Katie Hobbs, Governor
Carmen Heredia, AHCCCS Cabinet Executive Officer
and Executive Deputy Director

November 30, 2023

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

Sarah Brown, Director
Governor's Office of Strategic Planning and Budgeting
1700 W. Washington
Phoenix, AZ 85007

Dear Mr. Stavneak, and Ms. Brown:

Pursuant to A.R.S. §36-2903.11, please find enclosed the 2023 AHCCCS Report on Emergency Department Utilization. Please feel free to contact me if you have any questions about this report.
Sincerely,

Sincerely,

Carmen Heredia
Cabinet Executive Officer
and Executive Deputy Director

cc: Jennifer Loredo, Director of Policy, Legislative and Intergovernmental Affairs, Governor's Office
Zaida Dedolph Piecoro, Health Policy Advisor, Office of 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 2023

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 (PCP) in an office or an urgent care center if an individual is able to obtain timely services.

The American College of Emergency Physicians (ACEP) 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 2022).

[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 2023).

reducers such as aspirin and ibuprofen), and medical conditions requiring prescription drug management. Please refer to the ACEP website 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 circumstances such as the 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 two-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 maybe 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) 2013-2022 that are classified as Levels I-V, as well as the paid amount associated with those visits. Total ED visits were determined by the procedure codes that correspond with the five levels of severity. 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 2021. From SFY 2018 to SFY 2021, ED visits decreased by 22.8%, and payments decreased by 6.3%. The continued decline in SFY 2020 and SFY 2021 is believed to be attributable to the COVID-19 pandemic. From SFY 2021 to SFY2022, ED visits reversed the recent trend with visits increasing by 22.1% and payments increasing by 16.3%. The large increase in SFY 2022 ED visits appears to align with the return to normal operations and the increase in AHCCCS membership as a result of the Public Health Emergency (PHE).

Table 1: AHCCCS ED Utilization – SFYs 2013-2021

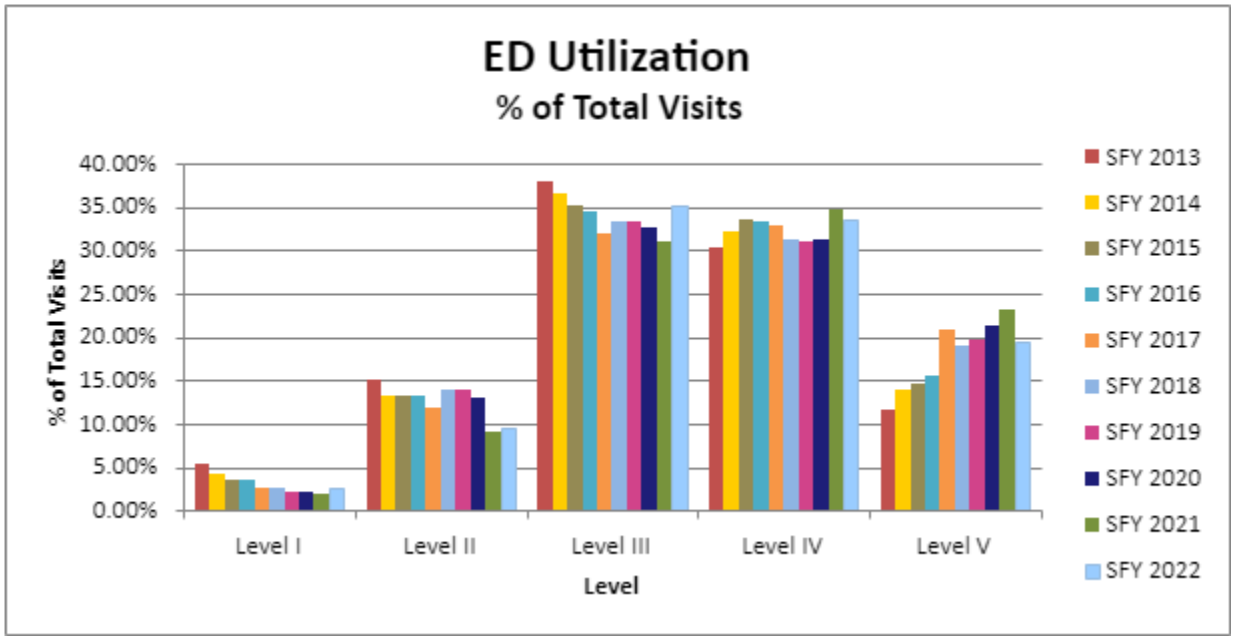
Visit Level	# Visits	% Total Visits	Paid Amount	% Paid Amount
SFY 2013				
Level I	43,732	5.3%	$3,911,371	1.1%
Level II	124,721	15.0%	$20,735,580	6.0%
Level III	313,562	37.8%	$91,417,985	26.3%
Level IV	251,398	30.3%	$134,740,191	38.8%
Level V	96,221	11.6%	$96,387,515	27.8%
Overall- Summary	**829,634**	**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%**

