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

In the Matter of:	)	
	)	
L.H.	)	
	)	OAH No. 19-0138-MDX

DECISION

I. Introduction

L.H. appeals a decision by the Division of Health Care Services (Division) placing her in the Alaska Medicaid program's Care Management Program (CMP). This decision concludes that the Division did not err by comparing L.H.'s usage of Medicaid services to that of other adults aged 40-49 in its Phase I review. Further, its Phase II review correctly determined that L.H. used Medicaid services at a frequency or in an amount that was not medically necessary between January 1, 2018 and June 30, 2018. Therefore, the Division was justified in placing her in the CMP for twelve months pursuant to 7 AAC 105.600. Its decision is affirmed.

II. Facts[1]

A. Relevant Procedural History

The Division determined that L.H. used Medicaid services at a level that was not medically necessary during a six-month review period from January 1, 2018 through June 30, 2018. On January 1, 2019, it notified her that it was placing her in the Care Management Program.[2] L.H. requested a hearing.[3] The hearing took place by telephone on March 27, 2019. It was audio-recorded. L.H. represented herself and testified. Laura Baldwin represented the Division. Diana McGee, the Division's Care Management Program manager, testified for the Division, as did Nurse Reviewer K.T., LPN, and Wes Amann, the CMP supervisor for the Division's contractor, Conduent. All exhibits offered by either party were admitted to the record. The record remained open until April 10, 2019, so L.H. could submit evidence showing that the Division of Public Assistance or the Supplemental Security Income program (SSI)

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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.

categorized her as a permanently disabled adult between January 1, 2018 and June 30, 2018. However, no documents were received after the hearing.

B. Overview of the Medicaid Care Management Program

The Department of Health and Social Services "may restrict a recipient's choice of medical providers if the department finds that a recipient has used Medicaid services at a frequency or amount that is not medically necessary."[4] When such a finding is made, the Division may place the recipient in the Care Management Program, which assigns the recipient one primary care provider and one pharmacy. Those providers become responsible for overseeing the recipient's medical care. The Medicaid program will only pay for medical services and items the recipient receives from the designated provider and pharmacy, unless the assigned provider refers the recipient to another provider, or unless emergency services are necessary.[5]

The CMP is designed for recipients who have been identified as over-utilizing Medicaid services. It is intended to reduce medically unnecessary, uncoordinated, and/or duplicative care by improving the recipient's continuity of care. It ensures that a single primary care provider is taking a comprehensive look at the patient's needs, educating and advocating for the patient, and communicating between various specialists.[6] CMP coordinators are also available by telephone to assist patients and providers with issues that may arise, including obtaining referrals or preauthorization.[7] The Division has found that this coordinated medical oversight is particularly beneficial to participants with chronic health problems and complex medical needs.[8]

Placement in the CMP is based on a two-phase review process. First, in a process known as a "Phase I review," the Division identifies Medicaid recipients who are using statistically high levels of Medicaid services. To do so, it uses specialized software that flags utilization rates significantly exceeding the norm for the recipient's peer group.[9] The software flags an

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[4] 7 AAC 105.600. As a requirement for continued receipt of Medicaid funding, federal law requires states have a plan in place "to safeguard against unnecessary utilization of [Medicaid] care and services." 42 CFR. § 456.1(a)(1). Each state's Medicaid agency "must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services[.]" 42 CFR § 456.3(a).

[5] 7 AAC 105.600(f). According to the Division's case presentation in this matter, mental health care services, and vision or dental services are not covered by these restrictions. McGee testimony.

[6] Exhibit B, p. 12; McGee testimony.

[7] McGee testimony.

[8] *Id.*

[9] McGee testimony; Amann testimony.

"exception" if a recipient's usage frequency for a particular indicator exceeds the peer group average for that indicator by two standard deviations or more.[10]

When a Phase I review reveals one or more "exceptions," a licensed health care provider then performs an individualized Phase II review.[11] This process includes the review of all medical records for Medicaid-paid services the member received during the review period "to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary."[12] The reviewer takes into consideration the recipient's age, diagnoses, complications of medical conditions, chronic illnesses, number of different physicians and hospitals used, and the type of medical care the recipient received.[13] If the Phase II reviewer determines that the recipient's use of a medical item or service was not medically necessary, the Division may place the recipient in the Care Management Program for a reasonable period of time, not to exceed 12 months.[14]

C. L.H.'s Use of Medicaid Services during the review period

L.H. is 42 years-old. Her medical history includes chronic back pain, acid reflux, anxiety, depression, asthma, fibromyalgia, hypertension, and sciatica.[15] She is treated by a specialist at Clinic A for her chronic pain. As part of this treatment, L.H. signed a pain contract in which she agreed to receive medication for pain only through that provider.[16] Her pain management plan includes regular use of hydrocodone as well as other prescription medications such as Nortriptyline and Zanaflex.[17]

Between January 1, 2018 and June 30, 2018, L.H. sought emergency department care six times.[18] Five visits involved complaints related to her chronic back pain. Three of those visits took place on the same day, January 24, 2018, when L.H. sought care twice from Hospital A and once from Hospital B.

