Alameda County
Health Care Services Agency

alameda county care connect

Whole Person Care / Alameda County Care Connect Is Ending December 31, 2021

FREQUENTLY ASKED QUESTIONS

Changes to Services that Providers Should Know About

Summary Points

- Alameda County Care Connect, the County's Whole Person Care Pilot Program, is ending on December 31, 2021.
- In Alameda County, most Whole Person Care services are not ending, but some are changing.
- All of the consumers who have been part of the program will be notified as required by the terms of the Whole Person Care Program. You may get questions from your clients and so we want you to know about the changes that are happening.
- For the vast majority of clients enrolled in Care Connect services as of December 31, 2021, services **will not change.**
- Starting January 1, 2022, some services will transition to CalAIM (California Advancing and Innovating Medi-Cal), which will be managed locally by the two Medi-Cal Managed Care Plans Alameda Alliance for Health and Anthem Blue Cross.
- For providers, this may mean new contracts and different reporting requirements—if you are affected, you will receive more information about this through your organization's leadership and health plan partners.

Frequently Asked Questions

What is Whole Person Care?

Since 2016, Alameda County has been participating in a Whole Person Care Pilot for Medi-Cal beneficiaries, funded by the State of California and the Centers for Medicare and Medicaid Services. Alameda County's Whole Person Care pilot is known as Alameda County Care Connect (sometimes called AC3). The goal of AC Care Connect is to make it easier for Alameda County residents who are experiencing homelessness or have complex care needs to get the care and services they need, when and where they need it. AC Care Connect has worked with many partners, including County departments, cities, and local community-based organizations to improve and strengthen our safety net system of care. Some Care Connect activities include:

- Creating the Community Health Record (CHR) and Social Health Information Exchange (SHIE)
    - The SHIE is a secure data platform that houses and integrates individuals' medical, mental health, substance use, housing, social care, legal, incarceration, and crisis response data.
    - Data from the SHIE powers the CHR, an electronic record that care team members can access for a "whole person" view of the individuals they serve. The CHR enables more efficient care

via comprehensive information about a client's utilization of services while also instituting additional protections for sensitive information.
  - Visit these links for more information about the Social Health Information Exchange (SHIE) and Community Health Record (CHR)
- Partnering with Alameda County Behavioral Health to expand Promoting Access to Health (PATH) programs, and to launch Crisis Connect and the Community Assessment and Transport Teams (CATT).
- Developing the Care Connect Academy -- cross-sector training for providers to help them access services for clients across the system (e.g., housing, primary care).
- Creating the Consumer Fellowship, a pipeline program for a cadre of peer support staff, made up of people who share the lived experience of consumers, to provide outreach, engagement, education and other services and expertise.
- Working in partnership with the Office of Homeless Care and Coordination and Health Care for the Homeless to rapidly respond to the COVID-19 crisis by planning, launching, and maintaining **Operation Comfort and Safer Ground** providing safe shelter at 9 hotel sites for over 2,700 households.

And, these two programs which have demonstrated reductions in Emergency Department and inpatient hospitalizations, and are part of the reason California has decided to offer new on-going CalAIM services that are rolling out January 1, 2022:

- Partnered with the Alameda Alliance for Health and Anthem Blue Cross to pilot the **Health Homes / Complex Care Management** programs—establishing Community Based Case Management Entities (CBCMEs).
- With local cities, community-based organizations and the Alameda County's Housing Solutions for Health team, developed the **Health, Housing and Integrated Services** housing support bundles.

For more information about Alameda County Care Connect, visit the website: https://accareconnect.org/.

What is CalAIM?

CalAIM, or California Advancing and Innovating Medi-Cal, is a five-year (2022-2026) statewide initiative intended to improve quality of life and health outcomes for Medi-Cal beneficiaries as well as achieving long-term cost savings/avoidance, by implementing broad delivery system, program, and payment reform across the Medi-Cal program. It builds on the successful outcomes of Whole Person Care Pilots (WPC), Health Homes Program (HHP), and other programs, and focuses on the needs of our most vulnerable community members, such as people experiencing homelessness, justice-involved individuals, and those who use multiple systems of care.