Visit Level	# Visits	% Total Visits	Paid Amount	% Paid Amount
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%**
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%**
SFY 2021				
Level I	17,502	2.0%	$2,159,423	0.4%
Level II	77,985	9.0%	$15,546,205	2.9%
Level III	269,130	31.1%	$92,116,214	17.3%
Level IV	301,202	34.8%	$185,073,847	34.7%
Level V	200,641	23.2%	$238,876,135	44.8%
Overall-Summary	**866,460**	**100.0%**	**$533,771,824**	**100.0%**

SFY 2022				
Visit Level	**# Visits**	**% Total Visits**	**Paid Amount**	**% Paid Amount**
Level I	26,693	2.5%	$3,362,381	0.5%
Level II	101,082	9.6%	$20,477,606	3.3%
Level III	370,850	35.1%	$132,008,160	21.3%
Level IV	353,812	33.4%	$216,378,656	34.9%
Level V	205,558	19.4%	$248,489,816	40.0%
Overall-Summary	**1,057,995**	**100.0%**	**$620,716,619**	**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 2013-2022



The 10-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 2019, SFY 2020, and SFY 2021.

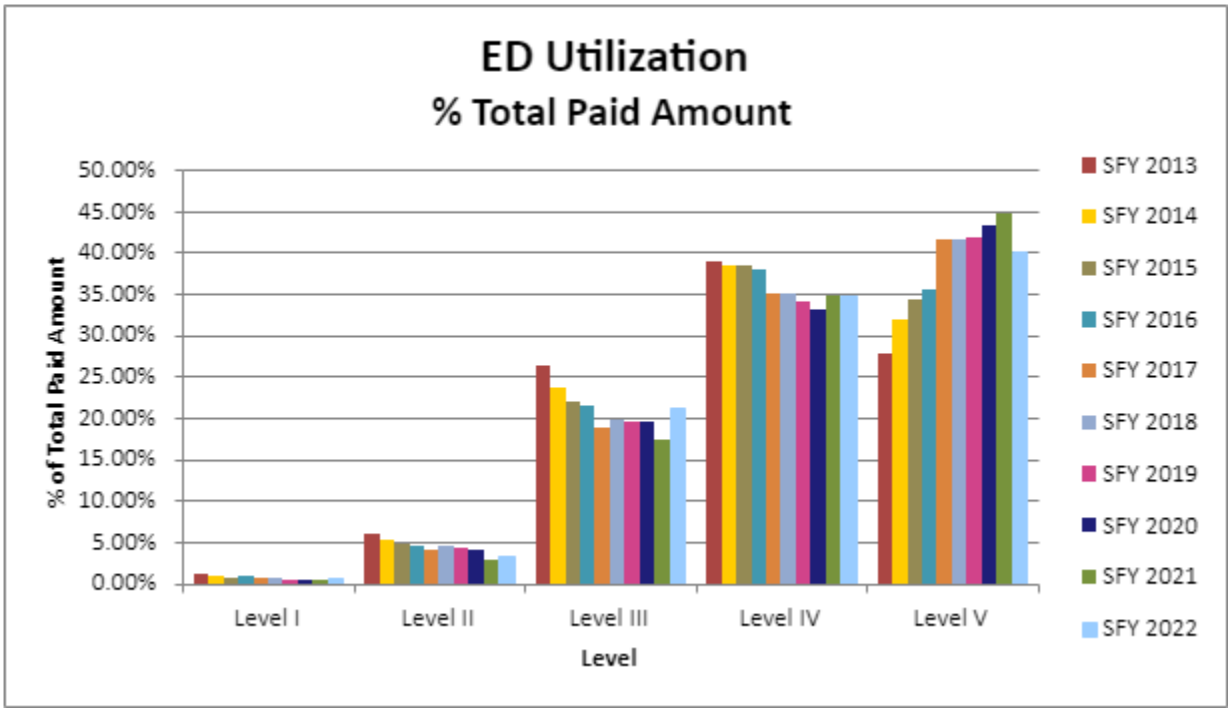
[3] An ED visit that results in an inpatient admission is not captured in AHCCCS data as an ED visit; the ED services are paid as part of the inpatient stay. If AHCCCS were able to capture such data, this would result in a higher percentage of Levels III-V ED visits and a lower percentage of Level I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

