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

In the Matter of	)	
	)	
D U	)	OAH No. 19-0032-MDX
	)	Agency No.

DECISION

I. Introduction

D U 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. This decision concludes that Ms. U's use of medical services during the time period at issue justifies her placement in the CMP. The Division's decision is affirmed.

II. Facts[1]

A. Overview of CMP and phased review process

The Division conducts periodic reviews of Medicaid recipients' use of medical services.[2] When a 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[.]," federal law allows states to restrict a Medicaid recipient's choice of provider.[3] In terms of "frequency or amount of use," such a 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.[4]

In Alaska's Medicaid program, the restriction on a recipient's choice of provider is implemented by placing qualifying recipients in the Care Management Program (CMP).

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

2 McGee Testimony; Amann testimony; Dixon Testimony.

3 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).

4 7 AAC 105.600(b)(3).

Recipients placed in the CMP are assigned a single primary care provider and a single pharmacy to oversee the recipient's medical care.[5]

The Division determines eligibility for the CMP through a two-phase process. In Phase I, the Division reviews and compares recipients' paid claims data—data covering a specific time period of at least 90 days—using specialized software to flag usage rates that deviate significantly from the norm for a recipient's peer group.[6] A recipients' usage is compared to peer groups based on age.[7] This is the step where usage "exceptions" are identified, and "a mathematical analysis of all of the recipient's claims during a particular review period[.]" is conducted.[8]

If a Phase I review reveals one or more areas of significantly high usage rates, referred to as "exceptions," the Division has a qualified health care professional perform an individualized Phase II review of the recipient's medical records to determine whether these "exceptions" were a medical necessity.[9] A license practical nurse (LPN) is a qualified health professional."[10]

In Phase II, the reviewer considers the recipient's age, diagnoses, complications of the recipient's medical conditions, chronic illnesses, the number of different physicians and hospitals, and the type of medical care.[11] It is at the "Phase II review that the circumstances surrounding the exceptions are then considered."[12] This is where "complex medical conditions" are taken into account.[13] If the Phase II reviewer, after evaluating all surrounding circumstance, finds medical justification for the exceptional use levels, no action is taken; however, if it does not find medical justification for the exceptional level of use, the Division may place the recipient into the CMP.[14]

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

Ms. U is a 38-year-old woman living in City A. She was identified through the Division's "statewide surveillance and utilization control" program as over-utilizing Medicaid

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5 McGee Testimony; Amann Testimony.
6 7 AAC 105.600(b); Amann Testimony.
7 *Id.*
8 7 AAC 105.600 (b)(3), *ITMO VE*, OAH No. 16-0146-MDX, (Comm'r of Dep't of Health and Soc. Servs., May 2016), available at https://aws.state.ak.us/OAH/Decision/Display?rec=3335
9 7 AAC 105.600(c); McGee Testimony; Amann Testimony.
10 AS 08.68. 410 (5).
11 7 AAC 105.600(c); McGee Testimony; Amann Testimony.
12 7 AAC 105.600 (b)(3); *ITMO VE*, OAH No. 16-0146-MDX.
13 *Id*.
14 7 AAC 105.600(c); McGee Testimony; Dixon Testimony.

services between January 1, 2018 and June 30, 2018.[15] Ms. U's usage of medical services during that time period triggered the review for eligibility in the CMP.[16] The Division's Phase I review of Ms. U's usage of Medicaid services for the review period identified exceptional levels of usage in thirteen different areas when compared to her peer group of Alaska Medicaid recipients aged 30-39.[17] These exceptional usage areas were in:

- "Number of GRP, Clinic Facility;
- Number of office visit claims;
- Number of rendering physicians;
- Number of rendering physician's assistants;
- Number of rendering APRNs;
- Number of initial office visit claims;
- Number of Lab/Pathology Services;
- Number of Radiology Services;
- Number of Pharmacies;
- Number of Prescribers All Drugs;
- Number of Controlled Drug Prescription 2-5,
- Number of Different Drugs and
- Number of Different Controlled Drugs 2-5."[18]

As to each of these thirteen categories of Medicaid service usage, Ms. U used these services at a rate that was significantly higher than others in her peer group.

