

December 7, 2020

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 2020 AHCCCS Report on Emergency Department Utilization. Please feel free to contact me if you have any questions about this report.

Sincerely,



Jami Snyder
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 2020

Director, Jami Snyder

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 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:

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, 2020).

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, 2020).

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<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 just 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) 2012-2019 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. From SFY 2018 to SFY 2019, ED visits decreased by 4.5%, and payments increased by 1.5%. SFY 2018 was the first year since expansion in which ED visits and payments decreased, and the trend continued for ED visits into SFY 2019. The increase in SFY 2019 payments can be attributed to three new level one trauma centers which received a higher reimbursement rate for level three, four and five visits for those hospitals.

Table 1: AHCCCS ED Utilization – SFYs 2012-2019

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%

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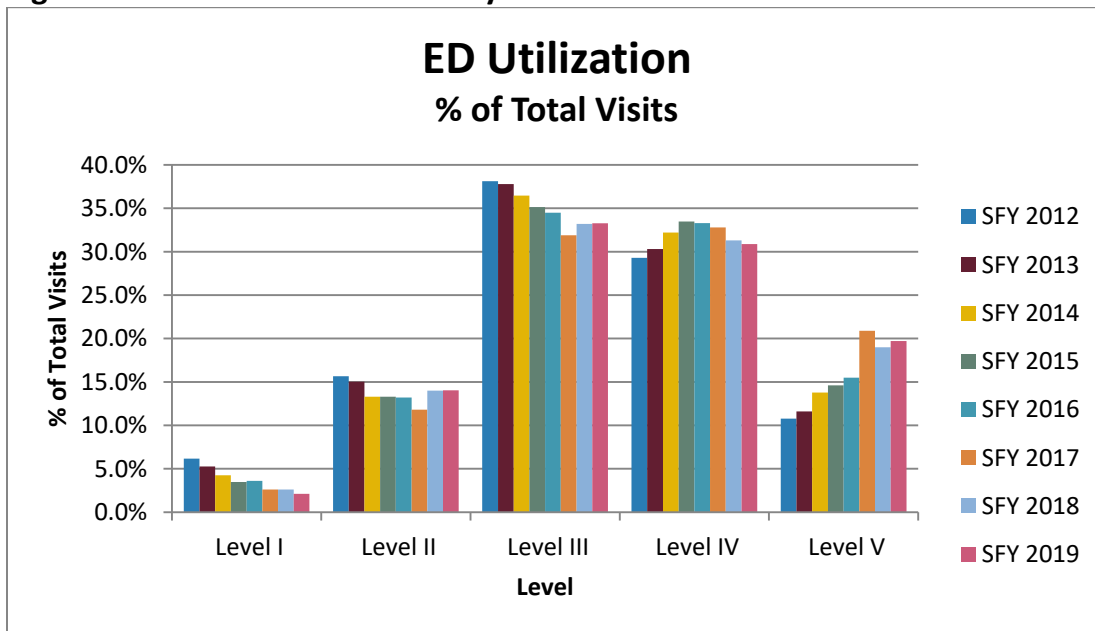
SFY 2014				
Level I	37,270	4.3%	\$3,472,834	0.9%
Level II	116,455	13.3%	\$20,509,576	5.2%
Level III	319,294	36.5%	\$93,194,912	23.6%
Level IV	282,037	32.2%	\$151,789,518	38.4%
Level V	120,654	13.8%	\$125,991,580	31.9%
Overall- Summary	875,710	100.0%	\$394,958,419	100.0%
SFY 2015				
Level I	36,964	3.5%	\$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%

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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%

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

Figure 1: AHCCCS ED Utilization by Level for SFYs 2012-2019⁴



The eight-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. Level V visits were observed to increase by 39% in SFY 2017, which was attributable to the adoption of new coding software by a health system.

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.