It's important to note that while volume of Level V visits decreased slightly from SFY 2020 - SFY 2021, it increased as a percentage of total visits to 23.2%. This means the distribution of visits had changed over time, with a higher percentage of visits in Level V and less in Level 1. However, in SFY 2022 this these trends reversed, with the Level V visit count increasing slightly and the percentage of visits in Level V decreasing to 19.4%. Level I visits comprised of 2.5% of the total visits. In SFY 2022, Level III visits represented the highest increase in visits from SFY 2021, and the highest percentage of total visits. Over the 10-year period since SFY 2013, Level I and II visits as a percentage of total visits has decreased by over 8 percentage points. Conversely, the Level V percentage of total visits has increased by almost 8 percentage points over the time period.

As with the number of visits, the 10-year trend for payments (shown in Figure 2 below) shows a decreasing percentage of payments related to lower level visits. In SFY 2021 and SFY 2022, a clear majority of the total amount paid falls within Levels IV and V. These levels make up $424 million, or 79%, of total amount paid in SFY 2021, and $465 million, or 75%, of total amount paid in SFY 2022. Meanwhile, the percentage of total paid in SFY 2022 for Levels I and II is 3.3 percentage points below the percentage paid in SFY 2013, while the percentage of total paid for Level V has increased by 12 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 2013-2022



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

The Public Health Emergency (PHE) that began in early 2020 with the outbreak of COVID-19 and ended in May 2023 has had an impact on industries across the board, particularly on the health care industry. This report includes data from SFY 2020 through SFY 2022, which capture the first two and half years of the pandemic. It is noted that COVID-19 is one of the top 10 diagnoses on each level for SFY2022, as is displayed 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 initiatives have components which continue AHCCCS' 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 appropriateness.

AHCCCS 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 Managed Care Organizations (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 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

The 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 can 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 can 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 eight AIMHs across the state, with approximately 28% of AIHP members empaneled with an AIMH.

Molina Healthcare (Molina)

Molina offers a 24/7 Nurse Advice Line as a resource for assisting members with a wide variety of healthcare and service needs. The Nurse Advice Line staff, who are all registered nurses, help members choose appropriate psychosocial, medical, and behavioral services, find a physician or hospital in their community, understand treatment and covered services options, achieve a healthy lifestyle, or answer medication questions. The Nurse Advice Line reinforces health education about appropriate emergency room use and helps members understand the resources and services available and how to access them.

All contracted Molina Healthcare providers must provide coverage 24-hours a day 7-days a week. Regular hours of operation must be clearly defined and communicated to the members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by Molina Healthcare. The after-hours coverage must be accessible using the medical office's daytime telephone number and the call must be returned within 30 minutes of the initial contact. Conformance to these provisions is monitored through Molina's Quality Improvement Committee by conducting the following activities:

- Ensuring an appropriate number of and access to urgent cares and crisis providers including: Psychiatric hospitals, substance use and mental health residential treatment centers, crisis stabilization units,
- Provider monitoring and compliance through on-site visits,
- Conducting secret shopper phone calls,
- Monitoring member complaints,
- Evaluation of appeals & grievances, and
- Ongoing provider education on polices and expectations by provider relation liaisons.

Molina Healthcare Services hosts weekly case rounds utilizing an interdisciplinary team approach to review and develop comprehensive service plans individualized to a member's medical, psychosocial, and situational needs. The interdisciplinary team reviews the effectiveness of prior interventions, present and potential barriers in the construction of appropriate interventions to optimize the health and well-being of the member which embrace quality care and cost-effective approaches. Identified service gaps will be evaluated with Molina Healthcare's Provider Network Team along with review of contracted service array. If a service is not available, expansion opportunities will be explored.

Blue Cross/Blue Shield Arizona Health Choice Arizona (BCBSAZ Health Choice)

BCBSAZ Health Choice also requires each primary care and specialist provider to have call availability 24 hours per day, 7 days per week and to arrange after-hours care and vacation coverage. It encourages providers to communicate appropriate urgent care availability as part of their after-hours answering service messaging. Additionally, as part of the credentialing application, providers are specifically required to list providers who share on-call responsibilities with them in their absence. BCBSAZ Provider Service Representatives educate providers and offer alternative levels of care to help decrease avoidable ED utilization. Many of their PCPs and OB/GYN providers offer extended hours and weekend appointments to allow for more access to care. PCPs and specialists are also contractually required to maintain availability within the appointment standards prescribed by AHCCCS which includes same-day care appointments. This is monitored and reported by their Network Services Department.

