ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

150 N. 18th Avenue
Phoenix, AZ 85007
602.417.4000

KATIE HOBBS
GOVERNOR

VIRGINIA ROUNTREE
DIRECTOR

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

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

Dear Mr. Stavneak and Mr. Henderson

Pursuant to A.R.S. § 36-2903.11, please find enclosed the 2025 AHCCCS Report on Emergency Department Utilization. Please feel free to contact Damien Carpenter, Chief Legislative Liaison, at (602) 396-0767.

Sincerely,

Virginia Rountree

Virginia Rountree
Director

cc: Meaghan Kramer, 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 2025

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, United Health 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

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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 thirties. 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. 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 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 - 2024 that are classified as Levels I-V, as well as the paid amount associated with those visits. This time span, July 1, 2019 through June 2024, covers a full year before the COVID Public Health Emergency from March 2020 to May 2023 plus thirteen post-pandemic months. Total ED visits were determined by the procedure codes that correspond with the five levels of severity.

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 and SFY 2023 ED visits appeared to align with the gradual return to normal operations and the increase in AHCCCS membership. SFY 2024 saw a 2.6% decrease in total ED visits over SFY 2023. Since the pre-Covid SFY 2019 through SFY 2024, there has been only a 2.6% increase in total ED visits despite a 16.5% increase in total AHCCCS membership over this period[1]

[1] https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/HistoricPopulationDataforJuly1985toCurrent.pdf

Table 1: AHCCCS ED Utilization – SFYs 2019 - 2024

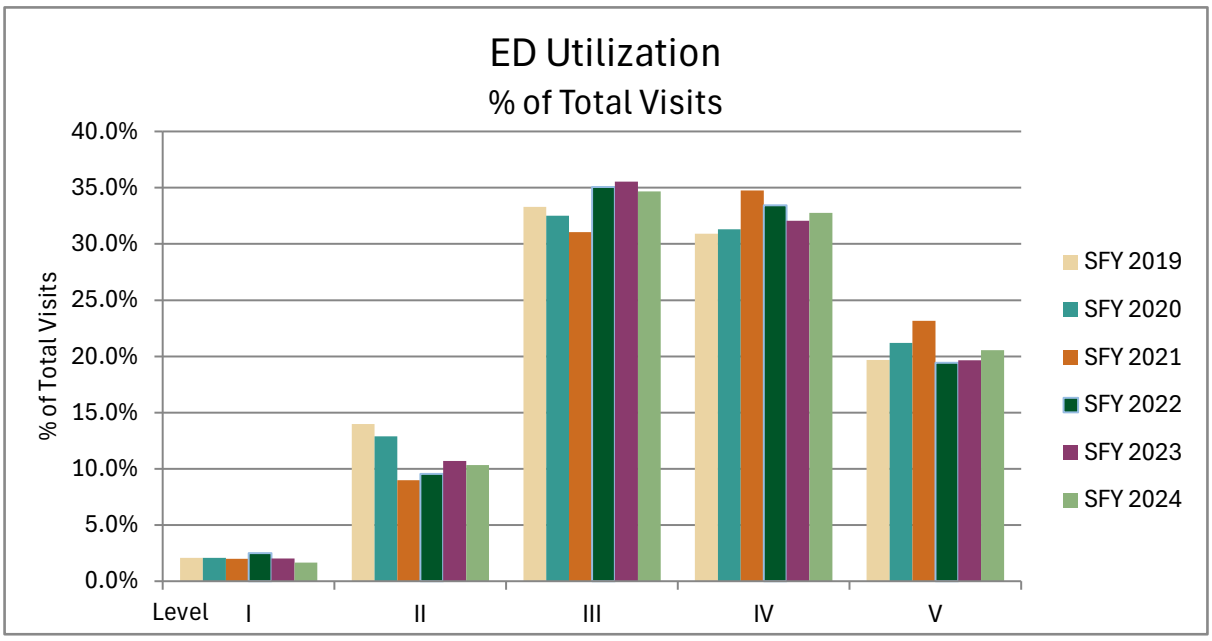
Visit Level	# Visits	% Total Visits	Paid Amount	% Paid Amount
SFY 2019				
Level I	22,594	2.1%	$2,195,192	0.4%
Level II	150,417	14.0%	$24,121,733	4.2%
Level III	356,593	33.3%	$112,808,133	19.5%
Level IV	330,799	30.9%	$196,641,909	34.0%
Level V	211,161	19.7%	$242,423,675	41.9%
Overall-Summary	**1,071,564**	**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%**

Visit Level	# Visits	% Total Visits	Paid Amount	% Paid Amount
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%**
SFY 2024				
Level I	18,470	1.7%	$2,275,502	0.4%
Level II	113,746	10.3%	$20,220,691	3.2%
Level III	381,361	34.7%	$124,357,478	19.7%
Level IV	360,259	32.8%	$233,816,988	37.0%
Level V	226,042	20.6%	$251,238,044	39.8%
Overall-Summary	**1,099,878**	**100.0%**	**$631,908,702**	**100.0%**

Figures 1 and 2 display these statistics graphically. The data represent outpatient ED visits and do not include ED visits that resulted in admission to the hospital.[2]

[2] 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.