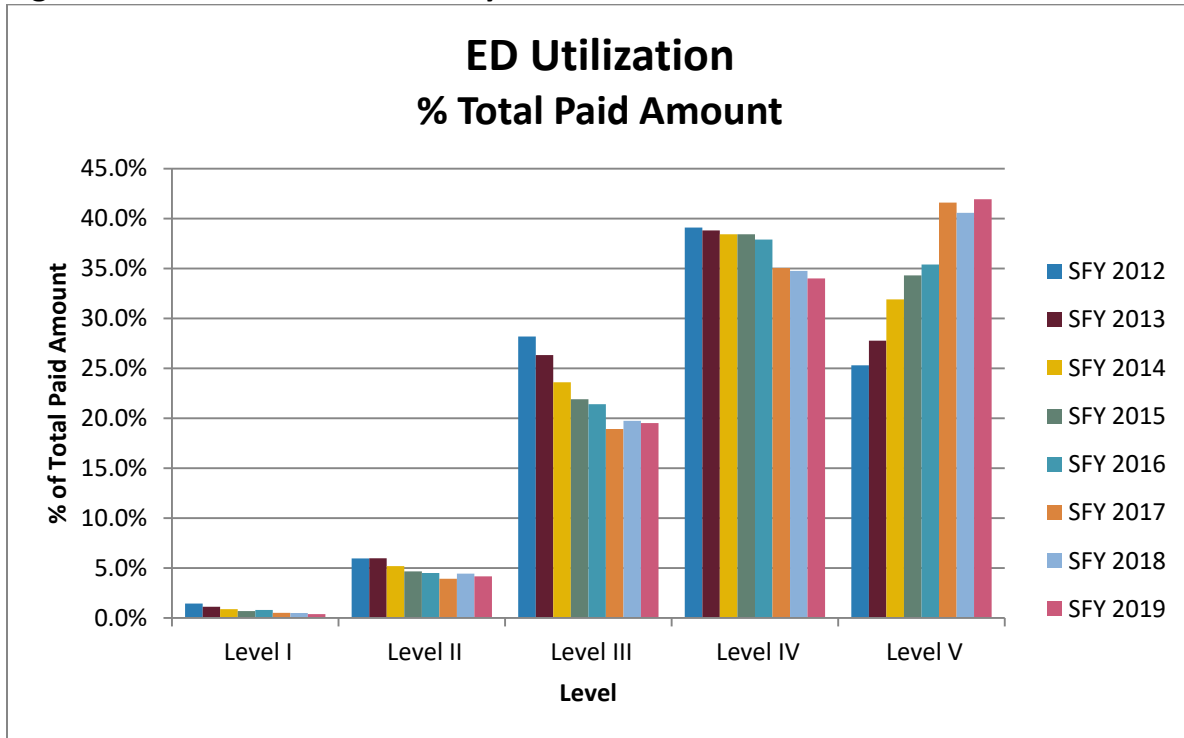
⁴ From SFY 2016 to SFY 2017, Level V visits increased by 68,084 visits, or 39%. Of that amount, 61,385, or 90%, were attributable to Banner hospitals. According to Banner Health, they adopted new software in March 2016 which assigns the charge code Level based on the hospital resources that were used 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.

Level V visits decreased slightly in SFY 2018 and SFY 2019. It’s important to note that while volume of Level V visits decreased slightly from SFY 2018 - SFY 2019, it increased as a percentage of total visits to 19.7%, meaning it still made up a larger share of visits than the previous year.

As with the number of visits, the eight-year trend for payments (shown in Figure 2 below) shows a decreasing percentage of payments are being spent on lower level visits. In SFY 2019, a clear majority of the total amount paid falls within Levels IV and V. These levels make up \$439 million, or 76%, of total amount paid in SFY 2019. This is very similar to SFY 2018, where they made up 77%. Meanwhile, the percentage of total paid for Levels I and II is 2.8 percentage points below the percentage paid in SFY 2012, while the percentage of total paid for Level V has increased by more than 16 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 2012-2019



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.

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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 AHCCCS Complete Care (ACC) plan for physical and behavioral health services. Arizona Long Term Care Services (ALTCS) Division of Developmental Disabilities (DDD) members became part of an integrated plan on October 1, 2019. 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. 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.

