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

In the Matter of	)	
	)	
A.J	)	OAH No. 25-3206-MDX
	)	

DECISION

I. Introduction

Mr. A.J appeals a decision by the Division of Health Care Services (Division) placing him in the Alaska Medicaid program's Care Management Program (CMP) due to overutilization of Medicaid services. Mr. J objects and raises several arguments. He asserts that the Division erred in placing him in the program, and such placement will compromise his ability to get the medications he believes are needed to address his medical conditions. He argues that this will exacerbate his anxiety, stress and paranoia.

The Division showed that Mr. J's usage of certain Medicaid services between August 2024 and July 2025 was at a frequency or amount that was not appropriate under applicable regulatory limits. As a result, the Division was justified in placing Mr. J in the CMP for 24 months. Its decision is AFFIRMED.

II. Facts[1]

A. Relevant Procedural History

The Division determined that Mr. J overutilized Medicaid services during the period of August 1, 2024, through July 31, 2025.[2] On October 13, 2025, the Division sent him a notice advising him of his placement in the Care Management Program.[3] Mr. J requested a hearing.[4]

The telephonic hearing began as scheduled on January 13, 2026. Mr. J participated and represented himself. Ms. Laura Baldwin, Fair Hearing Representative, represented the Division. Ms. Liz Larue and Ms. Katelyn Petty were prepared to testify as the Program Manager Supervisor and Program Manager, respectively. However, shortly after the hearing began, Mr. J seemingly experienced a significant medical event, as his breathing became labored and his speech garbled. With considerable difficulty, he indicated that he was alone, experiencing a

---

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

2 Ex. D, pp. 1-2.

3 *Id.*

4 Ex. C, p. 1.

seizure, and needed to hang up to call 911. The hearing abruptly ended. OAH staff later followed up and ascertained that Mr. J had received the medical assistance he needed.

Imagining that participating in-person might be less stressful for Mr. J, the hearing was initially rescheduled for the OAH conference room in Anchorage. However, Mr. J advised OAH staff that an in-person or video hearing would trigger another seizure and requested a disability accommodation. Accordingly, the matter was stayed to explore accommodation options. A telephonic status conference was held on February 26, 2026 to discuss what he needed to fully participate in the fair hearing. To avoid another stress-provoked seizure, Mr. J asked that the hearing be conducted via correspondence. His request was granted. Additionally, he agreed that the undersigned could rely on the January 26, 2026 email he sent to the parties as his written argument against placement in the CMP. Accordingly, an order issued stating that the record would include his January 26 email, as well as the Division's October 30, 2025 Position Statement. Furthermore, the Division was given a deadline of March 9, 2026 to submit any supplemental information to augment the record, and Mr. J was given until March 16, 2026 to submit responsive arguments.

On March 6, 2026, the Division submitted additional briefing. Mr. J did not submit anything further. On March 16, 2026, the record closed.

B. The Care Management Program

The Department of Health "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 appropriate….[.]."[5] There is a specific list of actions by the recipient that qualify as "not appropriate."[6] When such a finding is made, the Division will place the recipient in the CMP, which assigns the recipient one primary care provider and one pharmacy.[7] 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

[5] 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 C.F.R. § 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 C.F.R. § 456.3(a).

[6] 7 AAC 105.600(b).

[7] 7 AAC 105.600(d).

emergency services are necessary.[8] The CMP is designed for recipients who have been identified as over-utilizing Medicaid services.[9] It is intended to reduce medically unnecessary, uncoordinated, and/or duplicative care by improving the recipient's continuity of care.

C. Mr. J's Use of Medicaid Services During the Review Period

Due to his limited participation in the hearing, little is known of Mr. J's medically diagnosed health conditions. In communications with the parties, including his request for a fair hearing, he references other health issues including PTSD, depression, and attacks of tachycardia (fast heart rate) and uncontrollable shakes.[10] His age is unknown, as is his current living situation, support systems, or lifestyle. Therefore, the claims reflecting his Medicaid usage must be evaluated without this contextual information.

In making the decision to place Mr. J in the CMP, the Division relied upon claims records received from his providers.[11] The first area the Division alleges that his usage exceeded guidelines falls under 7 AAC 105.600(b)(1)(C): receiving an opioid prescription from two or more prescribers during a period of three consecutive months. In support of this assertion, the Division submitted records indicating that Mr. J received an opioid prescription from Dr. U. D with Medical Office 1 in April 2025, from Dr. T. H with Medical Office 2 in May 2025, and from M.G with Medical Office 3 in June 2025.[12] This represents three opioid prescriptions from different providers during a span of three consecutive months, April – June, 2025.

The second area of his reported Medicaid overutilization falls under 7 AAC 105.600(b)(1)(G): using a medical item or service more frequently than others in one's peer group during a period of not less than three consecutive months.[13] For Mr. J, the claims indicate

---

8 7 AAC 105.600(e).

9 Ex. D, p. 4.

10 J test., Ex. C, p. 1.

11 Division's March 6, 2026 supplemental briefing. Pursuant to 7 AAC 105.220, a provider's endorsement of a check received by the Division in payment of a service provided to a Medicaid recipient represents the provider's certification the claim is accurate. As all checks associated with the claims were endorsed by providers, the Division accepted them as true and accurate.

