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

In the Matter of	)	
	)	
N S	)	OAH No. 16-0088-MDX
	)	Agency No.

DECISION

I. Introduction

N S appeals a decision by the Division of Health Care Services to place her into the Alaska Medicaid program's Care Management Program (CMP) for twelve months, beginning February 1, 2016, based on her level of usage of Medicaid services. After a full hearing and based on the evidence presented, this decision concludes that Ms. S's use of medical services during the time period at issue in this appeal justifies her placement in the Care Management Program for a twelve-month period of time pursuant to 7 AAC 105.600. The Division's decision is affirmed.

II. Facts[1]

A. Overview of Care Management Program and phased review process

The Division of Health Care Services conducts periodic reviews of Medicaid recipients' use of medical services.[2] First, in a process known as a Phase I review, recipients' claims histories are reviewed and compared using specialized software to flag utilization rates that significantly are outside the norm for a recipient's peer group.[3] If a Phase I review finds one or more areas of significantly high usage rates, referred to as "exceptions," a licensed health care provider then performs an individualized Phase II review of the underlying medical records to determine whether these "exceptions" occurred due to medical necessity.[4]

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.[5] The Care Management 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

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

2 Testimony of Diana McGee; testimony of James Jarrett.

3 McGee testimony; Jarrett testimony. Medicaid providers have up to a year to bill for services. Accordingly, the review process described herein, which reviews "paid claims data," necessarily looks at medical services provided in the past – usually more than a year prior. Jarrett testimony.

4 7 AAC 105.600(c); Jarrett testimony; McGee testimony.

5 AAC 105.600(d); Jarrett testimony; McGee testimony.

advocating for the patient, and communicating between various specialists.[6] CMP participants are assigned a single primary care provider and a single pharmacy to be responsible for oversight of the recipient's medical care.[7] Participants may see specialists to whom their primary care provider provides a referral.[8] CMP coordinators are also available by phone to assist patients and providers with issues that may arise, including obtaining referrals or preauthorization.[9] The coordinated medical oversight provided by the program is particularly beneficial to participants with complex medical needs.[10]

B. The Division's review of Ms. S's use of Medicaid services

Ms. S is a 42-year-old woman living in Anchorage. The usage review in this case focused on Ms. S's usage of medical services between October 1, 2014 and March 31, 2015.[11] Ms. S's medical diagnoses at the time of the review period included back pain, neck pain, sleep apnea, insomnia, diabetes, hypothyroidism, and bradycardia.[12] She has a pacemaker, has had multiple spinal surgeries, and sometimes experiences seizures.[13] Ms. S was previously assigned to the Care Management Program in or around 2009, and did not find it beneficial.[14]

1. Phase I Review

In November 2015, the Division performed a Phase I review of Ms. S's utilization of services over a six-month period of time.[15] The Phase I review of Ms. S's usage of services between October 1, 2014 and March 31, 2015, identified exceptional usage in six different areas when compared to her peer group of Alaska Medicaid recipients aged 40-49.[16] These were: number of groups, clinics or facilities; number of "rendering physicians;" number of office visits; number of different diagnosis codes; the number of prescribers of all drugs; and the number of different drugs prescribed.[17]

During a Phase I Review, members are assigned "exception points" based on level of use, and are then ranked in comparison with other members of the study group. During the review

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6 McGee testimony.
7 McGee testimony. Where a provider practices within a medical practice or clinic, a participant may see any provider within that practice for primary care. McGee testimony.
8 7 AAC 105.600(f)(1); Jarrett testimony; McGee testimony.
9 Jarrett testimony; McGee testimony.
10 McGee testimony.
11 Ex. E, p. 1; Jarrett testimony; Testimony of Josie Sneed.
12 Ex. F, p. 1.
13 Ex. F, pp. 7-8, 24, 28; F S testimony.
14 F S testimony; Ex. C, p. 1.
15 Ex. E, pp. 1-2.
16 Ex. E, p. 1.

period, Ms. S had the 137th highest number of exception points out of the 6,896 individuals in her peer group of adults on Medicaid.[18] In other words, Ms. S's level usage was in the top two percent of all Medicaid users in her peer group.[19]

2. Phase II Review

Because the Phase I review found exceptions, the Division initiated a Phase II review of Ms. S's medical usage.[20] For that review, LPN Josie Sneed reviewed all of Ms. S's medical records for the review period, and analyzed those records to determine whether the exceptions were due to medical necessity, or whether they reflected inappropriate use.[21] Ms. Sneed produced two reports – a December 31, 2015, Phase II Review, and a lengthier Phase II Addendum dated February 2, 2015.