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10 7 AAC 105.600(b)(3).

11 *See* 42 C.F.R. § 456.3; McGee testimony.

12 7 AAC 105.600(c); Amann testimony; Dixon testimony.

13 7 AAC 105.600(c).

14 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.

15 Exhibit F, p. 1; Exhibit G, p. 1; L.H. testimony.

16 L.H. testimony; Exhibit G, p. 18.

17 *See e.g.,* Exhibit G, p. 47; L.H. testimony.

18 Exhibit F; Exhibit G.

1. January 24, 2018 emergency department visits

On January 24, 2018, a Wednesday, L.H. first presented to the Hospital A emergency department at 9:21 a.m., complaining of back pain.[19] According to the hospital's records, she described the pain as a mild ache but rated it at a 7 on a pain scale of 10. She told hospital staff she needed "something like morphine" to help her control her pain until her next pain management appointment, when she would receive an epidural injection.[20] The ED doctor advised L.H. that narcotics were not appropriate through the emergency department and concluded: "No emergency medical condition is identified."[21] The hospital provided non-narcotic pain relief, and at 10:00 a.m., L.H. reported an improvement in her pain level.

Within an hour of leaving Regional Hospital, L.H. presented at the Hospital B emergency department for treatment of the same problem. At 10:59 a.m., she complained of continuing low back pain and tailbone pain, informing hospital staff that the pain had been present for a week.[22] The emergency provider recommended use of an over-the-counter ointment called Icy Hot and discharged L.H..[23]

Around 4:00 p.m. on January 24th, L.H. returned to the Hospital A emergency department, again complaining of back pain.[24] As with her other hospital visits that day, L.H. did not appear to be in any significant distress or discomfort. The ED provider again informed her that narcotics were not warranted. L.H. replied: "That's ok, I have my own."[25] The hospital again provided non-narcotic medications and referred her to her pain management provider for follow-up.

2. April 13, 2018 emergency department services

On April 13, 2018, L.H. presented at the Hospital A emergency department around 12:30 p.m., vaguely complaining that her whole body hurt.[26] She informed the doctor that she had taken the last of her pain medication several hours before coming to the hospital. She also said she had not been taking her hypertension medication as prescribed, noting that she had not taken it "in a while."

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19 Exhibit G, pp. 1-6.
20 Exhibit G, pp. 1-4.
21 Exhibit G, p. 4.
22 Exhibit G, p. 14.
23 Exhibit G, pp. 14-19.
24 Exhibit G, pp. 7-13.
25 Exhibit G, p. 9.
26 Exhibit G, pp. 21-31.

The emergency department doctor rated L.H. as a vague and unreliable historian. By checking the Alaska prescription drug monitoring program, he also saw that she had filled a prescription for 120 tablets of Vicodin (10 mg) the prior month. He treated her pain with an injection of dilaudid, gave L.H. a prescription for hydrocodone, and advised her to follow up with her pain management provider.

3. June 17, 2018 emergency services

On June 17, 2018, L.H. arrived at the Hospital A emergency department shortly after midnight, complaining of moderate hip and back pain that had started the day before. She was treated with an injection of Toradol and counseled to follow up with Clinic A.[27]

4. June 27, 2018 emergency services

On June 27, 2018, L.H. was transported to the Hospital A emergency department by ambulance around 11:50 p.m. Her 8-year-old son had called 911 after finding her at home, face down and exhibiting decreased responsiveness.[28] When the emergency responders arrived, they observed that L.H. was surrounded by empty bottles of Nortriptyline and Zanaflex as well as empty alcohol bottles.

The emergency department doctor noted that L.H. was "somnolent but arousable to voice" and slurring speech but able to follow commands. Her chief complaint was documented as "altered mental status." L.H. told the doctor that she took the medications, which had been prescribed by her provider at Clinic A, because her muscles felt tense. She also stated that she drank alcohol with the medications.

The ED provider noted L.H.'s use of "multiple sedating medications including narcotics, benzodiazepines, and tricyclic antidepressants," which had been prescribed by multiple providers.[29] He concluded that L.H. passed out due to "multiple medication interactions." She was discharged home in good condition the next morning.