12 Ex. E, pp. 4-5.

13 More specifically, the individual "used 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." 7 AAC 105.600(b)(1)(G). For Mr. J, his usage was evaluated against that of eligible Medicaid recipients between 40 and 49 years of age. Division's March 6, 2026 supplemental briefing, pp. 3-4.

that between November 2024 and January 2025 he received services from 17 different provider groups, clinics, and facilities, while the average for his peer group at this time was 3.89 providers.[14] Between February and April 2025, Mr. J received services from 12 different providers, while the average for his peers was 3.86 providers.[15] Finally, between May and July 2025 he received services from 18 different entities, while the average for his peer group was 3.24 providers. [16]

The final area of Medicaid overuse alleged by the Division falls under 7 AAC 105.600(b)(1)(H): receiving treatment through an emergency department three or more times for a non-emergent condition during a period of 12 consecutive months. Pursuant to the submitted claims, between November 2024 and July 2025 – a period of 9 consecutive months – Mr. J was seen at Medical Office 4 in January 2025 for adjustment disorder with anxiety, in May 2025 for acute post-procedural pain, in June 2025 for a nosebleed, and July 2025 for pain in his right hand.[17] He was also seen at Providence in June 2025 for a nosebleed.[18]

III. Discussion

A. CMP Legal Framework

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."[19] 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."[20]

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 appropriate. Inappropriate usage of Medicaid services is then defined under 7 AAC 105.600(b) by a list of ten specific actions. For Mr. J, his over usage met

14 Ex. E, p. 7.
15 *Id.*
16 *Id.*
17 Ex. E, pp. 1-3.
18 *Id.*
19 42 U.S.C. 1396n(a)(2)(A).
20 42 U.S.C. 1396n(a)(2)(B).

the criteria of three of the actions, including receiving excess opioid prescriptions, seeking medical services at a rate far greater than his peers, and receiving emergency treatment for non-emergent conditions.

B. The Division Appropriately Placed Mr. J in the CMP

Mr. J argues that the Division has not justified his placement in the CMP, as it did not submit medical records, triage notes, discharge summaries, or evaluations by qualified clinicians to establish that his usage of Medicaid services was inappropriate.[21] He is correct that under 7 AAC 105.600(b)(2), a qualified health care professional may evaluate whether an individual's usage of Medicaid services was not medically necessary by reviewing the person's medical history. However, 7 AAC 105.600(b)(1) provides the Division with an alternative option. Instead of relying on a medical provider's opinion, the Division may show that an individual's usage of Medicaid services is inappropriate if it meets the definition of one or more of the listed actions that qualify as Medicaid overutilization. Under this section of the regulation, the Division is not required to rely on the opinion of a medical professional or submit the medical records of the Medicaid recipient. The alleged abuse of services may be established by other means.

Accordingly, the Division elected to submit claims records to establish its allegations of Medicaid overuse by Mr. J. First, the records indicate that Mr. J received opioid prescriptions from three separate providers during three consecutive months. This clearly meets the criteria of 7 AAC 105.600(b)(1)(C), which defines receiv[ing] an opioid prescription from two or more prescribers during a period of three consecutive months as an overutilization of Medicaid services. Second, 7 AAC 105.600(b)(1)(G) references us[ing] a medical item or service with a frequency more frequently than others in [ones] peer group during a period of not less than three consecutive months.[22] During three separate three-month periods, Mr. J received services from 17, 12, and 18 different medical entities, respectively. This usage clearly was at a rate many

---

[21] Mr. J's January 6, 2026 email.

[22] More specifically, the individual "used 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." 7 AAC 105.600(b)(1)(G). For Mr. J, his usage was evaluated against that of eligible Medicaid recipients between 40 and 49 years of age. Division's March 6, 2026 supplemental briefing, pp. 3-4.

times higher than his peer group during the same time periods, which averaged less than four visits.

The final area of Medicaid overuse alleged by the Division falls under 7 AAC 105.600(b)(1)(H), which references seeking emergency treatment three or more times for a non-emergent condition during a period of 12 consecutive months. The Division asserts that emergency services are medically appropriate only in response to the sudden and unexpected onset of an illness or accidental injury that requires immediate attention to safeguard the recipient's life. "Immediate medical attention" is defined as medical care that cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the injury.[23]

Pursuant to the submitted claims, over the course of 12 consecutive months Mr. J sought emergency treatment for an adjustment disorder, acute post-procedural pain, pain in his right hand, and two nosebleeds.[24] But without additional information about the severity of these medical conditions, it is not possible to determine if the emergency visits represent an overutilization of Medicaid services. The medical providers who treated Mr. J all made the same note: "Low level of medical decision making."[25] But without further explanation, this comment offers no insight into the severity of his medical issues. However, reaching a definitive conclusion regarding the emergency visits is unnecessary, given that the Division established inappropriate usage of Medicaid services under the other subsections discussed above.

IV. Conclusion

The Division established that pursuant to 7 AAC 105.600, Mr. J used Medicaid services at a frequency or amount that was not appropriate. Accordingly, the Division's decision to place Mr. J in the Care Management Program for a period of 24 months is AFFIRMED.

Dated: April 8, 2026

Signed

Danika Swanson
Administrative Law Judge

---

[23] *See* 7 AAC 105.610(e)(2). This definition pertains to recipient cost sharing and applies when the Division determines whether Medicaid will pay for emergency department care to individuals already in the Care Management Program.

[24] Ex. E, pp. 1-3.

[25] Ex. E, pp. 2-3.

Adoption

The undersigned, by delegation from the Commissioner of Health, 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 27th day of May, 2026.

By: *Signed*

Name: Danika Swanson

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.]