ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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December 5, 2024

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 2024 AHCCCS Report on Emergency Department Utilization. Please feel free to contact me if you have any questions about this report.

Sincerely,

Carmen Heredia
Director

cc: Zaida Dedolph Piecoro, Health Policy Advisor, Office of the Governor

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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 2024

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#:~:text=According%20to%20UnitedHealth%20Group%20research,and%20not%20an%20actual%20emergency (accessed September 2024).

[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 September 2024).

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.

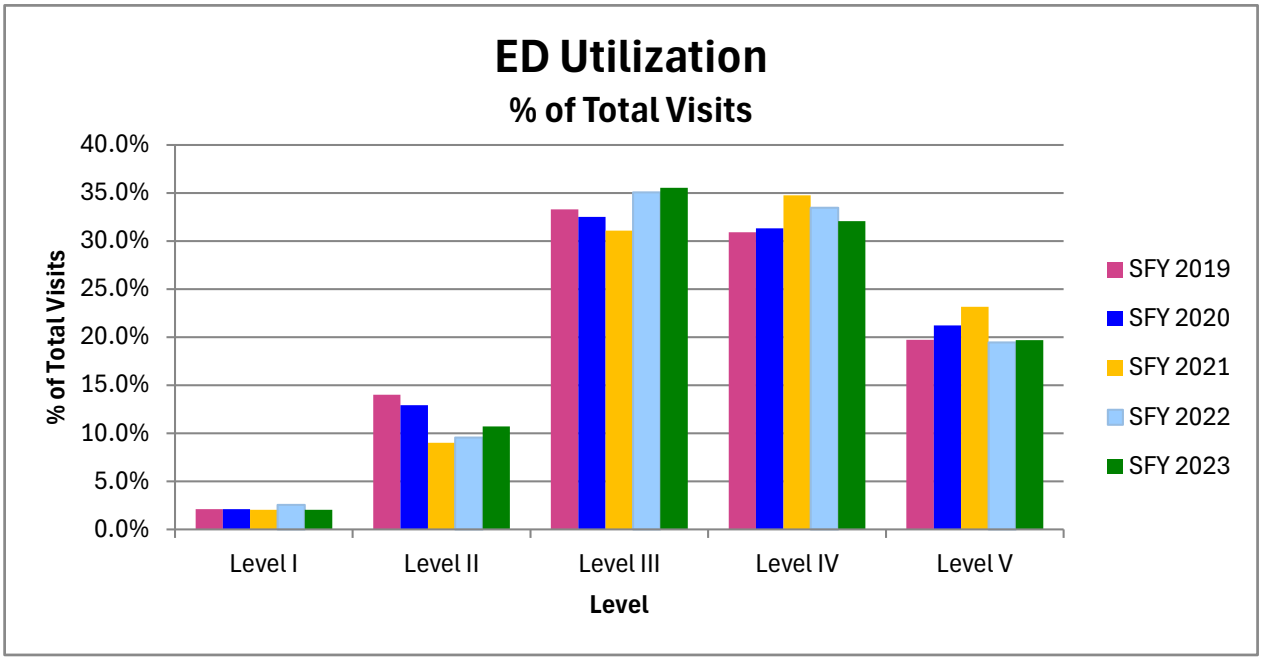
Table 1 identifies total ED visits for State Fiscal Years (SFYs) 2019 - 2023 that are classified as Levels I- V, as well as the paid amount associated with those visits. This time span covers a full year before the Covid Public Health Emergency (PHE) was declared in March 2020, including the end of the PHE in May 2023. Total ED visits were determined by the procedure codes that correspond with the five levels of severity. In SFY 2019, three new level one trauma centers began receiving a higher reimbursement rate for level three, four and five visits. The decline in total ED visits in SFY 2020 and SFY 2021 is believed to be attributable to the COVID-19 pandemic. The large increase in SFY 2022 ED visits, which continued into SFY 2023, appears to align with the gradual return to normal operations and the increase in AHCCCS membership.

