BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS
ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of:	)	
	)	
K E	)	OAH No. 12-0619-MDS
	)	HCS Case No.
	)	Medicaid ID No.

DECISION

I. Introduction

The ultimate issue in this case is whether it is appropriate to place K E in the Care Management Program (CMP) based on her utilization of Medicaid services during the period of July 1, 2010 through September 30, 2011. This decision concludes that Ms. E's over-utilization of medical services during the period at issue justifies her placement in the Care Management Program pursuant to 7 AAC 105.600.

The Division of Health Care Services (DHCS or Division) has a continuing duty under 7 AAC 105.600 to ensure that a recipient has reasonable access to Medicaid services of adequate quality throughout any period of placement in the Care Management Program. The preponderance of the evidence shows that the Division did not deny Ms. E reasonable access to adequate medical care during the timeframes covered at hearing. Ms. E has the right to request a hearing in the future should she assert that she has been denied reasonable access to adequate care during any subsequent period.

II. Facts

A. Agency Review of Service Utilization by Medicaid Recipients

The Division has a Medicaid services utilization review program; at the time of the events at issue here, that program was implemented through Affiliated Computer Services, Inc. (ACS).[1] ACS's Surveillance and Utilization Review ("SUR") Department uses specialized software to flag utilization rates that are outside the norm.[2]

If the software appears to indicate an over-utilization of services during a quarter, a 15 month period of utilization activity is then reviewed using the same software.[3] If this broader sample continues to suggest over-utilization, the utilization data is re-analyzed by diagnosis code to

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1 Jason Ball hearing testimony of June 8, 2012. ACS is now known as Xerox State Healthcare, LLC. *Id.*
2 Ball testimony (June 8, 2012).
3 *Id.*

determine if there is a diagnosis (such as cancer) which might explain the degree of utilization.[4] This process described in this paragraph is known as a "Phase I" review.[5]

If a Phase I review indicates an over-utilization of services, SUR proceeds to what is known as a "Phase II" review.[6] In the Phase II review, the medical records from the periods at issue are obtained and reviewed to either confirm or refute the exceptions previously identified in the Phase I analysis.[7] The Phase II review is performed by a licensed health care professional.[8]

B. Ms. E's Medical Issues and Relevant Use of Medicaid Services

Ms. E is 59 years old.[9] She has received Supplemental Security Income disability benefits since 2001 based on agoraphobia, diabetes, lupus, and Post-Traumatic Stress Disorder (PTSD).[10] She has also been diagnosed with anxiety, coronary artery disease, diabetes mellitus, lupus, and thyroid disease.[11] She has been homeless since about 2004.[12]

On April 1, 2011 Ms. E presented to the Emergency Department (ED) of Providence Alaska Medical Center (Providence) complaining of anxiety.[13] She was homeless at the time and was staying at a rescue mission.[14] When examined she appeared to be in minimal distress.[15] Her main concern was to gain admittance to the Crisis Recovery Center (CRC) so that she would not have to return to the rescue mission.[16]

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4 *Id.* Thus, although the Phase I review is primarily a quantitative analysis, it also has a qualitative component.

5 *Id.*

6 *Id.*; Linda Winner hearing testimony of June 22, 2012.

7 Ball testimony (June 8, 2012) at 26:00 - 26:30. The Phase II review is designed to differentiate between those Medicaid users who meet the CMP placement criteria of 7 AAC 105.600(c), and those who do not (Winner testimony (June 22, 2012) at 16:30 - 17:30).

8 7 AAC 105.600(c).

9 Ex. E8.

10 Ex. E11; K E hearing testimony of June 26, 2012 at 4:00 - 4:30.

11 Exs. E14, E20, E28.

12 E testimony (June 26, 2012) at 15:00 - 16:00.

13 Exs. E8, E10. Ms. E asserted, at hearing and in her post-hearing briefing, that her hospital visits were not to the emergency department per se, but rather to an "urgent care" section of the hospitals. *See* E testimony (June 26, 2012) at 9:00 - 10:00 and 16:00 - 17:00. However, there was no evidence presented, other than Ms. E's testimony, that any separate "urgent care" section exists in the hospitals at issue. Further, the hospital records introduced into evidence generally state that they are "ED Provider Notes" (see Exs. E8 - E12; E14 - E26; E28 - E29). The only hospital records which do not indicate they are from the "ED" have a section titled "Triage," which is something that typically occurs in an emergency room (Ex. E36). Finally, Mr. Ball testified that the procedure codes for the emergency room visits at issue here all described "full-blown emergency room visits" rather than some lesser urgent-care visits (Ball testimony (June 26, 2012) at 1:03:30 - 1:04:30). Accordingly, the preponderance of the evidence indicates that the hospital visits at issue were to the hospitals' Emergency Departments ("EDs").