The Division's detailed Phase II review of Ms. U's usage of Medicaid services during the time period in question, described further below, concluded her use of these services was excessive because of:

- "Closely adjoining dates of services with providers for same/similar presenting complaints;"
- "Inappropriate us[e] of the Emergency Department for non-emergent conditions;" and
- Ms. U's "non-compliance with specific medication directions and treatment modalities." [19]

More broadly, the Division concluded that this pattern of usage reflected "[t]he need to create and ongoing medical relationship with one provider to better meet all medical needs."[20]

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15 Exhibit E.
16 Exhibit D.
17 McGee Testimony; Amann Testimony; Exhibit E.
18 Exhibit E.
19 Exhibit D p. 1.
20 *Id.*

1. *The Division's Phase I Review*

During a Division Phase I Review, members are assigned "exception points" based on level of use and are then ranked in comparison with other members of the peer review group. In October 2018, the Division, through its contractor, Conduent, performed a Phase I review of Ms. U's usage over a six-month time period, after she was identified as overusing medical services or prescriptions.[21] The Division's Phase I found statistical over-usages as follows:[22]

- While Ms. U's peer group's average number of "GRP, Clinic, Facility" visits 4.6154, Ms. U sought these services 17 times.
- While Ms. U's peers average for "Office Visits Claims" was 4.3750; Ms. U had 48 office visits during the six-month review period.
- While Ms. U's peers averaged treatment 11.0159 times by a "Rendering Physicians;" her own records reflected treatment 31 times by a rendering physician during the review period.
- While Ms. U's peers averaged treatment 2.3750 times by a 'Rendering Physician Assistants," Ms. U was treated by seven different physician assistants during the review period.
- While her peers' averaged 1.4138 "Initial Office Visit Claims," Ms. U had five such visits during the review period.
- While Ms. U's peers averaged 8.4027 "ER Hospital Visit[s]-Outpatient," Ms. U had ten outpatient ER visits during the review period.
- While the average number of "Lab/Pathology Services" for Ms. U's peers was 13.3593, she used such services 38 times during the review period.
- The average number of Radiology Services" used by Ms. U's peers was 3.8590, while Ms. U used these services 19 times.
- The average number of "Pharmacies" used by Ms. U's peers was 2.1283; Ms. U used six.
- For number of "Prescribers All Drugs," Ms. U's peers' average usage was 5.1181, while Ms. U had 18 separate prescribers.
- While her peers averaged 4.2683 "Controlled Prescriptions" during the review period, Ms. U had 23 such prescriptions.
- While her peers averaged 9.6436 different prescribed medications during the review period, Ms. U's number of different drugs was 39.

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21 McGee Testimony; Amann Testimony; Exhibit E.

22 Exhibit E.

- Lastly, while Ms. U's peers averaged 2.0896 different controlled drugs during the review period, she was prescribed ten different controlled drugs during the same period.

As part of the Phase I review, recipients are assigned "exception points" based on the extent of their usage of services. Of the 519 peer group members whose usage was analyzed for the review period, Ms. U was ranked 1 of exception points out of the 519 individuals in her peer group on Medicaid.[23] In other words, Ms. U's use of Medicaid services during the review period was higher than any other Medicaid user in her peer group.[24]

2. *The Division's Phase II Review*

Because the Phase I review found at least one area of statistically high use of Medicaid services, the Division conducted a Phase II review of Ms. U's medical usage.[25] For that review, Division Reviewer Thomas Dixon, a licensed practical nurse, reviewed all of Ms. U's medical records for the review period, and analyzed those records to determine whether the exceptions were a medical necessity or reflected inappropriate use.[26]

Ms. U has complicated medical issues.[27] Her medical records document a history "that includes but is not limited to: [a]nxiety, back pain, degenerative disc disease-cervical, depression, and migraines."[28] Her records also reflect a diagnosis of "UTI, interstitial cystitis, drug seeking behaviors, IBS, gout, kidney stone as source of her pain."[29] In general she has various complaints about pain to hips, legs, knees, abdomen, kidneys, and pelvis.[30]

In the Phase II analysis, a recipient's exceptions are evaluated considering age, diagnosis, complications of medical conditions, any chronic illness number of different doctors and hospitals used, and the type of services the recipient is receiving.[31] Phase II does not second guess an actual medical diagnosis; it simply assesses whether the services sought were medically justified.[32] In short, Mr. Dixon reviewed all of Ms. U's records to determine if, despite the

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23 *Id*.
24 *Id*.
25 Exhibit E; Exhibit F; McGee Testimony; Amann Testimony.
26 Exhibit E; Exhibit F.
27 Ms. U testified she is disabled but did not provide any evidence of a diagnosed disability. Ms. U said she has applied for Social Security Disability, but there has been no disability determination thus far.
28 Exhibit F: Exhibit C.
29 Exhibit G p. 11.
30 Exhibit G pp. 11, 18, 24, 35.
31 Exhibit F.
32 Amann Testimony.

statistically high level at which she used medical services, her use of those services was medically justified.

