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

In the Matter of	)	
	)	OAH No. 17-0579-MDX
Q G	)	Agency No.
	)	

DECISION

I. Introduction

Q G appeals a decision by the Division of Health Care Services (Division) to place her in the Alaska Medicaid program's Care Management Program (CMP) for twelve months, based on her level of usage of Medicaid services. This decision concludes that Ms. G's use of medical services during a six-month review period justifies her placement in the Care Management Program for twelve months, pursuant to 7 AAC 105.600. Therefore, the Division's decision is affirmed.

II. Facts[1]

A. Relevant Procedural History

On May 1, 2017, the Division notified Ms. G that it was placing her in the Care Management Program, because it had determined that she used Medicaid services at a level that was not medically necessary during a six-month review period.[2]

Ms. G requested a hearing.[3] The hearing took place on June 28, 2017. Ms. G appeared in person and represented herself with the assistance of a friend, K C. Both testified in support of Ms. G's appeal. Laura Baldwin represented the Division. Diana McGee, the Division's Care Management Program manager, testified on behalf of the Division, as did Josie Sneed, LPN, and Mindy Frazee, the CMP Coordinator for Conduent, the Division's contractor. All exhibits offered by either party were admitted into the record, which closed following the hearing.

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

Ms. G is a 55-year-old Medicaid recipient who lives in No Name City.[4] She has an extensive and complex medical history. Her left eye was removed approximately nine years ago, after it was damaged by a parasitic infection.[5] She is legally blind in her right eye. Ms. G has ongoing problems managing chronic pain in her head, neck and low back. She attributes her

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1 The following facts are established by a preponderance of the evidence, based on the testimony at hearing and the exhibits submitted.

2 Exhibit D.

3 Exhibit C.

4 Exhibit E, p. 1; Exhibit A, p. 1.

5 G testimony; Exhibit G, pp. 5-6.

facial and head pain to nerve damage caused by the parasite and/or the removal of her left eye. Ms. G's medical history also includes hypertension, headaches and migraines, fibromyalgia, arthritis, lumbar disc degeneration, bipolar disorder, and depression.[6] The Division categorizes her as a permanently disabled adult.[7]

Ms. G has not had a primary care doctor for years, and no single doctor is overseeing her overall health care services. Instead, she sees a variety of specialists, who address the issues within their areas of expertise. Among other specialists, Ms. G sees Dr. K M, ENT, for her ear, nose and throat issues. She sees two eye specialists in No Name City, Dr. T and Dr. S, for eye issues. She sees two additional eye specialists in Seattle, who provide other services, including work toward a prosthetic left eye. Ms. G also sees a pain management specialist at No Name Health Care for her chronic pain.[8] During the time at issue in this case, Dr. Z at No Name Health Care was her pain management doctor.

In 2011, Ms. G signed a pain management contract with No Name Health Care. In the contract, she agreed to receive all her chronic pain medications solely from that provider.[9] Despite her contract, Ms. G has received prescription narcotic medications to relieve chronic pain from providers other than No Name Health Care. During the six-month review period in this case, she received six prescriptions for oxycodone from Dr. M, which provided a 72-day supply of the medication.[10] She received a three-day oxycodone supply following a Providence Hospital ER visit.

During the same six-month period, Ms. G also was receiving prescriptions for oxycodone and oxycontin (another form of oxycodone) from No Name Health Care.[11] However, neither Dr. M's records, No Name Health Care records, or Providence Hospital records indicate that the providers were aware of the other providers' prescription activities. In total, Ms. G received a 320-day supply of oxycodone or oxycontin from the three providers during the six-month review period from October 1, 2015 through March 31, 2016.[12]

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6 Exhibit F, pp. 1, 3; Exhibit H.

7 Exhibit E; Diana McGee testimony.

8 Exhibit H.

9 Division Exhibit I (No Name Health Care pain management agreement signed 7/13/2011, submitted to record during 6/28/17 hearing).

10 Exhibit F, p. 5; Exhibit H.

11 Exhibit F, p. 5; Exhibit H. The summary in Exhibit F refers to "oxycotin." No Name Health Center records reference "oxycontin," so that term is used in this decision.

12 *See* Exhibit F, p. 5.

