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

In the Matter of:	)	
	)	
B.C.	)	OAH No. 19-0143-MDX
______________________________	)	Agency No. 19-HCS-0029

DECISION

I. Introduction

B.C. is a Medicaid Recipient. She has a variety of serious medical problems, for which she frequently accesses medical services. Her use of services during the period January 1, 2018 through June 30, 2018 was so high that she was statistically identified as an exceptional user of medical services. Further qualitative analysis of her actual use of services revealed that B.C's use of services, particularly emergency room visits and her delays in treating serious medical conditions, was not consistent with medical necessity. Therefore, the Division of Health Care Services (Division) placed B.C. in its Care Management Program, which limits her access to medical providers.

B.C. appealed, and a hearing was held. During the hearing, the Division established that B.C.'s use of health care services was not always medically necessary. B.C. withdrew her participation in the hearing before it was completed, and as a result there was not a complete record on which to determine whether she had rebutted the Division's showing on the medical necessity issue. Based on the record presented, the Division has shown that B.C. meets the requirements for being placed in the Care Management Program. Therefore, the Division's decision is affirmed.

II. Facts

B.C. is a 24-year-old resident of City A of the City C area. B.C. has significant health problems. When she was born she apparently tested positive for crack cocaine as a result of her mother's drug use while pregnant. As a result she has a compromised immune system and is abnormally vulnerable to infection.[1] In addition, she is recovering from an unspecified substance abuse problem, has experienced suicidal ideation in the recent past, and suffers from kidney stones, urinary tract infections, peptic ulcer disease, bipolar disorder, and depression.[2] Her primary objection to being placed in the Care Management Program (the Program, or CMP) is that her current primary care provider, Physician's Assistant (PA) T.C., refuses to participate in the CMP. B.C. has been seeing

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[1] B.C. testimony. Division

[2] Exhibit F at 1.

PA T.C. as her primary provider for medical care for the past 7-8 years. PA T.C.'s medical practice is located in City B.

B.C. is a Medicaid recipient. Because she was a heavy user of medical services, her case file was referred to the Care Management Program of the Division of Health Care Services for review. The Program statistically analyzed her use of services during the period of January 1, 2018 – June 30, 2018. It found that, mathematically, she was identified as having "exceptions"—she was an extraordinarily high user of medical services. The Program then referred her case to medical professionals, who, after an individualized examination of her medical use, determined that at least some of her medical visits were not medically necessary. Therefore, on January 29, 2019, the Division placed B.C. in the Care Management Program, to begin on March 1, 2019.

Under the Program, B.C.'s choice of providers and pharmacies would be limited. She would be required to use the primary care physician and pharmacy designated by the Program, unless she received authorization or formal referrals to do otherwise. B.C. appealed the decision. A fair hearing was held on May 10 and May 15, 2019. Laura Baldwin represented the Division at the hearing. B.C. attended both hearing sessions telephonically and testified on her own behalf. She was assisted by her friend, G.P. Although B.C. did not present a formal power of attorney authorizing G.P. to act on her behalf, she orally stated at the outset of the hearing that G.P. would be assisting her and representing her interests in this case.

During the second hearing session on May 15, 2019, after about 35 minutes of testimony and discussion, G.P. stated as follows:

> Obviously I know where this is going, there's really no sense in continuing with this hearing. … So you guys can do what you want, she's just not going to see any of the care providers that are part of this. … She's going to be eligible, she can just choose not to use the services, I guess.

B.C. followed these comments with some brief testimony regarding her childhood difficulties and related health challenges and then hung up the phone. When she was called back, she declined to participate any further in the hearing, said "we're done," and hung up again.

III. Discussion

A. The Division properly identified B.C. under the Phase I review

Medicaid is a federal program that is implemented by participating states. Many aspects of Medicaid are governed by federal law. 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."[3]

In compliance with this directive, to ensure that medical services are not overused, the Division of Health Care Services conducts periodic reviews of Medicaid recipients' use of medical services. First, in a process known as a Phase I review, the Division mathematically analyzes recipients' claims histories. Recipients who use medical services at a rate that is two standard deviations above normal for their peer group (about 2.2 percent of all users) are flagged as exceptionally heavy users of medical services.[4]

Here, after the Division did the math required for a Phase I review of B.C.'s use of medical services, it found that B.C. was in this group of heavy users for her peer group, adults aged 19-29. In this appeal, B.C. disputed the Division's calculations. She did not present any evidence, however, that mathematically her use of services from January 2018 through June 2018 was not two standard deviations above the mean for her peer group in three categories of measured medical services.[5]

B.C. also argued that the Program's reliance on old 2018 data is flawed. The Division explained, however, that medical providers have up to one year to bill the Division for services provided to Medicaid patients, and it is required by law to wait until it has all billings in hand for a patient before performing its statistical review. In order for all records to be complete for the entire peer group so that the result is statistically defensible, the Division must use data from a snapshot in time that is complete. In short, the identification of B.C. as having "exceptions" in Phase I is a mathematical exercise based on the most reliable data reasonably available. B.C. presented no evidence that the Division's mathematical analysis was in error.