Mr. Dixon produced a Phase II Report dated November 13, 2018.[33] While not disputing the formal diagnoses made by Ms. U's medical providers, Mr. Dixon concluded that the records as a whole demonstrate "difficulties with continuity of care and overuse of medical services[.]"[34]

Mr. Dixon did not catalog or document all the records he received or reviewed, and instead provided examples which he contends "reveal the justification and/or rationale" justifying her placement in the CMP.[35] Those examples are described below.

The first example Mr. Dixon notes for unjustified medical usage was from February 12, 2018. Ms. U sought care from the Regional Hospital (RH) Emergency Department (ED) complaining primarily "of constant, non-radiating left groin pain" and "hip pain [that] radiates down into her left knee," both of which had worsened "over the past 12 hours," as well as various other intermittent issues with pain and/or numbness.[36] Ms. U reported having been seen by multiple providers for chronic pain, and "expressed frustration over lack of treatment."[37] ED physician K E concluded that the left leg pain for which Ms. U had sought ED care was "not acute," and that Ms. U should follow up with her primary provider.[38] Dr. E also noted that Ms. U had received 90 oxycodone and 60 Lyrica one week earlier.[39]

Six days later, Ms. U returned to the RH ED complaining of "severe bilateral flank pain" and lower back pain.[40] ED physician, L X, noted Ms. U had been seen at the RH ED two days earlier "for similar complaints." She was diagnosed at that time with kidney stones without obstruction, and was given IV morphine and a prescription for hydrocodone during that visit.[41] Dr. X observed Ms. U as "smiling, giggling, and moving her feet around" during the February 18 visit.[42] He noted that Ms. U had "received 18 prescriptions from 5 providers in the last year for controlled substances," not including the hydrocodone prescription two days earlier.[43] Dr. X

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33 Exhibit F.
34 Exhibit F.
35 Exhibit F.
36 Exhibit F p. 4; Exhibit G, pp. 1, 3, 4.
37 Exhibit F, p.4; Exhibit G, p. 1.
38 Exhibit F, p. 3.
39 Exhibit F, p. 4; Exhibit G; p.1.
40 Exhibit G p. 8.
41 Exhibit G, pp. 11-12.
42 Exhibit G, p. 10.
43 Exhibit F; Exhibit G p. 12.

also noted that Ms. U reporting being "out of her narcotic pain medications," and that, "her drug screen is negative for opiates," a result he called surprising "given the amount [that has] been prescribed for her in the last two weeks."[44]

Six weeks later, on April 5, 2018, Ms. U returned to the RH ED, this time complaining of various symptoms including leg pain, a cough, chest wall pain, upper left abdominal discomfort, and "shortness of breath secondary to her pain."[45] Her symptoms were "present intermittently for several days."[46] Her physical exam was remarkable for hyperventilation and "marked anxiety with rapid speech."[47] Dr. E advised her to follow up with her primary care provider.[48]

Ms. U returned to the RH ED the following day, complaining of abdominal pain and distension over the past 24 hours, as well as (again) left-sided back and leg pain, and months of intermittent urological and gynecological symptoms.[49] She was treated by Dr. F T, who discharged her with a diagnosis of constipation after lab work and multiple imaging tests were normal.[50]

On May 21, 2018, Ms. U visited the Medical Center ED "complaining of masses in various parts of her body (despite being told otherwise by various doctors) as well as many other medical complaints."[51] Ms. U's complaints included "waking up [that] morning feeling generally off," as well as a multitude of other subjective complaints.[52] She described having seen "multiple providers during the last few weeks" and being "frustrated they keep telling her she does not have any masses."[53]

Ms. U was seen by Dr. G H, who observed that Ms. U had been "seen 8 times in the ER between here and Regional" since January 2018. Upon examination of available recent medical records, Dr. H noted that Ms. U had been seen days earlier by an obstetric oncologist, whose chart notes reflected "a difficult visit with the surgeon trying to educate the patient that there is no mass or cancer."[54] Ms. U also reported having been seen by Dr. W Z several times.