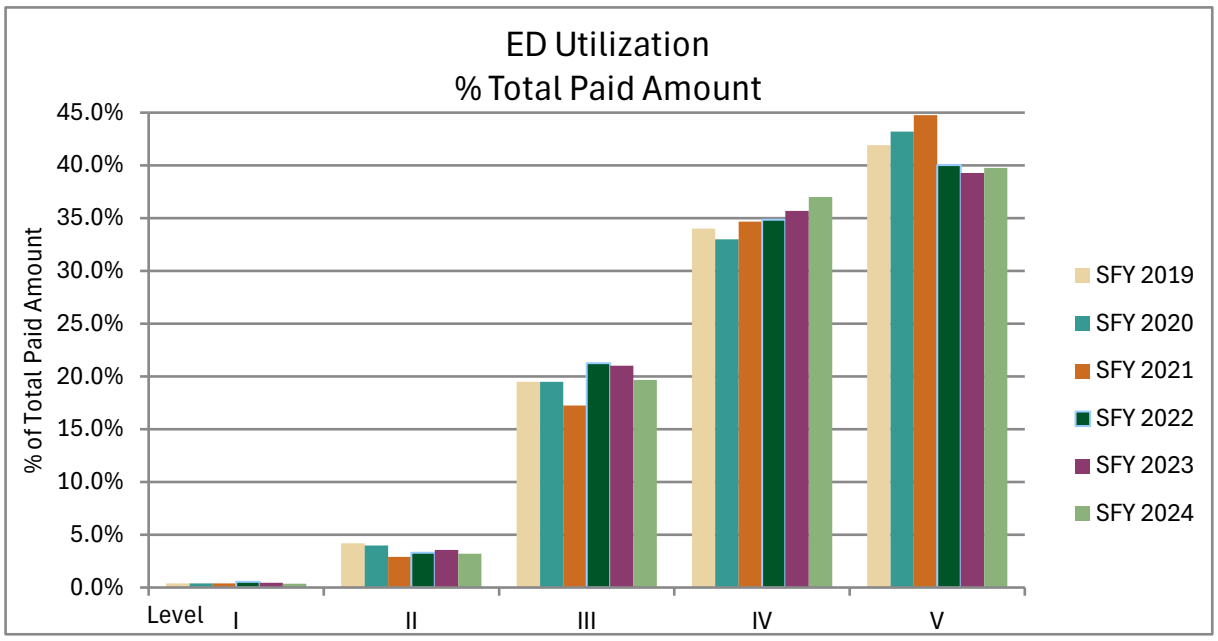
Figure 1: AHCCCS ED Utilization by Level for SFYs 2019 - 2023



The six-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. Comparing the two most severe levels over the six-year report period, the percentage of total visits has increased by 1.9 percentage points for level IV and by 0.9 percentage points for level V.

The relative distribution of visits across the five ED levels has been consistent except for SFY 2021, the first Covid year. Level VI visit counts and percentages of total visits were lower than Level III in every other SFY. In SFY 2021 this pattern diverged - level VI visits as a percentage of total visits peaked that year, as did level V, even as visit counts for all levels were at their lowest during this six-year period.

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



In all six SFYs, a clear majority of the total amount paid falls within Levels IV and V. These two levels comprised $485 million, or 76.8%, of total amount paid in SFY 2024. This combined percentage has fluctuated in a narrow range of 75.9% and 76.8% over the six-year period, except for the first Covid year SFY 2021 when it peaked at 79.4%. Comparing these two most severe levels, the percentage of total amount paid has increased by three percentage points for level IV and decreased by two percentage points for level V.

The distribution of primary diagnoses within each ED visit level was almost unchanged from SFY 2023. The 2019-NCOV acute respiratory disease (COVID-19) dropped out of the top ten diagnoses for levels I, II and V but remained close to the top. Acute upper respiratory infection, unspecified remained the top diagnosis overall.

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

AHCCCS continues its efforts to integrate administration for both physical and behavioral health services, serving almost 2.2 million Arizonans during this reporting period, and almost 2.2 million as of July 1st, 2024[3]. Among other benefits, integration can reduce costs by ensuring members receive the most appropriate care in the most appropriate and least restrictive settings. AHCCCS drives innovation in the health care system to improve delivery of care, improve health of populations, and curb the upward trajectory of per capita spending. Since the start of AHCCCS' integration efforts, all health plans

[3] https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/HistoricPopulationDataforJuly1985toCurrent.pdf

have engaged in aggressive efforts to lower unnecessary ED usage, utilizing incentive payments and High Needs/High Cost intervention.