B. The Division properly identified B.C. under its Phase II review

Because the Phase I review revealed areas of significantly high usage rates, the Division undertook a "Phase II" review of B.C.'s medical records. During Phase II, Licensed Practical Nurse K.T. was tasked with "determin[ing] how the recipient has used the disputed medical item or service and whether that usage was medically necessary."[6] This review must consider the recipient's age,

[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). 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 "that a recipient has used Medicaid services at a frequency or amount that is not medically necessary[.]" 7 AAC 105.600(a).

[4] Amann testimony. Mr. William Amann, a specialist with the Division's contractor Conduent, testified that there were 541 members of B.C.'s peer group; her usage ranked her at number 26 within that group. Division Exhibit E at 1.

[5] Division Exhibit E at 1-2.

[6] 7 AAC 105.600(c); K.T. testimony.

diagnosis, complications of her condition(s), chronic illnesses, number of physicians and hospitals used, and the type of medical care received.[7] If the Phase II reviewer "determines that the recipient's use of a medical item or service is not medically necessary," the Division may place the recipient into the Care Management Program "for a reasonable period of time, not to exceed 12 months[.]"[8] Thus, the key determination in this case is whether B.C. accessed any medical services in a manner that was not medically necessary.

LPN K.T. determined that services B.C. received during January through June of 2018 were not medically necessary because she (i) was not compliant with medication or treatment "modalities," (ii) made inappropriate use of the Emergency Room, and (iii) needed to "create an ongoing relationship with one provider to better meet all medical needs."[9] She explained at the hearing that the primary factor in her decision was the inappropriate use of the emergency room (ER) at Hospital A, which is located much closer to where B.C. lives than PA T.C.'s office.

As evidence, LPN K.T. pointed to a January 9, 2018 emergency department visit where the treating physician noted "female presents for evaluation of left-sided flank pain in association with difficulty urination and hematuria over the last 24 hours. She states she has had similar symptoms in the past."[10] The evidence showed that B.C.'s condition at that time did not meet the definition of a condition for which emergency services is appropriate under the applicable regulations.[11] LPN K.T. testified that a second emergency room visit on February 21, 2018 fell into the same category; this visit was for a "toothache on the left lower and left upper tooth pain that began one week ago."[12] B.C. failed to present evidence that might explain how either of these two emergency room visits fell within the definition of allowable emergency services under the applicable regulations.

The next emergency room visit discussed by LPN K.T. took place on March 23, 2018. B.C. went to Hospital A ER on that date due to an "overdose," as to which the ER physician noted: "[Patient] became upset and decided to take 18 oxycodone tablets… she was suicidal at the time but denies being suicidal here in the E.D. … She also notes she is supposed to be seeing a counselor but

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7 7 AAC 105.600(c).

8 7 AAC 105.600(d); 7 AAC 105.600(g) ("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[.]").

9 Division Exhibit F at 2; K.T. testimony.

10 Division Exhibit F at 4.

11 *See* 7 AAC 105.610(e)(2) (defining emergency services as "outpatient hospital services and physician services provided to a recipient in response to the sudden and unexpected onset of an 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 the onset of the illness or occurrence of the accidental injury").

12 Division Exh. F at 4.

has not been seeing that person."[13] LPN K.T. did not argue that this incident was not a true emergency; rather she contended that B.C.'s failure to see her counselor meant that she was non-compliant with a treatment modality. As to this incident, B.C. testified that the ER doctor must have misunderstood her comments at the time, because she was not seeing a counselor then and did not have a relationship with one.[14]

The next emergency room visit discussed by LPN K.T. took place on April 23, 2018. B.C. went to Hospital A ER on that date due to "flu symptoms;" the ER physician recorded that "she reports having a cough with nausea and vomiting intermittently over the past month."[15] LPN K.T. drew the conclusion that this incident did not meet the regulatory definition of emergency services, because B.C. had been experiencing the condition for a month.[16] B.C.'s response to this contention was that an urgent care physician directed her to go to the ER, and that after she was tested it turned out that she had pneumonia.[17] LPN K.T. testified that pneumonia is not *per se* an emergency condition, and B.C. failed to present evidence to the contrary.