BCBSAZ Health Choice has established collaborative partnerships with first responders throughout their assigned region. These partnerships provide an opportunity to identify ways to further streamline and improve the delivery of integrated care. Two coordination efforts that have been established include 911 diversion and priority mobile team dispatching. The 911 diversion program has been established in four northern 911 communications centers and allows dispatchers to transfer behavioral health related calls to the crisis hotline, before initiating a law enforcement response. Should law enforcement respond to a situation and encounter an individual who is experiencing a behavioral health crisis, they can call the northern Arizona crisis hotline to request a mobile team. At law enforcement's request, a mobile team will be automatically dispatched to the scene to provide support. Both approaches: 911 diversion and automatic dispatching encourage first responders to utilize crisis services, before utilizing emergency departments.

The BCBSAZ Health Choice network of crisis stabilization units has been a key method in preventing unnecessary utilization of hospital emergency departments for members who may be experiencing a behavioral health crisis. Crisis stabilization units provide specialized short-term stabilization and allow appropriate diversion from jail, emergency departments, and inpatient facilities. Facility-based crisis services are well utilized by local first responders, hospitals, and other justice system partners, and divert the number of individuals who present to an emergency department.

In addition to crisis stabilization units, BCBSAZ Health Choice has also contracted with Substance Abuse Stabilization Facilities. These facilities, known as detox facilities or safe shelters, provide a safe and supportive environment for an individual to recover from the effects of substance use. Current locations include the towns of Page and Winslow.

Proactive identification of members with high emergency department utilization is key to reducing avoidable emergency department costs and improve member quality of care. BCBSAZ Health Choice has several care management and care coordination programs to assist in addressing emergency department utilization. The programs are designed to assist members with establishing outpatient care, to improve health literacy, and thus improve self-management. Care Managers outreach to both the member and their providers to ensure all involved parties are aware of the identified concerns. The Care Manager works with the team, which includes the member, in the development of a care

plan which supports the needs of the member, while reducing emergency department utilization and establishing quality care with the members' outpatient providers.

In February 2021, to support members living with SMI, BCBSAZ Health Choice launched a pilot project, later expanded to all adult members, as a partnership with Arizona-based Pyx Health. This is a scalable mobile technology platform that reduces loneliness and isolation. Members who engaged with the crisis system were the cohort initially enrolled. BCBSAZ Health Choice noted a 30% reduction in loneliness, a 40% decrease in depression, and 53% reported avoidance of emergency and/or crisis services. The Pyx Health team works with the BCBSAZ Health Choice Care Management program staff, to ensure a collaborative approach to member care and outreach regarding key service needs and initiatives. Pyx pivoted to work with all BCBSAZ Health Choice members with a special focus on pregnant members.

Mercy Care

Mercy Care has several initiatives to identify and reduce unnecessary emergency department utilization targeted at both members and providers. Examples include:

- Identifying and coaching physicians in integrated clinics with high panel use of the ED – they conduct quarterly analysis of all PCPs that includes utilization comparison to other PCPs in the same practice type. Mercy Care's medical directors work with physicians that perform over two standard deviations above the average to discuss specific individual patients that may be over-utilizing and offer education on how to better direct patients to or from the emergency department in the future. They discuss ways to use after-hours clinics, urgent care, office scheduling for non-emergent care, and appropriate emergency room utilization.
- 24-hour behavioral health crisis intervention is available 7 days per week and is staffed by clinicians who verify the member's safety, work to stabilize the situation, and identify appropriate care. The clinician may refer the member to outpatient services or facilitate immediate access to an emergency service provider. Members who present to an emergency room with behavioral issues are evaluated on-site to identify admission needs or divert to a lower level of care.
- Mercy Care's Emergency Department Hold Coordinator identifies members who remain in an emergency department but who are medically clear and works with internal and external stakeholders and providers to ensure a seamless transition to a higher level of care or as appropriate with wrap around services, discharge back to a community setting. Data is shared internally to analyze trends to better serve the system and individual members' needs. Care management referrals are made for members as clinically appropriate to address member needs and thereby potentially reducing emergency department utilization.
- Mercy Care identified and implemented value-based strategies to incentivize BH providers to increase appointment adherence to clinic prescribers to a standard of at least 70 percent, recognizing that routine check-ins with the members clinical team are a great mitigation to emergency department visits.
- Expansion of Behavioral Health Residential Facilities, Housing providers, and increased service capacity for intensive outpatient services, have all been identified and implemented to assist in the reduction of inpatient stays for members.
- Mercy Care's data dashboard identifies members with frequent inpatient stays, allowing for data

analysis and outreach to the members clinical team to discuss alternatives for engagement at lower levels of care.