The three primary goals of CalAIM are:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health.
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

For more information about CalAIM, please visit the California Department of Health Care Services CalAIM webpage: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.

What does the transition from Whole Person Care to CalAIM mean?

In Alameda County, generally the services that have been provided as part of Whole Person Care are not ending, but some are changing. As required by the Whole Person Care Program, we will be notifying all of the consumers who have been part of the program. You may get questions from your clients and so we want you to know about the changes that are happening. Some services that have been funded through Care Connect will transition to other funding sources and administration. For some providers, this may mean new contracts and different reporting requirements. Providers who are affected will receive more information about this through their organization's leadership and health plan partners.

New Medi-Cal Managed Care Services

Some complex care coordination services that were provided by Whole Person Care will become **Enhanced Care Management,** a new Medi-Cal Managed Care benefit, administered by either Alameda Alliance for Health or Anthem Blue Cross. Medi-Cal Managed Care will cover a new group of services called **Community Supports.** Community Supports are specific services authorized by the local Medi-Cal Managed Care plans that are medically appropriate and cost-effective alternatives to the usual services covered by Medi-Cal. (Note: these were formerly known as In Lieu of Services, or ILOS).

What is Enhanced Care Management (ECM)?

The Enhanced Care Management benefit will provide a whole-person care approach to care coordination and services—it will address the clinical (e.g., medical, behavioral health) and social service (e.g., housing, food, community connections) to Medi-Cal enrollees who face ongoing challenges that impact their ability to thrive and be well. Under AC Care Connect, similar programs might be known to you as Care Neighborhood, Care Connect, Health Homes or AC3; the services are sometimes called complex care management or care coordination, or CBCME.

All Medi-Cal Managed Care members who are receiving complex care coordination through AC Care Connect as of December 31, 2021 will transition to this new free benefit, Enhanced Care Management. Clients will likely not experience any major changes in services. In general, the same agencies are expected to continue providing these services. People transitioning to Enhanced Care Management will also receive a letter from their Medi-Cal Managed Care Plan informing them of the change.

Important things for clients to know about Enhanced Care Management

- The client will get the same care coordination services as before. They do not need to do anything.

- The client's care coordinator and provider organization will likely stay the same. If for any reason, the client is assigned a new care coordinator, the current care coordinator will get information on helping the client to connect with their new care coordinator.
- The client can change their care coordinator at any time.
- The client's doctor(s) will stay the same.
- This benefit will not change their Medi-Cal eligibility.
- This benefit will not change any other Medi-Cal services they get.
- There is no cost to the client for Enhanced Care Management.

Who is eligible for Enhanced Care Management?

California's Department of Health Care Services has identified the below populations of focus for Enhanced Care Management services:

- Children or youth with complex physical, behavioral, developmental, and oral health needs.
- Individuals experiencing homelessness, chronic homelessness, or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED), or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

See California Advancing & Innovating Medi-Cal (CalAIM) Proposal January 2021 for more information.

What are Community Supports?

Community Supports are medically appropriate and cost-effective alternatives to usual services covered by Medi-Cal. They are optional services for Medi-Cal managed care plans (MCPs) to provide and are optional for managed care members to participate in.

What services will be offered as Community Supports in Alameda?

- Recuperative care (Medical Respite)
- Housing navigation
- Tenancy sustaining services
- Housing deposits
- Asthma remediation (note this is not an AC Care Connect service)

Who is eligible for Community Supports?

Community Supports are optional for Medi-Cal beneficiaries – beneficiaries are not required to participate, and the Medi-Cal managed care plan needs to approve them for each person. If you would like to learn more about how your client can receive these services, contact your client's health plan (below) and let them know you have a question about whole person care services.

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: 1-510-747-4567
Toll-Free: 1-877-932-2738
People with hearing and speaking impairments (CRS/TTY): 711/1-800-735-2929

Anthem Customer Care Center
Monday to Friday, 7 a.m. to 7 p.m.
Toll free at 800-407-4627 (TTY 711).

