THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services

Division of Health Care Services
Quality Assurance Unit

4501 Business Park Blvd., Building L
Anchorage, Alaska 99503
Main: 907.334.2400
Fax: 907.561.1684

Month xx, xxxx

[First MI Last]
[Mailing Addr]
[City, State Zip]

RE: Alaska Medicaid Coordinated Care Initiative: Reference#[ ]

Dear [First MI Last],

The Division of Health Care Services (DHCS) conducts periodic reviews of how Medicaid recipients are using Medicaid services. The Division reviewed your services and found that you used a higher number of Medicaid Emergency Room visits when compared to other Alaska Medicaid members. Your Medicaid claims history showed you used the emergency room five times or more during one of the two review periods. (The review periods were July 1, 2012 through June 30, 2013 and July 1, 2013 through June 30, 2014.)

Normally, this use requires further review to determine if your use should be restricted to one medical provider and one pharmacy as allowed under Medicaid regulation 7 AAC 105.600. **However, instead, we are offering you the opportunity to voluntarily participate in a new program called the Alaska Medicaid Coordinated Care Initiative (AMCCI). Please see the enclosed brochure for more information.**

By volunteering to participate in the AMCCI program, you will receive personalized one-on-one attention and services from a case manager who will assist you to make appointments, access services, address problems, and obtain referrals to specialists, as needed. You may choose to keep your current providers. The AMCCI is there to help members coordinate their care in the health care system and make the most appropriate use of the benefits of the Alaska Medicaid program.

Your participation in the AMCCI is NOT required. If you choose NOT to participate in the AMCCI, the number and type of services you have used will continue to be reviewed periodically and your use of Alaska Medicaid services *may* still be restricted if certain conditions are met under Medicaid regulation 7 AAC 105.600.

Please check ONE of the boxes and sign below. If you are the legal guardian, you may sign for the member.

☐ I DO want to participate in the AMCCI ☐ I DO NOT want to participate in the AMCCI

Signature: _____ Date: _____
Please check this box if you are signing as the legal guardian of this member ☐

Please return this letter in the pre-paid return envelope no later than Month xx, xxxx, even if you do not wish to participate in the AMCCI. If you decide to participate in the program, you will receive a welcome packet with more information and additional forms to return. If you have questions before signing up for the program, please call one of our Quality Assurance Team Representatives: Stephanie Purcell-Reynolds (907) 334 - 2460, Diana McGee (907) 754 - 3434 or PK Wilson (907) 334 - 2660.

Sincerely,

Debra Taylor

Debra Taylor JD, BSN, RN
DHCS Quality Assurance Manager
(907) 334 - 2400