14 Exs. E8, E10.

15 Exs. E9, E11.

16 Ex. E12.

On April 5, 2011 Ms. E presented again to the Providence ED.[17] Her chief complaint was PTSD and insomnia, which she believed had been triggered by staying at a rescue mission.[18] Upon examination, the ED physician found her to be in a "stable medical condition."[19] The nurse practitioner's notes from the encounter state that Ms. E's "primary concern is homelessness"[20] and that Ms. E had "made 3 visits to the Providence [ED] seeking alternative housing since becoming homeless on March 10th."[21]

On April 15, 2011 Ms. E presented again to the Providence ED.[22] Her chief complaint was sore throat pain.[23] She was discharged in good condition with antibiotics and pain relievers.[24]

On April 22, 2011 Ms. E presented again to the Providence ED.[25] Her chief complaint was swelling and pain in her right knee, and the ED confirmed some swelling and tenderness.[26] Her leg and knee were x-rayed, but no fractured, dislocated, or misaligned bones were found and no injured ligaments were detected.[27]

On May 9, 2011 Ms. E presented again to the Providence ED.[28] Her chief complaint was pain in her right leg.[29] The record does not reflect what tests were performed or what treatments were received during this visit.

On May 10, 2011 Ms. E was seen by Robert Artwohl, M.D. for pain in her right knee and feet and swelling and discomfort in her legs.[30] Imaging tests revealed venous insufficiency in her legs.[31]

On May 15, 2011 Ms. E presented to the Alaska Regional Hospital ED.[32] Her chief complaint was pain in her knee from a fall that occurred two to three weeks prior.[33] Her right knee was x-rayed but no problems were found; she was given a prescription pain reliever and released.[34]

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17 Ex. E14. Ms. E testified that she went to the EDs because private health care providers don't want to see patients on Medicaid (E testimony (June 26, 2012) at 3:00 - 12:00). Before going to the EDs, she would typically call the ED nurse and explain her health problem before coming in. *Id.* The ED nurses would always tell her to go ahead and come to the emergency room. *Id.*

18 *Id.*

19 Ex. E16.

20 *Id.*

21 Ex. E14.

22 Ex. E20.

23 *Id.*

24 Ex. E22.

25 Ex. E23.

26 *Id.*

27 Ex. E26.

28 Ex. E28.

29 *Id.*

30 Ex. E30.

31 Ex. E32.

32 Ex. E34.

33 *Id.*

Examination by an orthopedic specialist at Orthopedic Physicians Anchorage (OPA) in the summer of 2011 determined that Ms. E had a badly torn meniscus in her right knee, and she underwent surgery to repair the tear on August 26, 2011.[35] There is no evidence in the record to indicate whether Ms. E's meniscus had been torn for a significant amount of time *prior* to her visit to OPA or whether the tear occurred after the visits to the other providers. Ms. E stated she didn't know whether or not the tear was there "the whole time."[36]

C. The Division's Review of Ms. E's Use of Medicaid Services

Jason Ball is a senior data analyst with Xerox State Healthcare, LLC (formerly ACS).[37] In July 2011 Mr. Ball performed a Phase I review of Ms. E's utilization.[38] The review identified exceptional usage in five different areas when compared to the peer group of disabled adults: number of rendering physicians used, number of rendering pharmacies used, number of physician [emergency room] visits, number of different diagnosis codes, and number of ER visits in comparison to office visits.[39]

As indicated above, Mr. Ball's Phase I review found in part that Ms. E generally did not utilize a primary care provider and instead saw a large number of different providers.[40] When this occurs it typically reduces the efficiency and effectiveness of the recipient's medical services because each provider is generally unaware of the services being performed by the other providers and there is no coordination of care.[41] This in turn results in a needless duplication of services which unnecessarily increases the costs incurred by the Medicaid program.[42]

Mr. Ball's Phase I review concluded in early August 2011.[43] Based on Mr. Ball's Phase I review, he referred Ms. E's case on for a Phase II review.

Ms. E's Phase II review was conducted by ACS clinical review consultants Linda Mars, R.N. and Eboney White, L.P.N. during the period of August - November, 2011.[44] On November 29, 2011

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34 Ex. E35.

35 Linda Winner hearing testimony of June 22, 2012 at 28:30 - 29:00; K E hearing testimony of June 26, 2012 at 30:30 - 31:30.

36 E testimony (June 26, 2012) at 37:45 - 38:15.

37 Ball testimony (June 8, 2012).

38 *Id*. at 22:00 - 23:00.

39 *Id*. at 28:30 - 38:30, Exs. D1, E4.

40 Ball testimony (June 8, 2012) at 51:00 - 51:30. The only primary care providers revealed by the analysis were William F, A.N.P. (two visits) and Anchorage Community Health Center (52:30 - 53:30).

41 Ball testimony (June 8, 2012) at 1:00:00 - 1:01:00. This is particularly true of emergency room visits. Ms. E had seven emergency room visits for every one primary care provider visit (1:08:30 - 1:09:30).

42 *Id*. at 1:01:00 - 1:03:00.

43 *Id*. at 1:46:00 - 1:47:00.