Table 1: AHCCCS ED Utilization – SFYs 2019 - 2023

Visit Level	# Visits	% Total Visits	Paid Amount	% Paid Amount
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				
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%**
SFY 2023				
Level I	22,992	2.0%	$3,000,582	0.5%
Level II	120,828	10.7%	$23,238,640	3.6%
Level III	401,062	35.5%	$137,233,913	21.0%
Level IV	361,981	32.1%	$232,991,705	35.7%
Level V	221,948	19.7%	$256,524,141	39.3%
Overall-Summary	**1,128,811**	**100.0%**	**$652,988,981**	**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 2019 - 2023



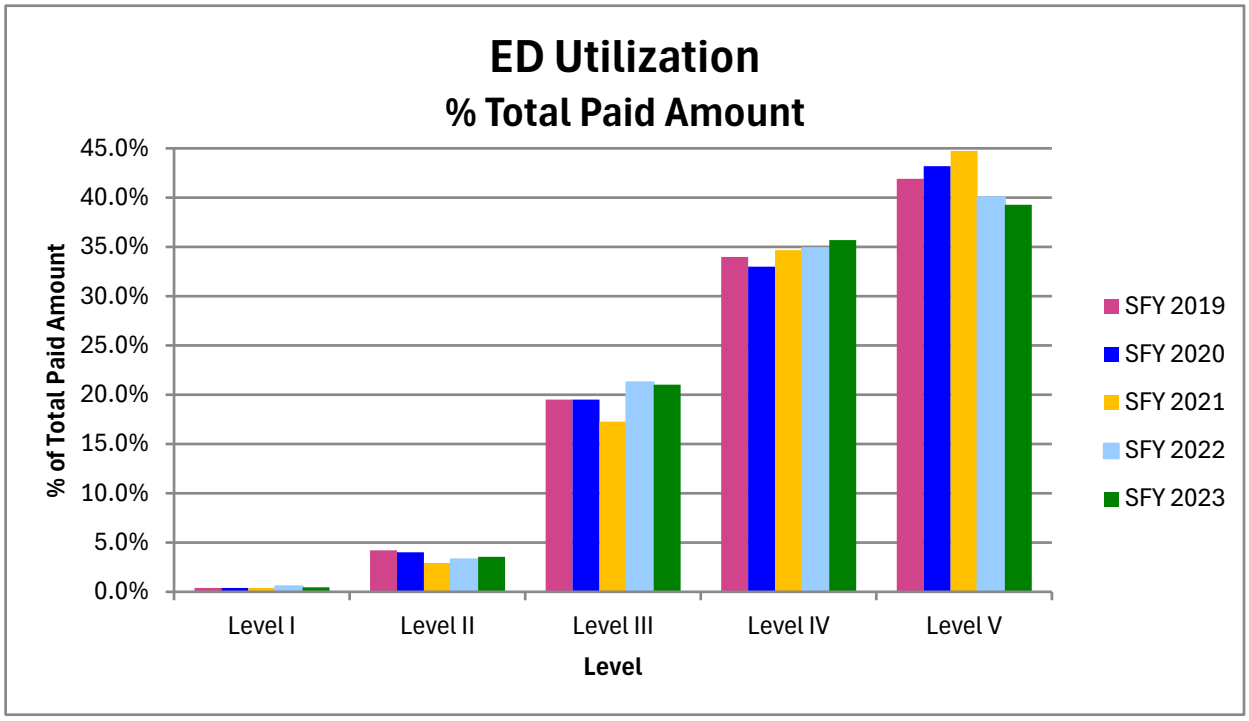
The 5-year trend (shown above in Figure 1) shows a reduction of lower level ED visits (Levels I and II) and a shift towards Level III, IV and V visits.

The Level V visit count was at its lowest in SFY 2021 and has increased in both SFY 2022 and 2023. Level V visits as a percentage of total visits peaked in SFY 2021, and returned to 19.7% in SFY 2023, which is the same as in the first full pre-Covid SFY 2019. This means the distribution of visits had fluctuated over time.

[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.

The percentages paid for lower level (I and II) versus higher level (III, IV, V) visits are comparable in SFY2023 to what was observed pre-COVID in SFY2019. In all five SFYs, a clear majority of the total amount paid falls within Levels IV and V. These levels make up $490 million, or 75%, of total amount paid in SFY 2023. The percentage of total paid for Level IV and V has decreased by 0.9 percentage point over the 5-year time period.

Figure 2: AHCCCS ED Utilization by Paid Amount for SFYs 2019 – 2023



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

The distribution of primary diagnoses within each ED visit level was almost unchanged from SFY 2022.

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 2019 through SFY 2023, which capture the entire period of the PHE. It is noted that COVID-19 remained one of the top 10 diagnoses for Levels II through V visits in SFY 2023, as is displayed in Appendix A. In contrast with SFY 2022, COVID-19 was an infrequent primary diagnosis for Level I visits.

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 nine AIMHs across the state, with approximately 31% of AIHP members empaneled with an AIMH.

Managed Care Organization (MCO) Programs

While Molina Healthcare and Blue Cross/Blue Shield Arizona Health Choice continue their ED utilization reduction programs, here we briefly highlight efforts by several other contracted MCOs.