C. Care Management Program Overview

The Care Management Program restricts a recipient's choice of medical providers to one assigned primary care provider and one pharmacy, who become responsible for oversight of the recipient's medical care.[13] Once assigned, the recipient may only obtain services and items from the designated provider and pharmacy, unless the assigned provider refers the recipient to another provider, or unless emergency services are necessary.[14]

The program is intended to help recipients with continuity of care by ensuring that a single provider is taking a comprehensive look at the patient's overall care, educating and advocating for the patient, and communicating between various specialists.[15] CMP coordinators are also available by telephone to assist patients and providers with issues that may arise, including obtaining referrals or preauthorization.[16] The Division has found that the coordinated medical oversight provided by the program is particularly beneficial to participants with complex medical needs.[17]

D. Care Management Program Selection Process

Pursuant to federal law, the Division of Health Care Services conducts periodic reviews of Medicaid recipients' use of medical services.[18] First, in a process known as a Phase I review, a recipient's claim history is reviewed using specialized software that flags utilization rates significantly exceeding the norm for the recipient's peer group.[19] This is a strictly statistical analysis. An "exception" is flagged when the recipient's usage frequency for a particular indicator exceeds the average usage of that indicator among the recipient's peer group by two standard deviations or more.[20]

When a Phase I review reveals one or more "exceptions," a licensed health care provider then performs an individualized Phase II review. The Phase II review involves an analysis of the underlying medical records to determine whether the "exceptions" exist because of medical necessity.[21] The reviewer takes into consideration the recipient's age, diagnoses, complications

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13 7 AAC 105.600(f). When a provider works within a medical practice or clinic, the participant may see any provider within that practice for primary care.
14 7 AAC 105.600(f).
15 McGee testimony.
16 *Id.*
17 *Id.*
18 *See* 42 C.F.R. § 456.3; McGee testimony.
19 McGee testimony; Frazee testimony.
20 7 AAC 105.600(b)(3).
21 7 AAC 105.600(c); Frazee testimony; Sneed testimony.

of medical conditions, chronic illnesses, number of different physicians and hospitals used, and the type of medical care the recipient received.[22] If the Phase II reviewer does not find medical justification for the exceptional level of use, the Division may place the recipient into the Care Management Program for a reasonable period of time, not to exceed 12 months.[23]

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

In January 2017, the Division initiated a Phase I review of Ms. G's use of Medicaid services during the six-month period from October 1, 2015 through March 31, 2016.[24] The review identified exceptional usage of medical services in seven different areas, as compared to Ms. G's peer group of permanently disabled adults.[25] The seven areas are: (1) number of office visits; (2) number of prescribers of all drugs; (3) number of controlled prescriptions; (4) number of days supplied controlled drugs DEA schedule 2-5; (5) number of pharmacies; (6) number of prescribers of controlled drugs DEA schedule 2-5; and (7) number of days supplied all drugs.[26] Six of the seven exceptions pertain to Ms. G's usage of prescription medications, including controlled opioid medications.

During the Phase I review, members are assigned "exception points" based on level of use, and they are then ranked in comparison with other members of the study group. In this case, Ms. G had the 219th highest number of exception points out of the 13,018 individuals in her peer group.[27] In other words, Ms. G's usage of Medicaid services was in the top two percent of all Medicaid users in her peer group.[28]

Because the Phase I review revealed exceptions, the Division initiated a Phase II review.[29] For that review, Registered Nurse Anita Lucente assessed all of Ms. G's medical records for the review period, to determine whether the exceptions were due to medical necessity or whether they reflected inappropriate use.[30] Ms. Lucente issued a Phase II Report on April 28,

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22 7 AAC 105.600(c).

23 7 AAC 105.600(d), (g). The Division is required to review the restriction annually. If it determines that the restriction should extend beyond 12 months, it must provide the recipient notice and an opportunity for a new fair hearing.

24 Exhibits E, H. Because Medicaid providers may submit claims for up to a year following a date of service, the review period is necessarily many months prior to the date of the Phase I review. This assures a complete and accurate review. McGee testimony.

25 Exhibit D; Exhibit E; Frazee testimony.

26 Exhibit E.

27 Exhibit E, p. 1; Frazee testimony.

28 219 ÷ 13,018 = 0.0168.

29 Frazee testimony; 7 AAC 105.600(c).

30 Exhibit F; Sneed testimony.

2017, finding that Ms. G uses the Alaska Medical Assistance Program in a manner that is inconsistent, disconnected and that does not reflect appropriate continuity of care.[31] The report expressed particular concern about discrepancies in Ms. G's medical records regarding her narcotic use history. It also noted discrepancies or inconsistencies regarding her medical history, and it concluded that Ms. G needs to establish a formal continuity of care.[32] Nurse Lucente recommended assigning Ms. G to the Care Management Program.