44 Ms. N and Ms. X are no longer with ACS and did not testify at hearing (testimony of Ball and Winner).

Ms. N and Ms. X completed a Care Management Program Phase 2 Medical Review Summary on Ms. E stating their findings.[45] That summary provides in relevant part as follows:

> This recipient was chosen for a records review as there were multiple "exceptions" which are represented in the statistical analysis of Medicaid services provided in the Phase 1 Initial Review. Exceptions occur when the recipient's Medicaid usage exceeds the peer group norm by two times the standard deviation plus the peer group average. Exceptions are defined in [7 AAC 105.600].
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> Exceptions. Ms. E "excepted-out" in five areas during the 15 month review. [These were]: [1] number of rendering physicians, [2] number of rendering pharmacies, [3] number of physician ER visits, [4] number of different diagnosis codes, [5] number of ER visits: office visits.
>
> [Exceptions 1, 2, and 3, above] are the focus of this review and will be evaluated using the following criteria: concurrent care with other provider, closely adjoining dates of service with other providers, same date-of-service with other providers for same/similar presenting complaint, diagnosis and consistency of medical history provided, [and] prescription medication activity/compliance with recommended treatment.
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> . . . .
>
> Medical History and Conditions. Ms. E has a documented medical history that includes but is not limited to: lupus, thyroid disease, diabetes mellitus, and anxiety state. Her surgical history that is documented includes, but is not limited to: hysterectomy, tubal ligation, retocele and cystocele.
>
> During the fifteen month review, Ms. E was diagnosed with 40 different ICD-9 codes . . . . This statistical analysis does not dispute the formal diagnoses that have been recognized by qualified medical providers. This analysis does expose difficulties with continuity of care and many inconsistencies that are documented in the medical records submitted . . . .
>
> Medical Facilities: Usage and Treatment. Ms. E utilized the services of 33 providers at 16 facilities and six pharmacies during the review period. Records were received and reviewed from each of the medical facilities to complete this statistical analysis . . . .
>
> Ms. E has received many medical evaluations, diagnostic tests, and referrals to specialists and physical therapy. One of the complications from her medical care that is evidenced in the records is a concern of non-compliance for medical therapies recommended for her chronic pain condition.
>
> Therapies and treatments have been mainly pharmacological in nature. Ongoing care along with numerous clinic and emergency department visits have resulted in narcotic injections and prescription medications from multiple classifications to include: narcotic analgesics. Other treatments for Ms. E's complaints of pain from strains,

[45] Exs. E4 - E7. Some of the formatting from the original document is modified here to make it more concise.

sprains, and falls have included: splints/casts, crutches, external braces, referrals to physical therapy, heat, ice, and rest, [and] exercise techniques.

. . . .

Summary of Findings. After careful consideration of Ms. E's age, diagnosis, complications of medical conditions, chronic illnesses, number of different physicians and hospitals, and type of medical care received, Ms. E's activity illustrates and corroborates multiple exceptions (5). This review finds numerous concerns as follows:

1. Concurrent care and/or closely adjoining dates of service and/or same date of service for same/similar presenting complaint.

2. Confirmation of all exceptions has been validated with this review of records.

3. No documentation is present to indicate if providers were aware of their colleagues' prescription activity with this recipient.

4. Confirmation of exceptions related to pharmacy providers used by this recipient. No documentation is present or could be located to justify multiple pharmacy use significantly over and above the recipient's peer group norm.

5. Non-compliance with specific medication directions and treatment modalities.

6. The need to create an ongoing relationship with one provider to establish formal continuity of care to better meet required medical needs has been identified.

Clinical Summary: Major areas of concern that exist for this patient include frequent visits to the Emergency Room (ER) for issues best addressed with a primary care provider. ACS has received three provider statements agreeing that Ms. E would benefit from the Care Management Program . . . . Without a centralized primary care provider and pharmacy assigned for this patient there is a high potential for drug overdose and negative drug interaction related to the receipt of care from multiple and unrelated providers. The ER is a triage care setting. Regular presentation to the ER versus a primary care provider decreases the likelihood that Ms. E will receive timely and effective treatment for her health issues. Based upon a review of the supporting documentation, it appears that placement in the Care Management Program will directly increase safety and continuity of care for this recipient.

Recommendation. Following an extensive review of records submitted to [ACS], and concurring with providers who returned ACS' Provider Statement for the Care Management Program, our Registered Nurse Clinical Reviewer has determined that Ms. E has met criteria for placement in the Care Management Program. [ACS] finds that the recipient has used an item or service paid for under Medicaid or General Relief Medical Assistance at a frequency or in an amount that is not medically necessary . . . . It is further noted that Ms. E's continuity of care and medical service needs can safely and efficiently be met by formal assignment to the State of Alaska's Medical Assistance Care Management Program.