The Phase II Review concluded that Ms. S "uses the Alaska Medical Assistance Program in a manner that is inconsistent, disconnected, and [ ] does not reflect continuity of care."[22] In the Phase II Addendum, Ms. Sneed indicated that her review focused on three of the exceptions identified in Phase I – "number of rendering physicians;" "number of groups, clinics, facilities;" and "number of prescribers all drugs" – and evaluated these using five criteria:

- "Concurrent care with other providers;"
- "Closely adjoining dates of service with other providers;"
- "Same date of service with other providers for same/similar presenting complaint;"
- "Diagnoses and consistency of medical history provided;" and
- "Prescription medication activity/compliance with recommended medical treatment."[23]

The Phase II Addendum analyzed five medical visits during the review period that Ms. Sneed found "substantiated" the exceptions identified in Phase I.[24] According to Ms. Sneed, these particular visits are the ones that stood out to her as "red flags," and supported placement in the CMP.[25] Of those five visits, two were to B M, a pain management specialist, two were to the No Name Hospital emergency room, and one was to an urgent care clinic.[26]

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17 Ex. E, pp. 1-2.
18 Ex. E, p. 1; McGee testimony.
19 137 ÷ 6,896 = 0.0199.
20 Jarrett testimony.
21 Ex. F; Sneed testimony.
22 Ex. F, p. 1.
23 Ex. F, p. 3.
24 Ex. F, p. 3.
25 Sneed testimony.

a. Dr. M/No Name Clinic visits

The pain management visits flagged in Ms. Sneed's review occurred on November 21, 2014 and December 19, 2014.[27] The records from the November 21, 2014 visit describe the visit as a follow-up, and reflect that a drug screen performed at the most recent appointment produced negative results "for all prescribed medications."[28] Despite these test results, Ms. S "denies overtaking medication or running out early."[29] Ms. Sneed flagged this visit as "demonstrat[ing] non-compliance with specific medication directions and treatment modalities."[30]

The records from the December 19, 2014 visit reflect that Ms. S's drug screen from the November 21, 2014 visit show continued issues with medication compliance, with Ms. S not taking the medications prescribed by Dr. M, while also testing positive for three separate non-prescribed substances:

> Her results from 11/21/14 drug screen show negative for prescribed Hydrocodone. She is however positive for Diazepam, Restoril, and Methadone, all of which are not prescribed by No Name.[31]

Dr. M reports that Ms. S first claimed that the Restoril had been prescribed by another provider, and then denied taking any of the medications.[32]

At hearing, Mr. S suggested that the medications at issue were appropriately prescribed to Ms. S by other providers. The evidence does not support this assertion. First, both Ms. McGee's testimony and Exhibit G establish that Ms. S's paid Medicaid claims between September 2014 and December 2014 did not include any prescriptions for any of these three medications.

Secondly, Mr. S testified that Ms. S had been provided methadone during an emergency room visit after difficulties with a different pain management provider, Dr. K.[33] But the medical records in the agency record reflect that Ms. S's treatment by Dr. K predated the review period. Based on these records, it is more likely than not true that Mr. S is confused about the timing of these events. Dr. M's records include the May 2014 chart note of Ms. S's first visit to Dr. M, and which summarizes Ms. S's description of her previous treatment with Dr. K, which ended in

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26 Ex. E, p. 4.
27 Ex. E, p. 4.
28 Ex. F, p. 8.
29 Ex. F, p. 8.
30 Ex. F, p. 4.
31 Ex. F, p. 4.
32 Ex. F, p. 15.
33 F S testimony.

April 2014.[34] This summary is sufficiently consistent with Mr. S's testimony to support the conclusion that the events described by Mr. S are the same events summarized in the May 2014 chart note. As a result, these events do not explain the presence of methadone or any other medication in Ms. S's November 2014 drug test.