A second Phase II reviewer, Licensed Practical Nurse Josie Sneed, also analyzed Ms. G's medical records. During the six-month review period, Ms. Sneed noted that Ms. G saw seventeen providers at twelve facilities, and she used four pharmacies.[33] In a report called a Phase II Addendum, issued on June 1, 2017, Ms. Sneed described the Division's concerns about Ms. G's use of Medicaid services in more detail.[34] She listed numerous concerns and conclusions, including:

• Ms. G received concurrent care or had closely adjoining dates of service for the same or similar presenting complaint;

• The medical records did not document that Ms. G's medical providers were aware of their colleagues' prescription activities for her;

• There was no documented justification for Ms. G's use of multiple pharmacies, significantly above her peer group norm;

• The medical documentation omitted narcotic medications or treatments Ms. G had previously received;

• The Phase II review confirmed and validated all seven exceptions identified in Phase I; and

• Ms. G needs to create an ongoing relationship with one provider to establish formal continuity of care.[35]

The Phase II Addendum specifically discussed examples from the review period that Ms. Sneed concluded further substantiate the exceptions identified in the Phase I review and that highlight Ms. G's need for better coordination and continuity of care.[36] In two of the examples,

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31 Exhibit F.
32 Exhibit F, pp. 1-2.
33 Exhibit F, p. 3.
34 Exhibit F, pp. 3-6.
35 Exhibit F, pp. 3-6. Sneed testimony.
36 Exhibit F, pp. 3-6. Sneed testimony.

Dr. Z advised Ms. G to seek care from a primary care provider, but Ms. G did not do so.[37] On October 12, 2015, Dr. Z referred her to a primary care doctor to address her elevated blood pressure. Ms. G did not follow up. On November 11, 2015, Ms. G asked Dr. Z to become her primary care provider, but he again advised her to see a primary care physician. She did not do so. The Division asserts that Ms. G's failure to comply with her doctor's instructions shows that she needs a relationship with a primary provider who can coordinate her overall care and better meet her medical needs.

The next example in the Addendum also addresses this conclusion. On March 6, 2016, Ms. G sought emergency care from Providence Hospital, complaining of bilateral ear pain, a recurrent problem. Hospital records show that the pain had existed for three days prior to Ms. G's visit, and Ms. G came to the ER because she could not wait for an appointment with Dr. M.[38] The ER doctor prescribed oxycodone and instructed Ms. G to follow-up with a previously-scheduled neurologist appointment. The Division concluded that a primary care provider could have treated Ms. G's problem, and she inappropriately relied on emergency department care for a non-emergent problem.

The last example in the Phase II Addendum summarized Ms. G's prescription medication activity. During the six-month review period, Ms. G received 14 prescriptions for oxycodone or oxycontin that provided a 320-day supply of those pain medications.[39] The report expressed particular concern about Ms. G's overlapping prescriptions from different providers. Even more significantly, neither Dr. M's nor No Name Health Care's records indicate that either provider was aware of the other provider's prescription activity.

The Division's overall conclusion was that Ms. G's usage of services during the review period reflected use that was not appropriate under the Medicaid regulations, and it showed problems with her continuity of care. Therefore, the Division decided to place Ms. G in the Care Management Program.[40]

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37 *See* Exhibit F, p. 4; Exhibit G, pp. 5-8.
38 Exhibit G, pp. 5-8.
39 Exhibit F, p. 5.
40 Exhibits D, F; Sneed testimony.

III. Discussion

A. CMP Legal Framework and Appropriateness of Each Review Phase

Federal law allows states to restrict a Medicaid recipient's choice of provider if the agency administering the program finds that the recipient "has utilized [Medicaid] items and services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the State."[41] Any restriction imposed under this provision must be "for a reasonable period of time," and must not impair the recipient's "reasonable access … to [Medicaid] services of adequate quality."[42]

Alaska's utilization guidelines, and the Care Management Program at issue in this case, are established through 7 AAC 105.600. That regulation allows the Department to restrict a recipient's choice of medical providers if it finds the recipient has used Medicaid services at a frequency or amount that is not medically necessary. A usage review is triggered when:

> [T]he 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.[43]

As described previously, the Phase I review compares the recipient to his or her "peer group norm" for various indicators during the review period. The indicators include, for example, the number of office visits, number of ER visits, number of pharmacies, number of drug prescriptions, and the number of days covered by various types of prescription drugs, including narcotics.[44] Here, the Phase I review found that Ms. G's usage during the six-month review period satisfied the exceptional use criteria in seven separate areas. These findings appropriately triggered a Phase II review under 7 AAC 105.600(c).

