THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health and Social Services
DIVISION OF HEALTH CARE SERVICES
Quality Assurance Unit
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Anchorage, Alaska 99503-7167
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Fax: 907.561.1684

Month xx, 2014

[First MI Last]
c/o Parent or Guardian
[Mailing Addr 2]
[City, State Zip]

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

Dear Parent or Guardian of [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 child's services and found that they used a higher number of Medicaid Emergency Room visits when compared to other Alaska Medicaid members. Your child's Medicaid claims history showed they 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 child's 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 your child 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, your child will receive personalized one-on-one attention and services from a case manager who will assist them to make appointments, access services, address problems, and obtain referrals to specialists, as needed. You may choose to keep your child's 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 child's participation in the AMCCI is NOT required. If you DO NOT want your child to participate in the AMCCI, the number and type of services used by your child will be continue to be reviewed periodically and your child's 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 parent or legal guardian, you may sign for the member.

☐ I DO want my child to participate in the AMCCI ☐ I DO NOT want my child 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 September 4, 2014, even if you do not wish your child to participate in the AMCCI. If you decide to have your child participate in the program, you will receive a welcome packet for your child 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