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44 Exhibit G, p. 12.
45 Exhibit. G, pp. 18, 22.
46 Exhibit G p. 22.
47 Exhibit. G, p. 21.
48 Exhibit G. p. 23.
49 Exhibit F, p. 5; Exhibit G, pp. 29-38.
50 Exhibit G, pp. 34-38.
51 Exhibit F, pp. 5-6; Exhibit G, p. 39.
52 Exhibit G, p. 39.
53 Exhibit G, p. 39.
54 Exhibit G, pp. 39-40.

Reportedly he told her she has a pelvic mass; however, she told Dr. H not to call Dr. Z for a consult. Ms. U was "not open to [Dr. H] discussing with her that there is no evidence of [a] mass," becoming "increasingly agitated" during the visit before ultimately eloping from the ED.[55] Dr. H's chart note expressed concern that Ms. U's concerns and complaints were reflective of either "somatization disorder or potentially drug seeking behaviors."[56]

The day after her May 21 visit to the MC ED, Ms. U visited the RH ED with similar complaints.[57] She described having been seen the previous day at MC, "where she states they did not listened to her and she was advised to see her PCP," but reported that her primary care provider had then told her to come to the ED.[58] She was diagnosed with bacterial vaginitis and prescribed antibiotics.[59]

Citing the above six ED visits, Mr. Dixon's Phase II Review concluded Ms. U "should be assigned to the CMP," and that such placement in the CMP "will directly increase the likelihood of establishing, encouraging and maintaining appropriate access to care for Ms. U."[60]

C. Case Management outcome following Phase I and Phase II assessments

Based on the results and conclusions of the Phase I and Phase II reviews, the Division exercised its discretion to restrict Ms. U's choice of providers under the CMP Guidelines of service for twelve months, beginning January 1, 2019.[61] Placement in the CMP means that, except in the case of a life-threatening or potentially disabling emergency or when her primary care physician provides a referral, a recipient must receive all Medicaid medical services from his or her assigned primary care physician and assigned pharmacy. [62] A recipient assigned to the CMP is responsible for payment for any non-emergency medical treatment received from other providers unless referred to those providers by the assigned Primary Care Provider.[63]

III. Procedural history

The Division notified Ms. U on December 1, 2018, that she would be placed in the CMP for twelve months, beginning January 1, 2019.[64] Ms. U's requested a hearing to challenge the

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55 Exhibit G, p. 40.
56 Exhibit G, p. 44.
57 Exhibit F, p. 6; Ex. G, pp. 46-59.
58 Exhibit G, p. 46.
59 Exhibit G, p. 51.
60 Exhibit F.
61 Exhibit D.
62 Exhibit D.
63 Exhibit D.
64 Exhibit D

Division's decision.[65] The hearing was initially scheduled for January 30, 2019, but was rescheduled to February 19, 2019. At the February 19, 2019 hearing, Ms. U requested a second continuance to gather documents. The request for a continuance was granted over the Division's objection.

The hearing was finally held, with all the parties and witnesses present by phone, on February 28, 2019. Laura Baldwin represented the Division. Diana McGee, Wes Amann, and Tom Dixon testified on behalf of the Division.[66] Ms. U testified on her own behalf. She also called her mother, M N, as a witness.

The Division's exhibits were admitted without objection. Ms. U did not submit any additional documents, but Exhibit C of the Division's exhibits were provided by Ms. U.

IV. Discussion

As noted above, when a Medicaid recipient uses items and services at a frequency or amount not medically necessary, federal law allows the state to restrict a recipient's choice of provider for a finite and reasonable time period.[67] The Division determines eligibility for the CMP through the two-phase process. The purpose of CMP is to help recipients with continuity of care by ensuring that a single provider takes a comprehensive look at the patient's overall care, communicates between specialists, coordinates care, and generally ensures that all providers are on the same page.[68]

A. The Division met its burden of showing that during the review period Ms. U used Medicaid services in a manner that is not medically necessary.

Mr. Dixon's review found that placement in the CMP is warranted based on patterns of use inconsistent with continuity of care. These patterns included inappropriate use of the emergency room for non-emergency care; closely adjoining dates of services with other providers for same or similar presenting complaints; non-compliance with specific medication directions and treatment modalities; an extensive prescription medication history; and providing inconsistent medical histories.[69]

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65 Exhibit C.

66 Ms. McGee is the CMP Programs manager within the Division of Health Care Services. Mr. Amann is the supervisor for statistical analysis on CMP cases. Mr. Dixon is the licensed professional nurse who reviewed the medical records.

67 42 U.S.C. 1396n(a)(2)(A); 42 U.S.C. 1396n(a)(2)(B).