Thirdly, Mr. S also suggested that the diazepam was given during a medical procedure that Ms. S had during the review period. The hearing record was held open to provide Mr. S the opportunity to submit evidence supporting this contention, but the materials submitted after the hearing do not support this claim. The materials – specifically, what appears to be a pre-procedure questionnaire dated October 24, 2014 – show that Ms. S had a medical procedure at No Name Clinic during the review period. Dr. M's records likewise show that Ms. S had a "Cervical Radio Frequency ablasion" performed on October 1, 2014, and an epidural steroid injection on November 6, 2014.[35] But the additional records submitted by Ms. S do not support his suggestion that the medications at issue in Ms. S's November 21, 2014 drug screen were related to this or any other procedure. In fact, the records support a contrary inference, since the procedure in question was performed at No Name, and Dr. M's chart note expressly describes the three medications at issue as "not prescribed by No Name."[36]

In short, the evidence does not support the suggestion made at hearing that Ms. S's positive drug screen was due to prescribed medications.[37] Dr. M discontinued all medication prescriptions at the December 19, 2014 visit, noting that Ms. S "was released from the pain contract due to inconsistent drug screen results."[38] In her review, Ms. Sneed concluded that the December 19, 2014 visit demonstrated further "non-compliance with specific medication directions and treatment modalities," as well as "discrepancy related to disclosure of prior medical assessment/treatment," and "prescription medication activity."[39]

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34 Ex. F, pp. 8-9.

35 Ex. F, p. 8.

36 Ex. F, p. 15. Mr. S also submitted discharge paperwork from Ms. S's April 20, 2016 surgical procedure, and these records do show a post-operative prescription for valium – one of the three medications flagged as problematically appearing in the 2014 drug screen. But this record from 2016 does not establish that Ms. S had a prescription for this medication in 2014.

37 As discussed further below, even if this were the case, these events would still strongly support a finding that Ms. S's medical treatment during the review period lacked a coordinated continuity of care.

38 Ex. F, pp. 19-21.

39 Ex. F, p. 4.

b. Emergency room and urgent care visits

The emergency room visits addressed in Ms. Sneed's review occurred on February 14, 2015 and March 19, 2015. On February 14, 2015, a Saturday, Ms. S went to the No Name Hospital Emergency Room complaining of a headache and neck pain.[40] The records of that visit indicate Ms. S appeared to be in "no acute distress," reported having a "history of chronic headaches," and indicated she had a "[h]eadache … described as similar to previous headaches."

> She also complains of worsening neck pain, again, chronic, for which she has seen several pain doctors, most recently Dr. M, and was given 10 norco tabs on the 15th of January. As well, she has received dozens and dozens of controlled prescriptions from multiple physicians in the past.[41]

At the emergency department, Ms. S reported that her chronic neck pain had gradually worsened over the past two weeks, with particularly greater pain in the last three days.[42] Ms. S was given five hydrocodone tablets, and told to follow up with her primary care doctor.[43]

In her review, Ms. Sneed identified this visit as an inappropriate use of the emergency room for non-emergency care, noting that emergency services are defined in the Medicaid regulations as those requiring medical care that cannot be delayed for 24 hours or more.[44]

On March 19, 2015, Ms. S again visited the No Name Hospital Emergency Room, again complaining of neck pain and "in mild distress."[45] The records of that visit note: "The patient was seen recently in a clinic (is seen at No Name, but states she cannot be seen until next week."[46] Ms. S reportedly requested "prescriptions for pain medicine to last until her appointment next week," but the emergency room physician denied this request, telling Ms. S, "I do not write prescriptions for opiates for chronic pain, especially when she is under the care of a pain clinic already."[47] She was prescribed Flexeril, a non-narcotic muscle relaxant.[48]

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40 Ex. F, p. 22.
41 Ex. F, p. 23.
42 Ex. F, p. 24.
43 Ex. F, p. 23.
44 Ex. F, p. 4 (quoting 7 AAC 105.610(E)(2)); Sneed testimony ("With her headache it's been going on for a long time . . . She's been seen there many times for the same thing. So, if it's happened before and it's the same symptoms as before, then it's not emergent. It shouldn't be seen in emergency care; it should be seen by your primary care provider").
45 Ex. F, p. 26.
46 Ex. F, p. 26.
47 Ex. F, p. 26.
48 Ex. F, p. 27. The records also reflect that Ms. S was initially discharged at 7:55 p.m. "prior to receiving ordered pain medication," and that the ER called her asking her "to come back for med admin." Ex. F, p. 28. She returned to the Emergency room, where she was given a shot of Dilaudid, as well as valium.