Emergency Department (ED) overutilization presents a significant challenge to healthcare systems, often resulting in increased costs, fragmented care, and suboptimal health outcomes. AHCCCS MCO programs have developed and implemented targeted Care Management (CM) strategies to address inappropriate ED use, focusing on early identification, member education, and coordinated interventions. This report consolidates the approaches of several health plans highlighting their efforts to improve access to appropriate care, reduce unnecessary ED visits, and enhance member engagement through data-driven and member-centric solutions.

AHCCCS requires that MCOs actively coordinate care with members demonstrating high behavioral and physical health needs and/or high utilization costs. The MCO must identify members with high needs/high costs (HNHC), plan interventions for addressing appropriate and timely care for these members, and report outcomes to AHCCCS. MCOs track interventions based on standardized criteria and report intervention summaries to AHCCCS within their annual plan submissions.

Across the AHCCCS MCO programs a shared commitment to recuring inappropriate ED utilization is evident through robust care management programs, predictive analytics, real-time data exchange, and collaborative partnerships. These strategies not only support timely access to care but also address underlying behavioral health and social determinants that contribute to Ed overuse. By aligning interventions with member needs and leveraging technology for proactive outreach, these plans are driving improvements in care quality, cost efficiency, and member outcomes. Continued innovation and cross-section collaboration will be essential to sustaining progress and expanding the impact of ED diversion initiatives statewide.

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 current 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 41% of AIHP members empaneled with an AIMH.

Managed Care Organization (MCO) Programs

While Mercy Care, United Healthcare Community Plan and Arizona Complete Health Complete Care Plan continue their ED utilization reduction programs, here we briefly highlight efforts by several other contracted MCOs.

Molina Healthcare

- Molina offers its members a 24/7 nurse advice line to assist them with a variety of healthcare needs. They help members choose appropriate psychosocial, medical, and behavioral health services. The advice line reinforces education about appropriate ED use and helps members understand available services and how to access them.
- Their health care services team monitors ED utilization through claims data supplemented by data from the Arizona Health Information Exchange; any member with four or more inappropriate ED services in a six-month period is contacted by a member of a care management team to help provide alternatives to ED usage.
- All Molina providers must offer coverage 24 hours a day, 7 days a week through on call and after-hours coverage such as an answering service, call forwarding or provider call coverage. This coverage must be accessible through the provider's office daytime phone number, and the call must be returned within 30 minutes. Compliance is monitored through Molina's Quality Improvement Committee.

Blue Cross/Blue Shield Arizona Health Choice

- BCBSAZ-HC also requires its primary care and specialist providers to have call availability 24 hours a day, 7 days a week to communicate appropriate urgent care availability. Many of their primary care and OB/GYN providers also offer extended hours and weekend appointments to allow for extended access to care.
- They also have established partnerships with first responders in their service area that include 911 diversion and priority mobile team dispatching programs. These allow the 911 dispatchers in their area to transfer behavioral health-related calls to their crisis hotline to avoid initiating a law enforcement response. Law enforcement responding to a person experiencing a behavioral health crisis can call BCBSAZ-HC's crisis line or 988 to request a mobile team. Both programs encourage first responders to utilize crisis services before using ED departments.
- BCBSAZ-HC has established a network of crisis stabilization units to prevent unnecessary use of hospital EDs. They provide short-term stabilization services as a diversion from jail, EDs, and

inpatient facilities. These are supplemented by Substance Use Stabilization Facilities in northern and central Arizona to provide a safe and supportive environment to recover.

- Similarly to Molina, BCBSAZ-HC reviews reports on members with ED use over a six-month period for follow up with their care management team. These include the number of visits per member and their primary diagnosis for the visit. The primary care provider, behavioral health provider and pain management specialist for members presenting at the ED with an opioid overdose are notified of the event.

Banner University Family Care

- Banner employs a navigation team who conduct daily outreaches for members discharged from Banner facility ED discharges. Members on the outreach list are stratified by risk of return to the ED. The calls reinforce the members' discharge instructions, ensure PCP follow up and generate referrals to their care management team as needed.
- Banner employs an ED Diversion team that also reviews member use of the ED over a six-month period. Members with four to ten visits will either receive a letter or an outreach call to identify barriers, refer the member to heath care or behavioral health management.
- Banner also employs nurse-on-call and crisis hotlines. These lines can escalate complex cases to staff on Banner integrated care teams.

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 also be true emergencies as noted previously. Since SFY 2019, these Level 1 through III visits, as a share of total visits, have declined by 2.7 percentage points. Even more encouragingly, looking at just Levels I and II as a share of total visits, these have declined by over four percentage points from SFY 2019. AHCCCS members demonstrate a relatively low rate of such visits, 12.0%, accounting for 3.6% 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 2024

Level I

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

Level II

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

Level III

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

Level V

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