The final emergency room visit discussed by LPN K.T. took place about 10 days later, on May 3, 2018. B.C. went to Hospital A ER for "evaluation of vomiting which began this morning … vomit was full of bright red blood … patient did not get refill of her Proton pump inhibitor after it ran out. … instructed to [follow up] with doctor for potential refills and reevaluation."[18] LPN K.T. did not contend that this incident failed to meet the definition of an emergency; rather she contended that B.C.'s failure to refill and use her proton pump inhibitor medication meant that she was non-compliant with a treatment modality.[19] B.C. responded in her testimony as to this incident by explaining that she had stopped using her Proton pump inhibitor and instead had resorted to an over the counter medication, but she had then run out of that medication, which led to the increased bleeding and need to visit the ER.

In addition to specifically analyzing each of these ER visits by B.C., LPN K.T. examined the issue of lack of "continuity of care," i.e., whether a continued relationship with one provider would better meet B.C.' medical needs. Continuity of care is defined by the American Academy of Family Physicians (AAFP) as "the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality,

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13 *Id.*
14 B.C. testimony.
15 Division Exh. F at 5.
16 *Id.*; K.T. testimony.
17 B.C. testimony; *see* Division Exh. G at 11-12.
18 Division Exh. F at 5.
19 K.T. testimony; Division Exh. F at 5.

cost-effective medical care."[20] In the context of this case, it essentially means reliance on a primary-care physician to coordinate and oversee the recipient's care and prescriptions. Clearly, on the surface it appears that B.C.'s reliance on a medical practitioner in City B, while living in City A, while at the same time needing to visit Hospital A ER five times over a span of less than four months, and while also utilizing the services of urgent care physicians in the City C area, does not demonstrate a pattern of coordinated, high quality, cost-effective medical care. The concept of continuity of care is not one of the bases listed in the Division's regulations for inclusion in the CMP. However, a serious absence of continuity of care can result in medical services being provided in a manner that is not medically necessary.

In this case, the Division established that three of B.C.'s ER visits (January 9, February 21, and April 23, 2018) were not medically necessary because they failed to meet the definition of a condition requiring emergency medical services. In addition, the Division established that one of the ER visits, on May 3, 2018, was the result of her non-compliance with a treatment modality. In addition, the Division established that the overall pattern of B.C.'s use of Hospital A ER was the result of a lack of continuity of care which could be remedied by her inclusion in the CMP.

The Division met its burden of proof on these issues, and B.C. failed to rebut the Division's evidence. Clearly B.C. was given a challenging start in life by being born to a mother who had used hard drugs during her pregnancy, causing B.C. to test positive for crack cocaine as a newborn infant, which in turn apparently caused her immune system to be compromised. It cannot be disputed that her medical outlook is vastly complicated by these challenges. However, these concerns are not inconsistent with the Division's argument that B.C. would benefit from having a consistent primary care provider, close to her place of residence, who can coordinate and oversee her medical care and hopefully treat her medical problems in a proactive fashion, so that frequent ER visits become unnecessary. In addition, B.C.'s refusal to participate in the latter portion of the hearing meant that the administrative law judge was unable to ask additional questions that might have shed more light on her overall medical situation or on her need to use Hospital A ER five times over a span of less than four months.

Based on the record presented, the Division's decision is upheld.

IV. Conclusion

B.C. used medical services during January 2018-June 2018 at a rate that was exceptionally heavy for a Medicaid recipient in her peer group. The Division of Health Care Services provided

[20] AAFP website (available online at http://www.aafp.org/about/policies/all/definition-care.html).

reliable and credible testimony from a qualified medical professional that specific incidents of her use of the emergency room were not consistent with medical necessity, and that her overall pattern of emergency room usage revealed a lack of continuity of care. Accordingly, the Division's decision to place B.C. in the Care Management Program for a period of 12 months is affirmed.

DATED this 26th day of June, 2019.

By: *Signed*________________________
Andrew M. Lebo
Administrative Law Judge

Adoption

Under a delegation from the Commissioner of Health and Social Services and under the authority of AS 44.64.060(e)(1), I adopt this decision 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 9th day of July, 2019.

By: *Signed*

Name: Andrew M. Lebo

Title: Administrative Law Judge

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