Linda Winner is a registered nurse (RN) currently employed as a medical consultant for the SUR department at ACS.[46] She was not originally involved in Ms. E's Phase II review.[47] However, she reviewed all of the documentation pertaining to Ms. Es' Phase II review, and concurred with the findings and conclusions reached by Ms. N and Ms. X.[48] In reviewing the Phase II study performed by her predecessors, Ms. Winner was aware of the fact that Ms. E had been found to have a torn meniscus, and had it surgically repaired, *after* the period covered by ACS' utilization review.[49] She did not believe that these subsequent events undermined the findings from ACS' utilization review because, even though Ms. E's assertions of knee pain were validated, Ms. E was still accessing care through inappropriate means (i.e. emergency rooms).[50]

Between August 2 and October 24, 2011 three different health care providers completed and signed forms, provided by ACS, in which the providers agreed that Ms. E "would benefit from the Care Management Program," and that they were "willing to provide [Ms. E] with basic medical care while [she was] in the Care Management Program."[51] From these three, ACS ultimately chose William F as Ms. E's primary care provider because the claims information indicated that Ms. E had previously seen him as such.[52]

On November 28, 2011 ACS mailed a 22 page document to Ms. E titled "Notice of Placement in the Care Management Program."[53] The notice stated in relevant part as follows:[54]

> Due to your usage of Medicaid services, a report was generated and has been assessed by [ACS] on behalf of [DHCS]. This report showed that from July 1, 2010 to September 30, 2011 your use of the following exceptions exceeded the usage of services by those in your peer group of Permanently Disabled Adults:
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> Number of rendering physicians, number of rendering pharmacies, number of physician [emergency room] visits, number of different diagnosis codes, number of ER visits: office visits.
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> A clinical review performed by a qualified health care professional found that your usage of the above listed areas during July 1, 2010 to September 30, 2011 was at a level that is not medically necessary. These services have been determined not to be medically necessary because:

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46 Winner testimony (June 22, 2012) at 1:00 - 3:00.
47 *Id*. at 3:00 - 5:00 and 38:30 - 39:30.
48 *Id*.
49 *Id*. at 29:30 - 30:30.
50 *Id*. at 30:30 - 32:30.
51 Exs. E1 - E3.
52 Ball testimony (June 8, 2012) at 1:11:00 - 1:13:00.
53 Ex. D.
54 Because Ms. E has asserted that the Division's notice was not legally sufficient, the notice is quoted extensively. The format of some of the material in the notice has been changed from its original list or table format to a paragraph format for purposes of brevity.

1. Concurrent care and/or closely adjoining dates of service and/or same date of service for same/similar presenting complaint.

2. Confirmation of all exceptions has been validated with this review of records.

3. No documentation is present to indicate if providers were aware of their colleagues' prescription activity with this recipient.

4. Confirmation of exceptions related to pharmacy providers used by this recipient. No documentation is present or could be located to justify multiple pharmacy use significantly over and above the recipient's peer group norm.

5. Non-compliance with specific medication directions and treatment modalities.

6. The need to create an ongoing relationship with one provider to establish formal "continuity of care" to better meet required medical needs has been identified.

The Division's notice indicates that one of the exceptions occurred during the period of January through March 2011, while the other four exceptions occurred during the period of April through June 2011.[55] No exceptions occurred during the other eight months of the review period.[56]

The Division's notice indicates that Ms. E had five different diagnoses during the period of July 1 through September 30, 2010; no diagnoses during the period of October 1 through December 31, 2010; nine different diagnoses during the period of January 1 through March 31, 2011; 18 different diagnoses during the period of April 1 through June 30, 2011; and eight different diagnoses during the period of July 1 through September 30, 2011.[57] The Division's notice also indicates that Ms. E used six different pharmacies to fill nine separate prescription claims during the period of July 12, 2010 through September 17, 2011.[58] The Division's notice further indicates that Ms. E had 117 medical and dental treatment claims, spread among 16 different hospitals and clinics, during the 15 month review period.[59] Fourteen of these claims were for emergency room visits.[60] Finally, the Division's notice stated:[61]

> These findings have determined that your choice of providers will be restricted under the Care Management Program (CMP) guidelines of service for twelve months of eligibility starting January 1, 2012.

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55 Ex. D6.
56 Ex. D6.
57 Exs. D8 - D9.
58 Ex. D9.
59 Exs. D9, D10.
60 Ex. D11.
61 Ex. D2.

> In accordance with 42 CFR 431.54(e) and 7 AAC 105.600, the following providers have been selected and have agreed to act as your primary providers for the Care Management Program: Physician: William F . . . Pharmacy: Carr Gottstein No. 1805 . . . .
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> Effective January 1, 2012 you must receive all Medicaid services from the above providers during your placement in the Care Management Program. These will be the only medical providers that Medicaid will reimburse while you are on the program, except in the case of a life threatening or potentially disabling emergency or when your assigned primary physician provides a referral for you to be seen by a specialist due to a medically necessary condition that your primary physician is unable to treat.
>
> . . . .
>
> This action is based on Federal Regulation[s] 42 CFR 431.51, 431.54 and 456.23; Alaska Administrative Code 7 AAC 105.600 and Alaska Medical Assistance Manual Section 5002-2.

