DEPARTMENT OF HEALTH & SOCIAL SERVICES

PROPOSED CHANGES TO REGULATIONS

MEDICAID CARE MANAGEMENT PROGRAM

7 AAC 105. MEDICAID PROVIDER & RECIPIENT PARTICIPATION.

- 7 AAC 105.600. Restriction of recipient's choice of providers.

PUBLIC REVIEW DRAFT
December 24, 2019

COMMENT PERIOD ENDS: February 25, 2019

Please see the public notice for details about how to comment on these proposed changes.

Notes to reader:

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.

4. When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

Title 7 Health and Social Services.

Chapter 105. Medicaid Provider and Recipient Participation.

7 AAC 105.600 is repealed and readopted to read:

7 AAC 105.600. Restriction of recipient's choice of providers.

(a) The department 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 as provided in (b) of this section.

(b) The department will identify a recipient as a candidate for restriction under this section if one or more of the following occur:

(1) a referral is made to the department indicating that the recipient has used a medical item or service at a frequency or amount that is not appropriate;

(2) the department identifies that the recipient

(A) received prescriptions from one or more providers for medications in total average daily doses that exceed those recommended in Drug Facts and Comparisons, adopted by reference in 7 AAC 160.900;

(B) during a period of three consecutive months, received prescription drugs from three or more pharmacy locations;

(C) during a period of three consecutive months, received an opioid prescription from two or more prescribers;

(D) during a period of three consecutive months, paid cash two or more times for a United States Drug Enforcement Administration-designated Schedule II – V drug;

(E) within a 30-day period, received concurrent prescriptions for opioid and benzodiazepine from more than one prescriber;

(F) over a period of not less than nine consecutive months, was dispensed medication containing buprenorphine with an average daily dose of greater than 16 milligrams;

(G) during a period of not less than three consecutive months, 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;

(H) during a period of 12 consecutive months, received treatment through an emergency department three or more times for a non-emergent condition; for purposes of this paragraph, “non-emergent condition" has the meaning given in 7 AAC 105.600(i);

(I) for a reason that was within the control of the recipient, traveled using department-authorized transportation and failed to receive services for which the travel was authorized;

(J) during a period of six consecutive months, failed to keep three or more appointments for services covered under 7 AAC 105 – 7 AAC 160;

(3) is recommended for restriction under this section by the department's Medicaid medical director or pharmacist, based on evaluation of the recipient's clinical history, including prescription drug monitoring program data, established under AS 17.30.200, and other tracking tools available to the department.

(c) Following identification of one or more instances identified in (b) of this section, the department will

(1) monitor the recipient's usage for 90 days; or

(2) notify the recipient, in writing, that the department will restrict the recipient's choice of provider as provided in (d) of this section and of the recipient's fair hearing rights under 7 AAC 49.

(d) The department will assign a restricted recipient one primary care provider and one pharmacy within reasonable proximity to the recipient's home, and may assign one dental provider and one behavioral health provider. The department will include the word "RESTRICTED" and will identify the designated providers on the recipient's Medicaid identification card.

(e) A restricted recipient may obtain services and items from only the designated providers identified under (d) of this section except that

(1) the recipient may receive medical services from a non-designated enrolled provider if the designated provider refers the recipient to the non-designated enrolled provider;

(2) the recipient may receive emergency services from any enrolled provider; for purposes of this paragraph, "emergency service" has the meaning given in 7 AAC 105.600(i).

(f) The department may restrict provider choice for a reasonable period of time, not to exceed 24 months of eligibility upon initial placement, and 36 months for each subsequent placement. The department will review the restriction before the end of each placement. The department will notify the recipient, in writing before each subsequent placement, of the department's decision to continue to restrict the recipient's choice of provider under (d) of this section and of the recipient's fair hearing rights under 7 AAC 49.

(g) The designation of a provider under (d) of this section may be changed only if the

(1) provider requests the change;

(2) provider disenrolls from the Medicaid program;

(3) recipient moves to a new geographic area; or

(4) department finds that the recipient does not have reasonable access to Medicaid services of adequate quality.

(h) Except as provided in (e) of this section, the department will pay for a service covered under 7 AAC 105 – 7 AAC 160 that is provided to a recipient who is restricted under this section only if the service is performed by a provider designated on the recipient's Medicaid identification card.

(i) In this section,

(1) "emergency service" means

(A) inpatient hospital care provided to a recipient admitted into the hospital from the emergency room of that hospital; and

(B) 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.

(2) “non-emergent condition” means a condition that does not require an emergency service defined in this subsection.

(Eff. 2/1/2010, Register 193; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040