D. Phase I Review of L.H.'s Usage of Medicaid Services

L.H.'s unusually high use of Medicaid services came to the Division's attention as part of the purely statistical analysis in the Phase I review. In this computerized review, the Division

[27] Exhibit G, pp. 32-40.
[28] Exhibit G, pp. 41-61.
[29] Exhibit G, p. 47.

compared L.H.'s usage of Medicaid services between January 1, 2018 and June 30, 2018 to that of her peer group, which the Division determined is "adults aged 40-49."[30]

The analysis identified exceptional usage of Medicaid services in one area as compared to the peer group: L.H.'s number of controlled prescriptions.[31] The average number of controlled prescriptions for adult Medicaid recipients aged 40-49 during the study period was 5.1545. The upper limit of normative usage – defined as the peer group average plus two standard deviations – was 17.0066 controlled prescriptions. L.H. had 19 such prescriptions during this time frame.[32]

During the Phase I review, members are assigned "exception points" based on their level of use of the various indicators. Their level of usage is then ranked in comparison to other members of the study group. For the six-month review period at issue, L.H.'s usage of Medicaid services or items ranked 61st out of the 381 individuals in her peer group.[33]

E. Phase II Review of L.H.'s Medical Records

Because the Phase I review revealed an exception – that is, a category of statistically high usage of Medicaid services – the Division initiated a Phase II review.[34] In this process, Licensed Practical Nurse K.T. reviewed L.H.'s medical records for all claims during the review period to determine whether her usage was due to medical necessity or whether it reflected inappropriate use.[35]

Ms. Sneed issued a Phase II Report on December 31, 2018, concluding that L.H. used Medicaid services at a frequency or in an amount that was not medically necessary. She identified problems including: inappropriate use of the emergency department for non-emergent care; same date of service with multiple providers for the same or a similar complaint; non-compliance with medication or treatment modalities; and high prescription medication activity.[36] She concluded that L.H. needs to create an ongoing relationship with one provider to better meet

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30 Exhibit E, p. 1.
31 *Id.* at p. 2.
32 *Id. See also* Exhibit G, p. 4 (noting 22 prescriptions from 5 different providers for various controlled substances as of 1/24/2018).
33 Exhibit E, pp. 1-2; McGee testimony.
34 Amann testimony; 7 AAC 105.600(c).
35 Exhibit F; Sneed testimony.
36 Exhibit F, p. 2.

all her medical needs. Ms. Sneed recommended assigning L.H. to the Care Management Program.[37]

In a report called a Phase II Addendum, issued on January 30, 2019, Ms. Sneed cited L.H.'s six emergency department visits during the review period as substantiating the Division's concerns and conclusions about overuse of Medicaid services.[38] The Phase II Addendum reiterated the earlier conclusion that L.H.'s medically unnecessary usage of services during the review period warrants placement in the Care Management Program.[39]

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."[40] 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."[41]

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.[42]

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,

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[37] Exhibit F.
[38] Exhibit F, pp. 3-6.
[39] Exhibits D, F; Sneed testimony.
[40] 42 U.S.C. 1396n(a)(2)(A).
[41] 42 U.S.C. 1396n(a)(2)(B).
[42] 7 AAC 105.600(b)(3).

including narcotics.[43] Here, the Phase I review found that L.H.'s usage during the six-month review period satisfied the exceptional use criteria for one indicator.

L.H. argues that the Phase I review in her case was flawed because her usage should have been compared to that of permanently disabled adults rather than adults aged 40-49. She asserts that the Division of Public Assistance recognized her as a permanently disabled adult throughout 2018, stating that she received interim assistance and/or adult public assistance benefits during the six-month review period. She also asserts that she has a pending SSI appeal seeking designation as permanently disabled.

The Division responded that its Phase I review compares members' usage by age group unless the member has been designated as permanently disabled by SSI or the Division of Public Assistance.[44] However, any such designation from the Division of Public Assistance must rely on the methodology used by SSI.[45] It disagreed that it compared L.H. to the wrong peer group, saying she was not rated as a permanently disabled adult between January 1, 2018 and June 30, 2018. If she was, the information it received from the Division of Public Assistance would have categorized her that way. The Division pointed to the Phase I review documentation dated October 9, 2018, which does not reflect a permanent disability rating. It shows that, as of October 9, 2018, the Division's information was that L.H. was not considered permanently disabled.[46] The Division further explained that any changes in her designation would have appeared in its database by October, if the change was effected sometime between January and June 2018.

The Division's evidence satisfies its burden to show it correctly reviewed L.H.'s usage to that of the peer group of adults aged 40-49. The burden then shifted to L.H. to show otherwise. The record remained open after the hearing so she could submit additional evidence, such as documentation showing her status as a permanently disabled adult with the Division of Public Assistance during the relevant time period. However, she did not provide any additional information.