ACS originally assigned Mr. F as Ms. E's primary care provider (PCP) because Ms. E's medical records indicated that he had previously acted as such.[62] There is no indication that ACS ever asked Ms. E who she wanted to be her PCP prior to assigning Mr. F.[63] However, following Ms. E's placement in the CMP, Ms. E requested that she be assigned a new PCP.[64] Ms. E and ACS each made phone calls and "were cooperating and trying to get another [PCP]."[65] However, Ms. E testified that "[n]o one wanted to take me . . . no one wanted to take me."[66]

ACS tried to make arrangements to have Independence Park Medical Services (IPMS) take over as Ms. E's CPC, and Ms. E indicated that IPMS would be acceptable to her.[67] ACS instructed Ms. E not to contact IPMS until ACS' arrangements with IPMS were finalized.[68] However, Ms. E made several phone calls to IPMS during this period, and shortly thereafter IPMS notified ACS that it was no longer willing to be Ms. E's PCP.[69] For this reason it was necessary for ACS to reassign Mr. F as Ms. E's PCP.[70]

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62 Linda Winner hearing testimony of June 22, 2012 at 3:00 - 13:00 and 44:30 - 45:30. Ms. E had been seeing Mr. F for about four years prior to his assignment as Ms. E's PCP (E testimony (June 26, 2012)).

63 Winner testimony (June 22, 2012) at 43:30 - 44:30.

64 Ball testimony (June 8, 2012) at 1:13:00 - 1:15:00. Ms. E stated that she had experienced significant difficulties in getting appointments with Mr. F; she stated that at one period she was unable to see him for a period of eleven months (K E hearing testimony of June 26, 2012 at 8:30 - 9:30, 24:30 - 28:30, and 31:30 - 34:30).

65 E testimony (June 26, 2012) at 36:15 - 36:35; Ball testimony (June 26, 2012) at 1:07:00 - 1:07:30.

66 E testimony (June 26, 2012) at 36:35 - 36:45.

67 Ball testimony (June 26, 2012) at 1:07:00 - 1:08:30.

68 *Id*. at 1:08:00 - 1:08:30.

69 *Id*. at 1:08:10 - 1:08:40. Ms. E testified that she only had two phone contacts with IPMS and that nothing in these phone contacts should have caused IPMS to change its position (E testimony (June 26, 2012) at 1:19:00 - 1:21:10).

70 Ball testimony (June 26, 2012) at 1:08:20 - 1:08:40.

During the pendency of these proceedings the parties stipulated to temporarily lift the restrictions otherwise imposed by Ms. E's CMP placement. Ms. E testified that her medical care was better without the CMP restrictions than with them.[71] She believes that people assigned to the CMP are viewed as hypochondriacs and prescription drug abusers and that doctors don't like to see them as patients.[72] Mr. Ball of ACS testified that medical care (or access to it) is no worse during a CMP placement than outside a CMP placement.[73] However, his perspective was based on being a program referrer rather than a program participant.

D. Relevant Procedural History

In response to the Division's November 28, 2011 notice, Ms. E requested a hearing on that action on January 17, 2012. After delays for motion practice, Ms. E's hearing began on June 8, 2012, continued on June 22, 2012, and concluded on June 26, 2012. Ms. E was represented by Mark Regan of the Disability Law Center of Alaska. Ms. E attended the hearings and testified on her own behalf. Kimberly Allen of the Attorney General's Office attended the hearings and represented the Division. Jason Ball and Linda Winner, R.N. of Xerox Government Health Care each attended one or more of the hearings and testified on behalf of the Division. The post-hearing briefing was concluded, and the record closed, on July 31, 2012.

III. Discussion

A. Statutes and Regulations Applicable to the Care Management Program

The federal Medicaid statute on which the Care Management Program (CMP) is based is 42 U.S.C. 1396n(a)(2).[74] That statute allows states to restrict "for a reasonable period of time the provider or providers from which an individual . . . can receive [Medicaid] items or services, if—

> (A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or

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71 E testimony (June 26, 2012) at 39:15 - 40:15.

72 *Id*. at 1:01:00 - 1:02:30.

73 Ball testimony (June 26, 2012) at 1:05:00 - 1:07:30.

74 The implementing regulations for 42 U.S.C. § 1396n(a)(2) are 42 C.F.R. § 456.3, titled "Statewide Surveillance and Utilization Control Program," and 42 C.F.R. § 431.54. The latter regulation provides in relevant part:

> (e) Lock-in of recipients who over-utilize Medicaid services. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met: (1) The agency gives the recipient notice and opportunity for a hearing . . . before imposing the restrictions. (2) The agency ensures that the recipient has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality. (3) The restrictions do not apply to emergency services . . . .

services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

The Department of Health and Social Services (DHSS) implements a Care Management Program through a regulation, 7 AAC § 105.600, which provides in relevant part:

(a) The department may restrict a recipient's choice of medical providers if the department finds that a recipient has used Medicaid services at a frequency or amount that is not medically necessary as provided in (b) and (c) of this section.