68 Testimony Mr. Amann; Testimony Ms. McGee; Testimony Mr. Dixon.

69 Exhibit F.

1. *Inappropriate use of the emergency department*

The Division defines an emergency as an "[o]utpatient hospital services and physician services provided to recipient in response to sudden and unexpected onset of illness or accidental injury that requires immediate medical attention to safeguard the recipient's life; in this paragraph 'immediate medical attention' means medical care that the department determines cannot be delayed for 24 hours or more after onset of the illness or occurrence of the accidental injury."[70] The Division's Medical Assistance statute defines emergency hospital services as those "that are necessary to prevent the death or serious impairment of health of the individual[.]"[71] Even using the more liberal definition of emergency, Ms. U over-used emergency services multiple times for non-emergency matters.

On February 12, 2018, Ms. U went to the ED for knee pain. She sought ED services on February 16, 2018 and February 18, 2018, for similar presenting complaints. She went to the ED on April 5, 2018, for bilateral knee redness "which began about 12 hours ago and has progressively improved[,]" and which the ED doctor concluded were not emergencies, and yet, Ms. U returned, to the ED the following day.[72] Ms. U went to the ED on May 21, 2018, because she was "feeling off." During the May 21, 2019 ED visits she told Dr. H she had "seen multiple providers during the last few weeks and she is frustrated they keep telling her she doesn't have any masses." And, again, on May 22, 2018, Ms. U went to the ED again for aching pelvic pain and 3-4 days of bloating, with the ED provider noting she had been seen at another ED the previous day "for the same complaint."

These are not emergencies. These are not sudden or unexpected. None of those complaints were serious impairments needing immediate attention; many of which had lasted for days before seeking emergency relief at the ED. These are chronic, subjective ailments that Ms. U could, and should, have contacted her primary doctor to establish a treatment plan, instead of seeking services from ED.

2. Failure to follow medical recommendations

Mr. Dixon also was concerned with Ms. U following medical recommendations. On February 12, 2019, Ms. U was directed to "follow up with her primary provider."[73] While there

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70 7 AAC 106.61(e)(2).
71 AS 47.07.900(8)(A); *In re B. N.* 18-1319-MDX (OAH February 2019)
72 Exhibit G p 30.
73 Exhibit G p. 4.

are no records reflecting that she spoke to her primary doctor, she returned to the ER, twice more for similar complaints.[74] On April 5, 2018, Ms. U went to the ED, and was again "instructed to follow-up with Her primary care physician. Strict return precautions were given." [sic].[75] Yet, Ms. U returned to the ER the following day for abdominal pain that had begun 24 hours beforehand, instead of following ED recommendations to see her primary physician.[76]

3. *Inaccurate medical history*

Mr. Dixon also noted concern with Ms. U's recitation to professionals of her medical history. The clearest example is her visit with Dr. H, at which she insisted she had "masses in various parts of her body," but became increasingly agitated and walked out of the ED when Dr. H attempted to discuss with her the records and evidence to the contrary.[77] She perpetuated this claim the following day to Dr. Dickie; he notes she was "apparently recently seen at gyn oncology clinic I suspect for abnormal Pap seen and did have either a procedure or biopsies done. I can't find no record of the exact events."[78] The designation of a primary care doctor can identify accurate medical findings and make referrals to an appropriate specialist for the benefit Ms. U.

4. *Prescription medicine history*

Mr. Dixon concluded Ms. U's prescription and pharmacy use during the review period was concerning because of the prescription activity during this time. Ms. U was on a pain contract but "received 18 prescriptions from 5 providers in the last year for controlled substances."[79] Ms. U also "received 90 oxycodone acetaminophen and 60 Lyrica around 5th of February."[80] Despite this February 18, 2018, Ms. U Dr. X observed" her drug screen is negative for opiates which would surprise me given the amount is being prescribed for her in the last two weeks"[81] Dr. X noted "patient has a history or narcotic dependence."[82] If Ms. U was not following recommendation of dosages for the prescriptions, this would be another example of her not following medical advice. If Ms. U's medical needs did not require the medication and

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74 Exhibit G pp. 9, 11, 13.
75 Exhibit G p. 23.
76 Exhibit G p. 30.
77 Exhibit G p. 43.
78 Exhibit G p. 52.
79 Exhibit G p. 12.
80 *Id.*
81 *Id.*
82 Exhibit G p. 52.