Ms. Sneed's review classifies this visit as another inappropriate use of the emergency room for non-emergent care.[49] Additionally, Ms. Sneed observes that both emergency room visits "illustrate the need to create an ongoing relationship with one provider to establish formal continuity of care to better meet the required medical needs of Ms. S."[50]

Ms. Sneed lastly included an urgent care visit on Sunday, March 22, 2015. At that visit, Ms. S was diagnosed with influenza and prescribed Tamiflu. Ms. Sneed concluded that this visit was an improper use of urgent care, since the records suggested Ms. S had had symptoms for 5-6 days.[51] Ms. Sneed also felt that this visit was concerning because Ms. S had visited another provider within this timeframe – the No Name ER visit three days earlier – and not mentioned any such symptoms, and again reflected "the need to encourage the continued relationship with one provider to ensure continuity of care."[52]

Ms. Sneed's overall conclusion was that Ms. S's usage of services during the review period reflected use that was not appropriate under the Medicaid regulations, and implicated problems with continuity of care. Ms. Sneed's greatest concern was the use of multiple providers, particularly where the records showed that Ms. S was receiving drugs from multiple sources despite a pain contract, and that various prescribers lacked full information about her prescription drug activity.[53]

C. Procedural history

The Division notified Ms. S on December 31, 2015, that she would be placed in the Care Management Program for twelve months, beginning February 1, 2016.[54] Ms. S requested a hearing to challenge the Division's decision.[55] The hearing was originally scheduled for February 22, 2016. At Ms. S's request, and over the Division's opposition, the hearing was rescheduled to March 2, 2016, because she wanted additional time to review the Division's position statement and exhibits.

When the rescheduled hearing was convened on March 2, 2016, however, Ms. S did not appear and did not answer her phone. An order was issued informing Ms. S that her appeal

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49 Ex. F, p. 4.
50 Ex. F, p. 4.
51 Sneed testimony. Ms. Sneed conceded that her addendum erroneously referenced "inappropriate use of the emergency department for non-emergent care," and clarified that the inappropriate use she identified in this visit was Ms. S's use of an urgent care for what Ms. Sneed considered non-urgent needs. Ex. F, p. 5; Sneed testimony.
52 Sneed testimony; Ex. F. p. 5.
53 Sneed testimony.
54 Ex. D.
55 Ex. C.

would be dismissed unless she showed good cause for her failure to appear. In response, Ms. S submitted a written statement indicating she had failed to appear because her phone had been shut off due to lack of funds, and asking for "a second chance." The hearing was rescheduled to April 7, 2016, over the Division's opposition.

When the hearing convened on April 7, 2016, the Division was unable to proceed because a citywide disruption in telephone and internet service had impacted telephone access to the Division, and its witnesses' ability to access case exhibits over the internet. The parties agreed to reschedule the hearing to April 27, 2016.

OAH staff confirmed the hearing date and time with Ms. S on April 19, 2016. When the hearing convened, however, her husband, F S, stated on the record that Ms. S had had an elective medical procedure the previous week, and was on too much pain medication to participate in the hearing.[56] The Division opposed another continuance, and Mr. S, who holds power of attorney for Ms. S, indicated that he was prepared to go forward with the hearing on her behalf. The Division did not oppose this approach. Accordingly, the hearing was held on April 27, 2016, as scheduled. Mr. S represented Ms. S and testified on her behalf. Ms. S did not testify. Terri Gagne represented the Division; Diana McGee, James Jarrett and Josie Sneed testified on behalf of the Division. All of the Division's exhibits were admitted without objection. At the close of the hearing, the record was held open until May 4, 2016, to allow submission of additional documentation or written argument. Both parties submitted additional records during this time.[57]

III. Discussion

A. The Division's review complied with its regulations

Ms. S objects to CMP placement as a violation of her right to freely choose her own medical providers.[58] However, 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

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[56] Ms. S did not contact the Division or OAH to reschedule the hearing upon scheduling this procedure, nor did she notify OAH staff of a potential conflict when contacted about the hearing on April 19, 2016.

