Headache
- Alcohol abuse with intoxication
- Asthma, unspecified, with (acute) exacerbation