Consistent with CMP regulations, Ms. Lucente and Ms. Sneed, both qualified medical professionals, conducted the Phase II review. After assessing all of Ms. G's medical records from the review period, both medical professionals identified serious concerns about Ms. G's disconnected use of Medicaid services, particularly her high use of narcotic pain medications

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41 42 U.S.C. 1396n(a)(2)(A).
42 42 U.S.C. 1396n(a)(2)(B).
43 7 AAC 105.600(b)(3).
44 *See* Exhibit E.

prescribed by different specialists who likely were unaware of other providers' prescriptions. Both reviewers concluded that Ms. G meets the criteria for CMP placement.

B. The Division Appropriately Placed Ms. G in the Care Management Program

There is no dispute that Ms. G experiences significant chronic pain, and she has struggled to manage it for many years. Her pain issues are one piece of a complex medical picture, as demonstrated by Ms. G's testimony, medical history, the number of specialists she sees, and her long-term reliance on prescription opioid medications to manage her pain. However, Ms. G's medical care is disconnected, because she only sees specialists who address very specific needs, and who lack complete information about her medical history and medications. Because she does not have a primary care provider, Ms. G does not have a doctor who is aware of the totality of her medical needs, who can care for many of those needs, and who can coordinate between various specialists on others, including prescription medications.

As a result, there are significant gaps in some parts of Ms. G's care and duplication in other areas, such as pain management. The gaps include, among others, the absence of a primary care provider to monitor and treat Ms. G's high blood pressure. It is troubling that Ms. G did not obtain a primary care physician, even after Dr. Z's two referrals during the review period. Her lack of such a provider was likely a contributing factor to her March 2016 ER visit, in which she sought emergency care for a chronic, nonemergent problem that a primary care doctor could have addressed.

The ER visit also highlights Ms. G's disconnected and overlapping use of narcotic pain medications, which is at the heart of the Division's concerns. That visit resulted in another medical provider authorizing the same (or similar) narcotic medication that Ms. G was already receiving from two other providers, because the provider lacked adequate information about Ms. G's medical history. The hospital records lack any suggestion that the ER doctor was aware of Ms. G's other opioid prescriptions.[45]

Similarly, neither Dr. M's records nor No Name Health Care records suggest those providers were aware of the other's opioid medication prescriptions. The overlapping nature of their prescriptions is evident from the medical records, however. For example, on October 7, 2015, Dr. M issued a prescription for a 12-day oxycodone supply. Five days later, Dr. Z wrote a

[45] Those medications were not included on the hospital's list Ms. G's current medications, and they are not referenced by the ER doctor in his report. Exhibit G, pp. 5-9. The ER doctor acknowledged that Ms. G has a long history of chronic neuropathic pain and pain management problems, however.

28-day prescription for the same medication. Eleven days after that, on October 23, 2015, Dr. M wrote another 12-day oxycodone prescription. On November 9, 2015, a different No Name Health Center provider wrote a new prescription for a 28-day oxycontin supply. Ten days later, on November 19, 2017, Dr. M authorized another 12-days' worth of oxycodone.[46]

Despite her pain management contract with the No Name clinic, Dr. M's records show that Ms. G made appointments with him specifically to obtain refills on her prescription pain medications.[47] Likely without knowledge of Dr. M's activities, Dr. Z expressed concerns about the high doses of opioid medications Ms. G was taking, as prescribed by the No Name Health Center alone.[48] A different pain management specialist at the Algone Center also expressed significant concerns about Ms. G's high opioid doses – which at that time were 260 mg daily of oxycontin or oxycodone.[49] The Algone provider expressed additional concerns about Ms. G's risk of misuse or abuse of her medications and questioned whether Ms. G's opioid use was contributing to her headaches.

Ms. G testified that she had informed each provider of her complete prescription history. She could not explain why the providers' records did not reflect this information, except to speculate that the medical staff in each office had omitted her statements by mistake. Given applicable standards for medical record-keeping and the number of providers involved, however, this explanation is highly unlikely to be true.

It is far more likely that the providers were unaware of the other providers' prescriptions, or else they had very incomplete information. Dr. M's records offer no hint he was aware of the opioid prescriptions Ms. G was receiving from No Name Health Care.[50] No Name Health Care records include a specific summary of the "outside medications" Ms. G was taking as of each date of service during the review period - meaning "[a]ll OTC medications and drugs prescribed by other providers."[51] The records identify a long list of medications, but never the oxycodone that was being concurrently prescribed by Dr. M.[52] The No Name records do not otherwise

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46 *See* Exhibit F, p. 5 (summary); Exhibits G, H.