[57] On May 3, 2016, Mr. S faxed the following to OAH: a three-page handout from No Name Clinic, dated October 24, 2014; a copy of Ms. S's September 30, 2015 Division of Public Assistance "Family-Self-Sufficiency Plan;" 5 pages of an apparently 10-page April 20, 2016 "discharge orders" document from No Name Hospital; discharge instructions from an October 2015 visit to the No Name hospital emergency department; and copies of appeal-related correspondence that also appear in the record at Exhibit C. On May 4, 2016, the Division filed Exhibit G – a screen shot of all medication claims submitted for Ms. S from September 2014 through December 2014 –and accompanying argument.

[58] F S testimony.

in accordance with utilization guidelines established by the State."[59] Alaska's utilization guidelines are set out in 7 AAC 105.600. That regulation allows the Department to restrict a recipient's choice of medical providers if it finds "that a recipient has used Medicaid services at a frequency or amount that is not medically necessary[.]"

In terms of "frequency or amount of use," such restriction is allowed where:

> [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.[60]

Thus, the Phase I review compares the recipient to his or her "peer group norm" for various indicators – such as the number of physicians seen, the number of office visits, the number of emergency room visits, or the total number of different medications prescribed – during the review period.[61]

When a recipient's use of services as measured by a particular indicator significantly exceeds the norm, the recipient is deemed to have an "exception" – that is, an overutilization of services – as to that indicator. Specifically, an exception occurs when the recipient's usage for a particular indicator exceeds the sum of the peer group's average *plus* twice the standard deviation for that indicator.[62] Here, the Phase I review using these criteria found that Ms. S's usage during the six-month review period satisfied the exceptional use criteria in six separate areas.[63] These findings triggered a Phase II review under 7 AAC 105.600(c).

The Phase II review process requires a qualified health care professional to "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

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59 42 U.S.C. 1396n(a)(2)(A). 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 U.S.C. 1396n(a)(2)(B).

60 7 AAC 105.600(b)(3).

61 *See* Ex. D, pp. 4-5.

62 7 AAC 105.600(b)(3). The example provided in the Division's position statement is that, if the peer group average for a service was 4.51, and the standard deviation is 2.12, an "exception" would occur if the recipient's value for that service exceeded 2 x 2.12 (the standard deviation) plus 4.51 (the average usage). Because (2 x 2.12) + 4.51 = 8.76, the recipient's use of that service would have to exceed 8.76 to receive an exception. Ex. A, p. 2.

63 Ex. E, p. 1. Ms. S's appeal argued that the "peer group" used – all Medicaid recipients ages 40-49 – was inappropriate. Ex. C. But a recipient's placement in a particular "peer group" is based on the recipient's Medicaid eligibility type. Division's Position Statement, p. 4; McGee testimony.

necessary" under the totality of the circumstances.[64] Despite some minor issues in Ms. Sneed's Phase II Review Addendum,[65] the Division met its burden of showing that Ms. Sneed reviewed Ms. S's records for the review period in light of her medical history and the factors identified in 7 AAC 105.600(c).

B. The Division met its burden of proving that placement in the Care Management Program is appropriate

Ms. Sneed's review found that placement in the CMP was warranted based on patterns of use inconsistent with continuity of care. These included Ms. S's high number of rendering physicians, her use of emergency medical services for non-emergencies, and the concerning prescription medication issues demonstrated in the records.[66] The Division has met its burden of proving that placement in the CMP is appropriate on these grounds.

The records from the review period show a failure to take prescribed medications, while also taking other medications that do not appear to have been prescribed and that were not disclosed to her pain specialist, and while also seeking pain medication from the emergency department in an apparent violation of a pain contract.[67] The records reflect a level of either confusion, at best, or deception, at worst, regarding which medications Ms. S was taking and why. Even if the medication discrepancies and inconsistencies were the result of genuine confusion, as opposed to an intent to deceive her various providers, such confusion – particularly when coupled with an exceptionally high number of different rendering physicians – would still support CMP placement.