Mercy Care plan has additional efforts to reduce the amount of time an individual is held in the emergency department through the following efforts:

- Providing training as needed to the State's crisis provider and their contracted hospital emergency department staff on the available services, and how to access the services.
- Working to establish alerts shared with staff to have a greater awareness of members who are presenting at emergency departments across the state. This will reduce the amount of time members are holding and ensure transition to the most clinically appropriate setting.
- Assessing the needs of members enrolled in their plan who have frequent interaction with law enforcement/public safety, crisis, and/or emergency departments. Police are trained through CIT (Crisis Intervention Team) Training to identify behavioral health crisis services that are available and can help to educate individuals, families/caregivers to get individuals to the most appropriate setting without delay.

Care1st

Like other plans, Care1st also monitors emergency department utilization to identify trends and address potential contributors to those trends. Emergency department utilization is frequently driven by changes in members' health status, potential problems with access to care, lack of knowledge about appropriate utilization, and more. Care1st's goal is to identify these issues and address them accordingly to achieve best outcomes for members and ensure that care is provided "at the right time" and "in the right place." To achieve this goal Care1st utilizes an array of interventions at the member, provider, and network levels. These include:

- Post Emergency Department visit phone calls, where the Care1st Care Management conducts proactive outreach manager calls (POM) for members recently discharged from emergency departments. These outreach calls serve as reminders to members to schedule follow-up appointments with their provider. If additional assistance is needed members may request Care Management support.
- Controlled Substance Monitoring Program, where Care1st engages in activities to monitor controlled and non-controlled medication use to ensure members receive clinically appropriate prescriptions. Their pharmacy department monitors pharmacy data, services utilization pattens, and individual needs to determine if there is a need for an exclusive pharmacy provider program.
- Post discharge follow-up calls, where Care1st Care Management calls all members upon discharge from a facility to ensure their discharge planning needs have been met. The care management staff performs a discharge screening tool that includes confirmation that items like durable medical equipment and oxygen where delivered, and follow up appointments were kept.
- Care management for high-risk pregnant members, where hospitals notify Care1st of emergency department visits by pregnant members who are seen in the emergency

department. Care1st's Maternity Care Team reaches out to these members as appropriate to address their needs in a timely manner, including enrollment in the plan's high risk prenatal care management program for continued follow up and support throughout their pregnancy. Members can also be referred to the High-Risk OB program through real-time referrals by Care1st staff, providers or their office staff, facilities, and the members themselves.

AHCCCS' Targeted Investment Program

The AHCCCS' Targeted Investments Programs, including the original program (TI 1.0) closing out this year and the renewed program (TI 2.0) that will continue through 2028, incentivizes AHCCCS providers to develop systems of integrated and highly coordinated care to improve the quality of life for AHCCCS members. The programs implement several strategies to reduce the utilization of high-cost and impersonal ED visits through participating outpatient clinics that are best suited to develop relationships and help patients manage their care, such as:

- TI 1.0 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 Primary Care Physicians 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.

- All participating program providers must receive admission/discharge/transfer alerts (ADT alerts) from hospitals, including emergency departments, through the health information exchange, Contexture. New Mental Illness ADT alerts, developed by Contexture in recent years, increase the providers' awareness when a part 2 Substance Use Disorder (SUD) or Behavioral Health condition is prevalent. This enables primary care and/or behavioral health providers to

follow up with members at high risk of readmission while ensuring protection of particularly sensitive health information. The final years of TI 1.0 reinforced the utility of these alerts by tying incentives to nationally-endorsed performance measures such as: quickly **following up with the patient after hospitalization for mental illness** and quickly **initiating and engaging the patient for SUD treatment after a related ED visit or similar event**. Hospital, PCP, and BH participants collaboratively improved coordination protocols to meet their targets and ultimately reduce ED utilization and rehospitalization.