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 initiatives are described below:

- AHCCCS' 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 members are able to receive Primary Care Case Management, diabetes education, care coordination, and 24 hour access to their care team. By having anytime

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- 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.
- Arizona Complete Health (AzCH), an ACC plan and RBHA, has developed several strategies involving different departments to reduce hospital ED utilization. AzCH identifies top ED utilizers for outreach by its Care Management staff who are mailed a letter or receive calls that address ED alternatives such as local urgent care facilities. AzCH also develops a plan of care for the member in collaboration with the member and their treatment team that includes a focus on reducing ED utilization. At an organizational level, AzCH's Medical Management Committee meets twice each year to review ED utilization rates, reviews high utilizing members, and examines members who visited EDs but had prior gaps in care such as missed prescriptions.
 - United Healthcare Community Plan (United) receives daily admission, discharge and ED information from 31 Arizona hospitals who conduct outreach to determine if the visit was emergent or non-emergent. Their goal is to re-engage the member into primary care within 7 days of the ED visit at least 60% of the time. When high volume users are identified, specific outreach measures are taken. United meets regularly with each hospital and shares a report showing the likelihood of an admission to Observation or IP once a member presents at an ED. This allows them to show the hospital how they compare to other county, state, regional US facilities in their propensity to admit members to the ED and help develop initiatives to reduce ED usage. Second, the data allows them to analyze the causes of ED volume by facility and diagnosis.
 - Care1st conducts a variety of member level interventions, such as post discharge follow up calls to ensure their discharge planning needs have been met, identification of members with high ED utilization or high overall costs, and targeting them for care management. Provider interventions include a new payment model that includes care management fees and performance based payments that achieve quality and utilization outcomes, contracting with urgent care centers and partnering with non-governmental organizations to focus on appropriate ED alternatives and support services.
 - Mercy Care also focuses on member and provider-based initiatives to identify and reduce unnecessary emergency department utilization. Examples include identifying and coaching members through a review of member utilization patterns including ER and pharmacy use, and identifying and coaching physician groups with high panel use of the ER. For members in Patient Centered Medical Homes, using report cards to review and share utilization data specific to members receiving services in the Home that includes the level of severity of the services provided, and having providers discuss with members the reasons for ER utilization and provide guidance on appropriate use of service locations.
 - 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

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readmission. The final years of TI reinforced these efforts through performance-measure-based incentives for hospital, PCP and behavioral health 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 behavioral health participants, most of whom were required to increase the rate of diabetic screening for metabolic monitoring of patients on antipsychotic medications. 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 final years of TI, where performance-measure-based incentives require Justice participants to initiate and continue engaging referred members for alcohol and other drug abuse dependence treatment. These services directly reduce the number of ED visits common among individuals with substance use disorder and other behavioral health conditions.

CONCLUSION

Since SFY 2014, the percentage of Levels I-III ED visits has fallen by almost five 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, particularly when compared to national averages, 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 improper ED utilization, AHCCCS continues to work with its contracted MCOs, hospitals, and other providers to further reduce ED utilization for non-emergency use.

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
- 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
- Viral infection, unspecified
- Rash and other nonspecific skin eruption
- Fever, unspecified
- Toxic effect of venom of scorpion, accidental (unintentional), initial encounter
- Unspecified abdominal pain

Level II

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

Level III

- Acute upper respiratory infection, unspecified
- Urinary tract infection, site not specified
- Acute pharyngitis, unspecified
- Viral infection, unspecified
- Streptococcal pharyngitis
- Headache
- Fever, unspecified
- Low back pain

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- Cough
- Vomiting, unspecified

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
- Noninfective gastroenteritis and colitis, unspecified
- Other chest pain
- Chest pain, unspecified

Level V

- Other chest pain
- Chest pain, unspecified
- Suicidal ideations
- Unspecified abdominal pain
- Urinary tract infection, site not specified
- Syncope and collapse
- Alcohol abuse with intoxication, unspecified
- Epigastric pain
- Asthma, unspecified, with (acute) exacerbation
- Major depressive disorder, single episode, unspecified