(b) In order for a recipient to be identified as a potential candidate for restriction under this section, one of the following must occur:

(1) a referral is made . . . indicating that the recipient has used a medical item or service at a frequency or amount that is not medically necessary;

. . . .

(3) the recipient, during a period of not less than three consecutive months, uses a medical item or service with a frequency that exceeds two standard deviations from the arithmetic mean of the frequency of use of the medical item or service by recipients of medical assistance programs administered by the department who have used the medical item or service as shown in the department's most recent statistical analysis of usage of that medical item or service.

(c) Once a recipient is identified under (b) of this section, the department will conduct an individualized clinical review of the recipient's medical and billing history to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary. The review must be conducted by a qualified health care professional. The reviewer shall consider (1) the recipient's age; (2) the recipient's diagnosis; (3) complications of the recipient's medical conditions; (4) the recipient's chronic illnesses; (5) the number of different physicians and hospitals used by the recipient; and (6) the type of medical care received by the recipient.

(d) If after the review under (c) of this section is complete the reviewer determines that the recipient's use of a medical item or service is not medically necessary, the department will (1) monitor the recipient's usage for 90 days; or (2) notify the recipient in writing that the department will restrict a recipient's choice of provider as provided in (e) of this section.

(e) If the department determines that it is necessary to restrict a recipient's choice of provider under (d)(2) of this section, the department will first offer the recipient the opportunity for a fair hearing in accordance with 7 AAC 49. The department may immediately restrict the recipient's choice of providers if the recipient does not request

a hearing 30 days or less after receiving notice of the department's intent to impose a restriction.

(f) If the department prevails after a fair hearing or the recipient does not request a fair hearing 30 days or less after receiving notice of the department's intent to impose a restriction, the department will select one primary care provider and one pharmacy within reasonable proximity to the recipient's home . . . . The recipient may obtain services and items from only the designated provider and pharmacy, except as follows: (1) the recipient may receive medical services from another enrolled provider if the designated provider refers the recipient to the other enrolled provider; (2) the recipient may receive emergency services from any enrolled provider . . . .

(g) The department may only restrict provider choice for a reasonable period of time, not to exceed 12 months of eligibility. The department will review the restriction annually. If the department determines that the restriction should extend beyond 12 months of eligibility, the department will provide the recipient notice and an opportunity for a new fair hearing under (d)(2) and (e) of this section.

B. The Parties' Contentions

The Division asserts that its placement of Ms. E into the CMP was correct because its actions complied with 7 AAC 105.600.[75] Ms. E, on the other hand asserts:

1. The notice provided by the Division was not legally sufficient because it did not properly inform Ms. E of what she needed to do at hearing to contest the Division's decision.[76]

2. ACS' Phase II Review did not adequately analyze Ms. E's individual circumstances, and particularly the psychological reasons why Ms. E might have sought medical help in the way that she did.[77] Ms. E's impairments make it difficult for her to schedule and keep medical appointments.[78]

3. Ms. E's circumstances have changed since the period on which the Division's CMP placement decision was made.[79]

4. The relevant federal statute and regulation require that a recipient placed in a CMP still have reasonable access to medical services of adequate quality. The Division did not make an effort to ensure this, and Ms. E has not had reasonable access to medical services of adequate quality since being referred to the CMP.[80]

These arguments are addressed below in the order stated.

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75 The Division's Responsive Post-Hearing Brief at p. 1.
76 Ms. E's Position Statement of May 29, 2012 at p. 3; Ms. E's Initial Post-Hearing Brief at pp. 9-10.
77 *Id.*
78 Ms. E's Initial Post-Hearing Brief at pp. 8-9.
79 Ms. E's Initial Post-Hearing Brief at pp. 8-9.
80 Ms. E's Initial Post-Hearing Brief at pp. 10-11.

C. Ms. E Received Adequate Notice of her Placement in the CMP

Ms. E initially asserts that the Division's CMP placement notice of November 28, 2011 (Ex. D) was not legally adequate.[81] Assessment of this argument requires a review of the applicable state and federal regulations concerning required notice of adverse action.

Federal Medicaid regulation 42 C.F.R. § 431.210(a) requires in relevant part that notices issued in the administration of the federal Medicaid program which involve the suspension, reduction, or termination of benefits provide (1) a statement of what action the department intends to take; (2) the reasons for the action; and (3) the specific regulation that supports the action. Similarly, DHSS Fair Hearings regulation 7 AAC § 49.070 provides in relevant part that "unless otherwise specified in applicable federal regulations, written notice to the client must detail the reasons for the proposed adverse action, including the statute, regulation, or policy upon which that action is based."

In this case, the Division's notice stated the action the Division intended to take (*i.e.*, placement of Ms. E into the CMP).[82] It also detailed its reasons for placing Ms. E in the CMP.[83] Finally, the Division's notice stated the specific regulation (7 AAC §105.600) supporting the Division's action.[84] Accordingly, the notice provided to Ms. E was sufficient under both 42 C.F.R. § 431.210(a) and 7 AAC § 49.070.