she sought them for other reasons, this is further support of her seeking medical services in non-emergency circumstances. Whatever the reasons, the designation of one doctor and one pharmacy will help sort out these inconsistencies and will streamline Ms. U's care.[83]

5. *Frequency of ED visits for related complaints*

Mr. Dixon also noted the frequency with which Ms. U sought services at the ED, and the closely adjoining dates with same or similar complaints, supports placement in the CMP. Between February and June 2018, Ms. U "was seen 8 times in the ER between here and Alaska Regional."[84] She sought treatment from the ED on February 5, February 12, February 16, February 18, and April 5, 2018 for hip and knee pain from her motor vehicle accident 16 years ago.[85] And on April 6, 2018 she was seen for abdominal pain.[86] She went to the ED again for abdominal pain on May 21, 2018, and, again, on May 22, 2018 "for the same complaint."[87] The records support Mr. Dixon's conclusion that Ms. U's frequent use of the ED for the same or similar issues reflected an improper over usage of these services and justifies the Divisions placement of Ms. U on CMP.

B. Ms. U has not demonstrated that placement in the CMP is inappropriate

The Division has provided ample examples of the basis for which Ms. U qualifies for the CMP. However, Ms. U does not want to be in the CMP. While she advances various arguments against this placement in the program, none are persuasive.

1. *Ms. U was appropriately evaluated under Phase I and Phase II for eligibility in the CMP*

Ms. U asserts she should not be part of the CMP program. She believes because she is disabled, if she were categorized with other disabled peers, she would not have had statistically exceptional usage under Phase I. However, to be placed in a "peer group" of permanently disabled adults, Ms. U needed to show she belonged in the that peer group. To be a member of that peer group, as Mr. Amann testified, the Division of Public Assistance must have documentation that Ms. U has been diagnosed as a permanently disabled adult. However, Ms. U did not provide evidence that she is a permanently disabled adult. Absent a disabled diagnosis,

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83 Exhibit G p. 11.
84 Exhibit G.
85 Exhibit G pp 1 -28.
86 Exhibit G p 30.
87 Exhibit G pp. 3-959.

the Division appropriately placed her in the peer group of same-age Medicaid recipients for purposes of the Phase I review.

Because Ms. U was appropriately found to be statistically exceptional under Phase I, it is appropriate to have her usage reviewed under Phase II. In the Phase II review, Ms. U's complex history was considered when determining whether the services used, even if statistically high, was medically justified. However, as described above, there are multiple examples of Ms. U utilizing services in a manner that was not medically justified. In short, Ms. Ms. U's objections to the way she was categorized for each Phase is without merit, and the process in which the Division determined Ms. U's eligibility was appropriate.

2. *Ms. U Ongoing Medical Treatment Needs Are Not a Barrier to Participation in the Care Management Program*

Ms. U also objects to placement in the CMP because she fears her complex ongoing needs will go unmet in the CMP. Ms. U seemed very set on "proving" that she was in legitimate pain each time she went to the ED. She seems to conflate having a medical need with having a medical emergency. It is undisputed Ms. U has a complicated medical history. But her efforts to address her problems has resulted in her utilizing services in a manner that is not medically justified.

While Ms. U expressed concern about her complex needs being unsuitable for the CMP, the Division's placement of Ms. U in the CMP complements rather than undermines coordinated care for her complex medical needs. As Ms. McGee testified, the CMP is expressly intended to assist patients with complex health histories, and CMP coordinators are available to assist patients in accessing needed services and making referrals to specialists and logistical support in a streamlined fashion.[88]

Thus, while Ms. U has reservations about the program meeting her needs, the objective evidence in the record does not support her opposition on that basis. The evidence in the record supports the conclusion that Ms. U will benefit from placement in the CMP, with a single provider charged with overseeing her general care and, where appropriate, directing her to services that will meet her needs.

[88] 7 AAC 105.600 (b)(3); 7 AAC 105.600 (f); Dixon testimony; McGee testimony; *ITMO VE*, OAH No. 16-0146-MDX.

V. Conclusion

The Division has met its burden of proving that Ms. U's usage of medical services during the review period justifies her placement in the Medicaid CMP. Accordingly, and because Ms. U's objections to that placement did not refute the basis for which she qualifies for CMP placement, the Division's decision to place Ms. U in the CMP is AFFIRMED.

Dated: March 29, 2019

Signed
Hanna Sebold
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 10th day of May, 2019.

By: *Signed*
Name: Jillian Gellings
Title: Project Analyst
Agency: Office of the Commissioner, DHSS

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]