Ms. S objects to placement in the CMP because she already has a relationship with a primary care physician.[68] As a preliminary matter, the Division is entitled to make a CMP placement based on the member's usage activity during the review period. As such, subsequent changes in the member's usage of services – for example, the subsequent development of a

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64 7 AAC 105.600(c) ("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.")

65 For example, Ms. Sneed's "Summary of Findings" listed a factor as justifying CMP placement – use of multiple pharmacies – that was not in fact one of the exceptions in Ms. S's Phase I review. *See* Ex. F, p. 6. At hearing, Ms. Sneed was not able to satisfactorily explain the inclusion of this item, which was also not supported by the medical records that accompanied her Review Addendum. Certainly, this error raises questions about the reliability of Ms. Sneed's review. However, Ms. Sneed testified credibly that she had reviewed and considered all of Ms. S's medical records from the review period in light of the required factors. And, as discussed below, her testimony and the medical records submitted in Exhibit F satisfactorily established the appropriateness of CMP placement in this case based on other exceptions.

66 Ex. F, pp.1-2, 5-6; Sneed testimony.

67 Sneed testimony; Ex. F, pp. 19, 22.

relationship with a primary care provider after the review period – do not preclude the Division from placing a member in the CMP based on events that occurred during the review period. In any event, the provider that the Division has assigned as Ms. S's primary care provider under the CMP – Dr. L – is her current primary care physician.[69] So CMP placement will not adversely impact Ms. S's relationship with her primary care provider. In short, as a legal matter, Ms. S's existing relationship with a primary care provider does not preclude placement in the CMP, and, as a factual matter, her existing relationship with Dr. L supports the placement decision.

Ms. S objects to placement in the CMP because she feels it will interfere with her ongoing care for her serious medical needs.[70] But the seriousness of Ms. S's health concerns is not a basis on which to reject the Division's decision. Ms. McGee testified that the CMP is expressly intended to assist patients with complex health histories. And Mr. Jarrett testified that CMP coordinators are available to assist patients in accessing needed services. While Ms. S is concerned that CMP placement will interfere with her continuity of care, including her existing relationships with several specialists, there is no evidence to suggest that Ms. S's necessary care will be impeded by this placement. The 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 Care Management Program staff work closely with patients and their primary care providers to ensure continuity of care – including working to ensure that necessary referrals are in place before the CMP placement formally begins.[71] The CMP has an established relationship with Dr. L's clinic, and Mr. Jarett testified that the clinic has worked well with CMP coordinators to ensure that patient needs are met. The objective evidence in the record does not support Ms. S's opposition.

Plainly, the Ss are distrustful of the Care Management Program. But the Division has met its burden of proving that Ms. S's usage of Medicaid services during the review period – particularly, her use of multiple rendering physicians, facilities, and prescribers – was at a frequency or amount that was not medically necessary. The Division is thus legally entitled to place Ms. S into the Care Management Program – a placement supported by the evidence, and which appears likely to be beneficial– and certainly not adverse – to Ms. S's overall health care.

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68 Ex. C, p. 1 ("I already have a primary care physician (which is my right to choose)").
69 Jarrett testimony; F S testimony.
70 Ex. C, p. 1; F S testimony.

Ms. S's speculative assumptions about difficulties she expects to encounter are insufficient to overcome the Division's legal right to enforce the restrictions in 7 AAC 105.600, and its evidentiary showing in support of that placement in this case.[72]

IV. Conclusion

Ms. S's usage of medical services during the review period justifies her placement in the Medicaid Care Management Program pursuant to 7 AAC 105.600. Accordingly, the Division's December 31, 2015 decision to place Ms. S in the Care Management Program is AFFIRMED.

DATED May 10, 2016.

By: *Signed*
Cheryl Mandala
Administrative Law Judge

Adoption

The undersigned, by delegation from 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 24th day of May, 2016.

By: *Signed*
Name: Cheryl Mandala
Title: Administrative Law Judge/OAH

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

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[71] Jarrett testimony. The Division is directed to work with Ms. S's designated primary care physician to ensure that referrals deemed necessary by her primary care provider are in place in order to ensure continuity of care.

[72] Similarly, to the extent to which Ms. S objects to placement in the CMP because she had an unsatisfactory experience in the program in 2009, this is not a legally sufficient basis on which to challenge the Division's current placement decision.