47 *See* Exhibit H, pp. 5, 7.

48 See Exhibit G, p. 4.

49 Ms. G went to the No Name Center in February 2016 on Dr. S's referral. See Exhibit H, pp. 34, 67-68. It is unclear if the No Name Center provider was aware of Dr. M's prescriptions, or if the No Name review only addressed the narcotics Ms. G was receiving from the No Name clinic.

50 Exhibit H, pp. 2–8.

51 Exhibit H, pp. 11, 25.

52 *See* Exhibit H, pp. 11, 13, 15, 17, 19, 21, 24, 26.

suggest that No Name Health Care providers had any awareness of Dr. M's prescription activities. Because of the duplicative prescriptions, Ms. G more likely than not received excessive and medically unnecessary narcotic medications.

One intended benefit of the Care Management Program is to assure oversight of the complete picture of a recipient's medications, thereby avoiding potentially dangerous medication interactions or overdoses, as well as inconsistent treatment plans.[53] The evidence in the record supports the Division's conclusion that Ms. G has overutilized Medicaid services, specifically with reference to her use of prescription medications for controlled drugs. Ms. G clearly received duplicative and overlapping narcotic pain medications from different providers, while those providers had incomplete information about her use of other opioids from other prescribers. She also received disconnected care from a variety of specialists, which resulted in uncoordinated and overlapping care. The Division has met its burden to show that placement in the Care Management Program is appropriate.

C. Ms. G's Ongoing Medical Treatment Needs Are Not a Barrier to Participation in the CMP

Ms. G did not contest the Division's evidence as to the frequency or volume of her use of services. She first argued that she does not need a primary care doctor, because her specialists can handle her medical issues and provide all the services she requires. She asserted, for instance, that Dr. M prescribes the medication she uses to manage her hypertension. In Ms. G's view, a primary care provider is an unnecessary middleman.

This argument is unpersuasive, because Ms. G has care needs that a primary care provider can manage effectively and more efficiently than Ms. G's collection of specialists. Hypertension is one example. However, Ms. G has many other medical issues and concerns that a primary care provider can address, and she will no doubt experience new problems in the future. Further, because she lacks a primary care physician, no one is coordinating between Ms. G's specialists, both to close gaps in her care and to avoid conflicting treatment plans or unnecessarily duplicative care, which is a significant problem in her case. The Division identified legitimate concerns that Ms. G does not receive adequate continuity of care, and she would benefit from a primary care provider who could better track her overall health picture.

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[53] Sneed testimony.

The evidence presented supports the Division's position that placement in the CMP complements rather than undermines Ms. G's need for coordinated care for her complicated medical needs. As Ms. McGee testified, the program is designed for members like Ms. G. The program goal is not to get in the way of the member's health care, but to partner with a provider to advocate for, treat, and coordinate the care of recipients in need of such services.[54] The evidence supports Ms. G's need for such assistance.

Ms. G expressed concern about continuing to see a variety of specialists. The Care Management Program expressly permits referrals to specialists, and it provides logistical support in obtaining those referrals.[55] Further, the Division has a continuing duty under 7 AAC 105.600 to ensure that a recipient has reasonable access to Medicaid services throughout his or her placement in the program. There is no evidence that Ms. G's ability to obtain medically necessary specialty care will be impeded by assignment to the Care Management Program.

Ms. G expressed a strong dislike of the primary care provider to which she was assigned, the No Name City Neighborhood Health Center. During the hearing, the Division explained that it had assigned that provider because it offers many different services under one roof. However, it also expressed its willingness to work with Ms. G on this issue, and it explained how she can request a change to a different primary care provider.

IV. Conclusion

The Division is justified in placing Ms. G in the Medicaid Care Management Program pursuant to 7 AAC 105.600 based on her overutilization of Medicaid services during the review period. Accordingly, the Division's May 1, 2017 decision to place Ms. G in the Care Management Program is AFFIRMED.

DATED: July 12, 2017.

By: *Signed*
Kathryn Swiderski
Administrative Law Judge

54 McGee testimony.
55 Frazee testimony; McGee testimony.

Adoption

The undersigned 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 2nd day of August, 2017.

By: *Signed*
Name: Erin E. Shine
Title: Special Assistant to the Commissioner
Agency: Office of the Commissioner, DHSS

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