More broadly, the primary purpose of notice in this context is to allow a party to prepare a defense or response to the proposed change in the administration of her benefits. This purpose was adequately served in that Ms. E had extensive information about the reasons for her placement in the CMP before the first hearing session began, and even more information before the third and last hearing session concluded. Her counsel did not request additional time, beyond the third session of the hearing, to develop the case further in response to the testimony of the Division's witnesses.

Ms. E observes that the notice did not explain the law to Ms. E, telling her that high usage does not inevitably lead to a CMP, that she could still have reasonable access to care, and that she could challenge details such as the selection of her PCP. However, notice need not be perfect in order to be legally sufficient.[85] The Division's notice in this case complied

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81 *See* Ms. E's Initial Post-Hearing Brief at pp. 7-11; Ms. E's Post-Hearing Reply Brief at pp. 3-5.

82 Ex. D1.

83 Exs. D5 - D22.

84 Ex. D2.

85 *See Fairbanks North Star Borough v. College Utilities Corp*., 689 P.2d 460, 463 (Alaska 1984); *Nhall v. Provision House Workers Union, Local 274*, 623 F.2d 1322, 1325 (9th Cir.1980).

with applicable state and federal regulations. Accordingly, the notice provided by the Division was adequate.

D. The Phase I Review Properly Found Ms. E's Utilization of Medicaid Services to be Statistically Exceptional

In order to place Ms. E in the Care Management Program, the Division must first demonstrate that she meets at least one of three "Phase I" criteria described in 7 AAC 105.600(b), one of which relates to statistically exceptional usage. Ms. E did not assert that these "Phase I" criteria had not been satisfied, focusing instead on issues related to the Phase II review.

E. The Phase II Review Adequately Considered Ms. E's Unique Circumstances

After the Phase I threshold is met, the Division must then demonstrate that Ms. E satisfies the "Phase II" criteria set forth in 7 AAC 105.600(c). This entailed an individualized clinical review of Ms. E's medical history to determine how Ms. E used the medical services, and whether that usage was medically necessary. That "Phase II" review was required to consider (1) Ms. E's age; (2) Ms. E's diagnoses; (3) any complications from her medical conditions; (4) her chronic illnesses; (5) the number of different physicians and hospitals she has used; and (6) the type of medical care she received.

The nurses who originally performed Ms. E's Phase II review are no longer employed by ACS and did not testify. However, another nurse (Ms. Winner) reviewed all of the evidence on which the original reviewers' decision was based, and reached the same conclusion they did. Ms. Winner credibly testified that she reviewed Ms. E's entire medical history for the 15 month period in question, determined how Ms. E had used medical services, and determined whether that usage was medically necessary. Ms. Winner concluded that Ms. E had over-used Medicaid services (used medical items or services at a frequency or amount not medically necessary), and that she was therefore eligible for placement in the Care Management Program pursuant to 7 AAC 105.600(b)-(c).

Ms. Winner's conclusions appear to be facially valid based on the medical records in the hearing record in this case. Ms. E asserts, however, that ACS' Phase II Review did not adequately analyze her individual circumstances, and particularly the psychological reasons why she sought medical help in the way that she did. Ms. E asserts that her impairments make it difficult for her to schedule and keep medical appointments.

Initially, it should be noted that Ms. E does not challenge the CMP selection criteria themselves as stated in 7 AAC 105.600(b) and (c). Rather, she asserts that 7 AAC 105.600(b) and (c) were not properly applied because they did not consider her individual circumstances.

Ms. E asserts several arguments as to why the Phase II review did not appropriately consider her individual circumstances. First, she asserts that her visits to hospital emergency departments were really visits to hospital "urgent care" facilities, and that she did not really make an excessive number of trips to emergency rooms. This argument fails, as a factual matter, for the reasons stated in Section II at p.3, above.

Next, Ms. E asserts that her emergency department visits should not be held against her because she was seeking treatment for her knee, and an orthopedic specialist later determined that Ms. E in fact had a badly torn meniscus in her right knee. This argument is superficially appealing. However, of the seven ED visits reviewed, only three were for knee and/or leg pain.[86] Three other ED visits were related to anxiety and efforts to avoid staying at homeless shelters, and the other one involved sore throat pain.[87] Further, even though the evidence supports Ms. E's complaints of knee and leg pain, the fact that this had become a chronic (rather than an emergent) problem means that Ms. E's use of the ED to treat this problem could still be inappropriate. Accordingly, the fact that Ms. E ultimately underwent surgery to repair her torn meniscus in August 2011 does not render the Phase II review suspect.

Finally, Ms. E asserts that her agoraphobia and Post-Traumatic Stress Disorder (PTSD) made it difficult for her to schedule and keep medical appointments, and that this was an important reason that she sought medical help from EDs on an unscheduled basis. However, this was asserted solely as argument by Ms. E's counsel, and there is no real evidence in the record to support it. Further, even assuming that people with mental impairments have a difficult time making and keeping appointments, Ms. E's peer group of permanently disabled adults undoubtedly contains many with mental impairments, so this issue was necessarily taken into consideration to some extent by the Phase I review.