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[43] *See* Exhibit E.

[44] McGee testimony.

[45] *Id.*

[46] Exhibit E, pp. 1, 3. The October 9th Individual Profile for L.H. included a COE or "category of eligibility" of AF20, which does not identify her as a permanently disabled individual. Exhibit E, p. 3; McGee testimony; Amann testimony.

L.H. did not overcome the Division's showing on this issue. Therefore, the Division did not err by comparing her use of Medicaid services to that of other adult recipients aged 40-49, and the Phase I review correctly flagged her exceptionally high usage of services in at least one category. This justified the Phase II review.

Consistent with CMP regulations, Licensed Practical Nurse Sneed conducted the Phase II review. She reviewed all L.H.'s medical records from the review period and identified serious concerns about her use of Medicaid services during that time. Among other issues, she expressed concerns with L.H.'s frequent emergency department visits for non-emergent needs. She also noted L.H.'s multiple visits to the ED on the same day for the same or similar complaints and her noncompliance with medication and treatment instructions. Nurse Sneed concluded that many of L.H.'s ED visits were not medically necessary and reflected uncoordinated care. She found that L.H.'s usage showed a need for an ongoing relationship with a primary care provider to better provide for her medical needs.

B. The Division Appropriately Placed L.H. in the CMP

There is no dispute that L.H. experiences significant chronic pain. However, the Division showed that she regularly sought emergency department care during the review period for needs that were not emergent and that could have been handled by her primary care provider or pain specialist. This resulted in disconnected, unnecessarily costly, and unnecessarily duplicative medical care. L.H.'s multiple prescriptions from different providers, and her failure to consistently follow the providers' instructions for taking those medications, also resulted in unnecessary problems and showed her need for better coordinated care.

In discussing her repeated use of emergency department services, L.H. acknowledged that some of her visits were not medically necessary. However, she also argued she sometimes needed emergency care because her pain prevented her from properly caring for her children. When that happens, she asserted it is an emergency, as she needs to be able to move around and function for them.

This argument is unpersuasive and does not establish a medical emergency.[47] Under any definition of medical necessity or the need for emergency services, the evidence strongly supports the Division's conclusion that L.H. did not require emergency department care for most

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[47] Even regarding the potential for a social services emergency, L.H. agreed that another adult lives in her home. That individual likely could assist with the children on days L.H.'s pain is particularly problematic.

of her six ER visits during the review period. To warrant placement in the CMP, the Division need not show that every emergency department visit during the review period was medically unnecessary; it need only show that L.H. received some medically unnecessary services.

Here, the Division clearly made that showing for the care received on January 24, 2018. That day involved three different emergency department visits. Each visit was for the same or similar complaint, which the medical documentation shows was clearly non-emergent. The Division also made that showing for the April 13th and June 17th emergency visits, which similarly involved non-emergent issues that could have been handled by L.H.'s primary care doctor or pain management provider. The Division additionally showed significant problems resulting from L.H.'s multiple medications from different providers and noncompliance with her providers' instructions, which created or contributed to other medical problems on April 13, 2018 and June 27, 2018.

Though the Division need not tie its Phase II determination to the specific exceptions flagged in Phase I, L.H.'s medically unnecessary emergency care visits resulted in additional controlled prescriptions. The totality of the evidence supports the Division's conclusions that L.H. over-utilized Medicaid services during the review period, and that she likely would benefit from the coordinated care and oversight offered by the CMP.

C. The CMP is not a barrier to L.H.'s treatment needs.

L.H. objected to the assignment of one primary care provider to coordinate her care, particularly if she must start with a new provider. The Division alleviated this concern when it advised that her current primary care provider could become the assigned provider, if the provider agrees. The Division also explained the process for accessing a different pharmacy if the assigned provider is unable to fill a prescription. This addressed Ms. Goudeau-Smith's concern about relying on one pharmacy for her medications.

There is no evidence that L.H.'s ability to obtain medically necessary care will be impeded by assignment to the Care Management Program. Rather, the evidence is that the program is likely to improve her continuity of care.

IV. Conclusion

The Division showed that it complied with applicable regulations in placing L.H. in the Care Management Program. L.H.'s testimony did not demonstrate that placement is

inappropriate or that her access to medical care is likely to be unreasonably limited by the CMP. The Division's decision is affirmed.

Dated: April 18, 2019

*Signed*___________________________
Kathryn Swiderski
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 2nd day of May, 2019.

By: *Signed*___________________________
Name: Lawrence A. Pederson
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.]