Arizona Complete Health Complete Care Plan

- (AzCH-CCP) has an ED Diversion program that looks at the top 1% of high ED users to educate them on appropriate ED use and alternative services. This program includes direct outreach by a team of nurses, social workers and others to members with complex needs for up to a year to support them in engaging outpatient care.
- AzCH-CCP expanded its Urgent Engagement pilot project so that all members presenting at an ED have their Health Home identified. The Health Home provides and/or coordinates and monitors the provision of all primary, physical health, behavioral health and services and supports to treat the whole person; it can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center (FQHC) or an Integrated Care Provider. The health home coordinates discharge planning and care need to avoid repeated ED visits.

Banner University Family Care (BUFC)

- BUFC Care Management and Case Management staff engage members to encourage them to use outpatient providers, and self-management behaviors. They track member utilization to monitor this outreach for effectiveness.
- BUFC provider contracts include requirements for after hours and weekend availability through a call center or answering system.
- BUFC also partners with major health systems to identify high need behavioral health members seen at an ED, with the goal of stabilizing, reducing utilization, and provide support services.

United Healthcare Community Plan (United)

- United receives daily data on admit and discharge for its members from the state health information exchange. This information is shared with its clinical partners such as Accountable Care Organizations, who conduct outreach and engagement with members. These partners have a goal of engaging these members within 7 days of the ED visit. United meets with its partners regularly to discuss performance.
- The data is also shared with United's internal Care Management team to identify high ED utilizers for education and outreach to support the member.
- If a member is seeing the ED for a behavioral health related need and is at the facility more than 24 hours, United identifies them and offers assistance and support to look for appropriate services in a non-ED setting.
- United trends ED utilization from year to year to monitor emergent and non-emergent ED utilization.

Mercy Care

- Mercy Care identifies physicians whose member panels have a high use of EDs, and coaches them on appropriate usage and alternatives such as after-hours clinics, urgent care and office scheduling for non-emergent care.
- Mercy Care identifies members in an ED who are medically cleared to be released and works with stakeholders to transition the members to an appropriate level of care.
- Mercy Care has adopted value-based strategies that incentivize behavioral health providers to increase their appointment adherence standard, recognizing that seeing a provider mitigates ED usage.
- Mercy Care noted that children most often end up in an ED due to referrals by public safety personnel, or caregivers. Mercy managers training and education for public safety personnel and caregivers on the availability of alternatives and how to get members there without delay.

AHCCCS' Targeted Investment Program

The renewed AHCCCS Targeted Investments Program (TI 2.0), continuing through 2028, incentivizes AHCCCS providers to develop systems of integrated, highly coordinated, and culturally responsive care to improve the quality of life and decrease the cost of services for AHCCCS members. The TI 2.0 focus on addressing healthcare service inequities includes redirecting level 1-2 ED visits to outpatient settings that may provide more personalized care for members.

Participating primary care and BH outpatient providers are incentivized to implement mutually-developed closed-loop-referral protocols with medical, behavioral, and community service providers that can address the individuals needs outside of the ED.

All participants are incentivized to implement National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards and to routinely evaluate patient experience. This is critical for ensuring that each member is comfortable seeking services from an outpatient setting instead of the ED

Sixty participating, co-located justice clinics engage incarcerated-involved individuals with high-risk physical or behavioral health conditions and coordinate appointments with reentry planners to ensure the individual is actively enrolled in AHCCCS, aware of and able make it to the appointment (e.g., providing transportation when necessary), and released with a temporary supply of medication to prevent unnecessary visits to the ED.

CONCLUSION

Level I through III ED visits 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, but which may be true emergencies as noted previously. Since SFY 2019, these Level 1 through III visits, as a share of total visits, have declined by over 1 percentage point. Even more encouragingly, looking at just Levels I and II as a share of total visits, these have declined by over 3 percentage points from SFY 2019. AHCCCS members demonstrate a relatively low rate of such visits, 12.7%, accounting for 4.1% of total ED visit cost. 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 primary diagnoses for each visit level (categorized by volume) for SFY 2023

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
- Toxic effect of venom of scorpion, accidental initial encounter
- Acute pharyngitis, unspecified
- Rash and other nonspecific skin eruption
- Viral infection, unspecified
- Unspecified abdominal pain

Level II

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

Level III

- Acute upper respiratory infection, unspecified
- 2019 NCOV acute respiratory disease (COVID-19)
- Viral infection, unspecified
- Influenza due to other identified influenza virus with other respiratory manifestations
- Urinary tract infection, site not specified
- Streptococcal pharyngitis
- Acute pharyngitis, unspecified
- Fever, unspecified
- Unspecified injury of head, initial encounter
- Headache, unspecified

Level IV

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

Level V

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