F. Post-Placement Changes in Some of Ms. E's Circumstances do not Invalidate the Division's CMP Placement Decision

Ms. E next asserts that, because her prior knee problem has now been surgically resolved, it is no longer appropriate to place her in the CMP. However, this argument assumes that Ms. E was referred to the CMP *only* because of her use of hospital EDs to treat her knee pain. However, as noted above, of the seven ED visits reviewed at Phase II, only three were for knee and/or leg pain.[88] Three other ED visits were related to anxiety and efforts to avoid staying at homeless shelters, and

[86] See Section II at pp.3-4, above.
[87] *Id.*
[88] See Section II at pp. 3-4, above.

the other one involved sore throat pain.[89] As of the date of hearing, Ms. E was still homeless, and still had medical issues unrelated to her knee pain; her knee surgery has not remedied these other problems. There is no evidence indicating that Ms. E would not continue to misuse EDs for her other medical problems, or for her housing problems, just because her knee has been fixed. Finally, over-use of EDs comprised only two of Ms. E's five exceptions; the other three exceptions would be completely unaffected by an improvement in Ms. E's knee and leg pain. Accordingly, although Ms. E's knee surgery is clearly a positive development, it does not, by itself, make her referral to the Care Management Program inappropriate.

G. The Division has not Denied Ms. E Reasonable Access to Medical Services of Adequate Quality

Finally, Ms. E asserts that the Division has not taken appropriate action to ensure that she has reasonable access to medical services of adequate quality since her referral to the CMP. Ms. E asserts that the Division should not have designated ANP F as her CMP provider in the first place, and that it is difficult for her to get appointments to see Mr. F.

Initially, it is clear that both 42 U.S.C. 1396n(a)(2) and 7 AAC 105.600(h) require the Division to provide those placed in the CMP with reasonable access to medical services of adequate quality. What is not clear is whether any difficulties Ms. E may have had in accessing medical services, since being referred to the CMP, can be attributed to the breach of any duty owed Ms. E by the Division.

Admittedly, ACS never asked Ms. E who she wanted to be her primary care provider (PCP) prior to assigning Mr. F. However, it was not unreasonable for ACS to assign Mr. F as Ms. E's PCP in the first instance because Ms. E's medical records indicated that he had previously acted as such. When, following Ms. E's placement in the CMP, Ms. E requested that she be assigned a new PCP, ACS worked with Ms. E to find someone. ACS almost succeeded in securing Independence Park Medical Services (IPMS) as Ms. E's PCP, but IPMS backed-out after contact with Ms. E, and it was necessary for ACS to reassign Mr. F as Ms. E's PCP. Ms. E herself testified that "[n]o [provider] wanted to take [her]."[90] While this is unfortunate, the record does not indicate that this situation is in any way attributable to the Division or ACS.

Ms. E broadly stated at hearing that she had difficulties in getting in to see Mr. F and that, at one point after being referred to the CMP, she had been unable to access Medicaid services for a

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89 *Id.*

90 E testimony (June 26, 2012) at 36:35 - 36:45.

period of four months. However, ACS's phone records indicate that, when ACS contacted Ms. E on March 15, 2012 to assist her in getting a new PCP, she told ACS that she had not been able to work on that because she had been "overwhelmed" and "dealing with housing issues."[91] This was still the situation when ACS called again to work with Ms. E on March 20 and March 26, 2012.[92]

Further, ACS's records indicated that, when Ms. E called ACS about getting taxi vouchers to visit Mr. F on May 11 and May 14, 2012, she did not indicate that she was having any trouble getting in to see him.[93] In addition, Ms. E did not testify that any of her medical conditions were exacerbated as a result of any delay that might have occurred in getting in to see her PCP. Finally, under 7 AAC 105.600(f), Ms. E still had the right to receive emergency services from *any* enrolled provider in the event that an inability to access her PCP was actually creating a medically serious situation.

In summary, the law prevents the Division from restricting those placed in the CMP from reasonable access to medical services of adequate quality. The preponderance of the evidence indicates that the Division has not so restricted Ms. E in this case.

IV. Conclusion

The Division is justified in placing Ms. E in the Medicaid Care Management Program, pursuant to 7 AAC 105.600, based on her over-utilization of medical services during the period at issue. Accordingly, the Division's decision of November 28, 2011, placing Ms. E in the Care Management Program, is affirmed.

Dated this 18th day of December, 2012.

Signed
Jay Durych
Administrative Law Judge

91 Ex. G3.
92 Ex. G4.
93 Exs G4 and G5.

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 8th day of January, 2013.

By: *Signed*
Name: Jared C. Kosin
Title: Executive Director, Office of Rate Review
Agency: DHSS

[This document has been modified to conform to the technical standards for publication.]