All Medi-Cal Managed Care members who are enrolled in the relevant AC Care Connect service as of December 31, 2021 will transition to the corresponding Community Supports service with no interruption in service. In general, clients will not experience any major changes to their services. The same agencies are expected to continue providing these services, however, there may be changes in the funding sources and reporting requirements, and therefore new contracts will be initiated effective January 1, 2022.

See California Advancing & Innovating Medi-Cal (CalAIM) Proposal January 2021 for more information.

What about clients who are not in Medi-Cal Managed Care?

CalAIM services are only available to Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care. These are managed care plans that beneficiaries must enroll into to become members. The managed care plan contracts with organized networks of systems of care and providers to provide the care its members need. Medi-Cal Managed Care members are usually required to seek care within the managed care network of providers. All counties in California have Medi-Cal Managed Care.

Some Medi-Cal beneficiaries have Fee-for-Service (FFS) Medi-Cal, also referred to as "Straight" Medi-Cal. FFS Medi-Cal is a payment and delivery system of care in which beneficiaries can receive care from any provider who accepts Medi-Cal, and the provider is able to be reimbursed for each individual service or care visit. **To receive Enhanced Care Management or Community Support services, FFS Medi-Cal beneficiaries need to change to Medi-Cal Managed Care**. To find out how to change from Fee for Service to Managed Care, contact the below resources.

Clients who are not yet enrolled in Medi-Cal can apply and may be eligible for Cal-AIM and other services. Please check with your clients and/or your county Social Services Agency to verify their Medi-Cal status and reporting requirements.

- **Health Care Options program** (Monday through Friday, 8 a.m. to 6 p.m. PT, except holidays)
  - For questions about Medi-Cal Managed Care: 1-800-430-4263 (TTY 1-800-430-7077)
  - For people enrolled in Medi-Cal and Medicare: Coordinated Care Initiative at 1-844-580-7272 (TTY 1-800-430-7077)
  - If you want Health Care Options to contact you, fill out this HCO Contact Form.
- **Alameda County Social Services Offices** (Monday - Friday; 7:30 AM - 5:00 PM)
  - 1-510-263-2420
  - 1-888-999-4772

How will other Whole Person Care / Care connect services change?

No change related to the ending of AC Care Connect

Some services that have been a part of AC Care Connect will continue to be provided with no change after Whole Person Care / AC Care Connect ends on December 31, 2021. As required by the State, clients will be notified of the end of Whole Person Care, but **the change will not affect them, and they don't need to do anything.** These include:

- Integrated Behavioral Health Care Services
  - Provided at many Community Health Centers and PATH programs
- Substance Use Disorder Treatment Access Points
  - SUD Diversion / Drug Court
  - Center Point Portals (Alameda County Substance Use Access and Referral Helpline, Criminal Justice Case Management Program)
  - Cherry Hill Sobering Center
- Street Outreach Teams
- Home Stretch Housing Assistance Fund

Some reduction in service

Services that will continue but may accept fewer new clients or have different funding sources include:

- Individual Legal Assistance
- Crisis Connect

Services that will no longer be funded as part of the transition

A few AC Care Connect services will not continue to be funded by Health Care Services Agency after the end of Whole Person Care / AC Care Connect. These services will not continue or will need to find other sources of funding:

- Independent Living Association

Other Care Connect resources

Finally, you may have interacted with other Care Connect resources, such as the Community Health Record / Social Health Information Exchange or the Care Connect Academy. Please see our website for more information about these programs.

Questions?

If you have additional questions about Whole Person Care/AC Care Connect:

- Call: 510-346-1096
- Email: ACCareConnect@acgov.org.

If your clients have additional questions for Alameda Alliance for Health:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: 1-510-747-4567
Toll-Free: 1-877-932-2738
People with hearing and speaking impairments (CRS/TTY): 711/1-800-735-2929

If your clients have additional questions for Anthem Blue Cross:

Anthem Customer Care Center
Monday to Friday, 7 a.m. to 7 p.m.
Toll free at 800-407-4627 (TTY 711).
Tell them you have a question about changes to Whole Person Care Program services.