- All participating provider organizations are incentivized to participate in the TI Program Quality Improvement Collaborative (TIPQIC). In partnership with ASU process improvement and data science experts, providers identify root causes of poor health outcomes related to the measures described above, explore process revisions to ameliorate them, and disseminate these best practices with their peers through documentation and discussion. These discussions increase collaboration amongst the provider community.

- All providers participating in TI 2.0 will develop closed-loop referral protocols to identify health-related social needs, refer to a community partner as appropriate, and confirm needed services were provided. Stable access to transportation may increase utilization of outpatient preventative services that significantly decrease ED utilization and emergency transportation. Access to stable housing reduces exposure to trauma-inducing weather, such as heat-related strokes and hypothermia. In addition to the range of health-related activities a family can focus on after securing their next meal, addressing food insecurity supports their growing and aging bodies to prevent ED visits related to pregnancy complications, malnourishment, and interpersonal violence.

- All providers participating in TI 2.0 will conduct population health analyses that identify common attributes of members inequitably experiencing poorer health outcomes. Providers will develop strategies to address these inequities such as: engaging and educating the underserved community, ensuring availability of culturally and linguistically appropriate services, and building relationships with individuals that typically go to the ED and urgent care centers to meet their acute needs.

- All TI 2.0 Justice clinics will engage incarcerated individuals to coordinate services and enrollment upon release from jail or prison. Health insurance coverage reduces the cost of all services rendered and increases the likelihood an individual will seek outpatient/ preventative services. Referrals and relationship-building prior to release decrease the likelihood of a member seeking preventative health services from an ED (e.g., an inhaler).

Behavioral Health (BH) Affinity Workgroup

The BH Affinity workgroup, initiated by CMS, conducted short-term process improvement studies with a few BH clinics, crisis-response providers, the Health Information Exchange, and health plans. The purpose was to evaluate and improve protocols for receiving, interpreting, and disseminating the alerts to care managers who would engage members before, or shortly after, discharge from the ED. To impact the outcome measure of follow up after ED visit for mental illness, the workgroup enlisted stakeholders to address identified challenges in receiving actionable data and operationalizing them in a variety of modalities.

CONCLUSION

Since SFY 2013, the percentage of Levels I – III ED visits have fallen by almost 11 percentage points, demonstrating, in part, the continued success of AHCCCS, the MCOs, and AHCCCS providers. Overall, AHCCCS members demonstrate a relatively low rate of non-emergency ED utilization, at 12% of all ED visits which account for only 3.8% of the cost 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) for SFY 2022

Level I

- Acute upper respiratory infection, unspecified
- Procedure/treatment not carried out due to patient leaving prior to being seen by health care provider
- Encounter for issue of repeat prescription
- 2019-NCOV acute respiratory disease (COVID-19)
- Unspecified injury of head, initial encounter
- Encounter for removal of sutures
- Fever, unspecified
- Toxic effect of venom of scorpion, accidental initial encounter
- Viral infection, unspecified
- Cough, unspecified

Level II

- Acute upper respiratory infection, unspecified
- 2019-NCOV acute respiratory disease (COVID-19
- Viral infection, unspecified
- Other specified disorders of teeth and supporting structures
- Rash and other nonspecific skin eruption
- Laceration w/out foreign body of other part of head, initial encounter
- Periapical abscess without sinus
- Acute pharyngitis, unspecified
- Otitis media, unspecified, right ear
- Otitis media, unspecified, left ear

Level III

- Acute upper respiratory infection, unspecified
- 2019 NCOV acute respiratory disease (COVID-19)
- Viral infection, unspecified
- Urinary tract infection, site not specified
- Fever, unspecified
- Acute pharyngitis, unspecified
- Nausea with vomiting, unspecified
- Influenza due to other identified influenza virus with other respiratory manifestations
- Streptococcal pharyngitis
- Acute obstructive laryngitis (croup)

Level IV

- 2019 NCOV acute respiratory disease (COVID-19)
- Unspecified abdominal pain
- Urinary tract infection, site not specified
- Nausea with vomiting, unspecified
- Headache, unspecified
- Acute upper respiratory infection, unspecified
- Noninfective gastroenteritis and colitis, unspecified
- Viral infection, unspecified
- Chest pain, unspecified
- Epigastric pain

Level V

- Chest pain, unspecified
- 2019-NCOV acute respiratory disease (COVID-19)
- Other chest pain
- Suicidal ideations
- Alcohol abuse with intoxication, unspecified
- Syncope and collapse
- Urinary tract infection, site not specified
- Pneumonia, unspecified organism
- Unspecified asthma with (acute) exacerbation
- Unspecified convulsions