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Providing Access & Transforming Health

BluePath HEALTH

Alameda CalAIM PATH Collaborative

April 19, 2024

Welcome! Please grab some coffee, find a table, and introduce yourself to someone you haven't met before.

2024 Collaborative Aims and Objectives

BluePath HEALTH

By December 2024, increase eligible members authorized for ECM by 15% & Community Supports by 15%

1. **Build resources and relationships to drive community referrals**
2. **Strengthen ECM and Community Supports provider capacity**
3. **Facilitate relationship building between providers, plans, and referral partners**

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Today's Agenda

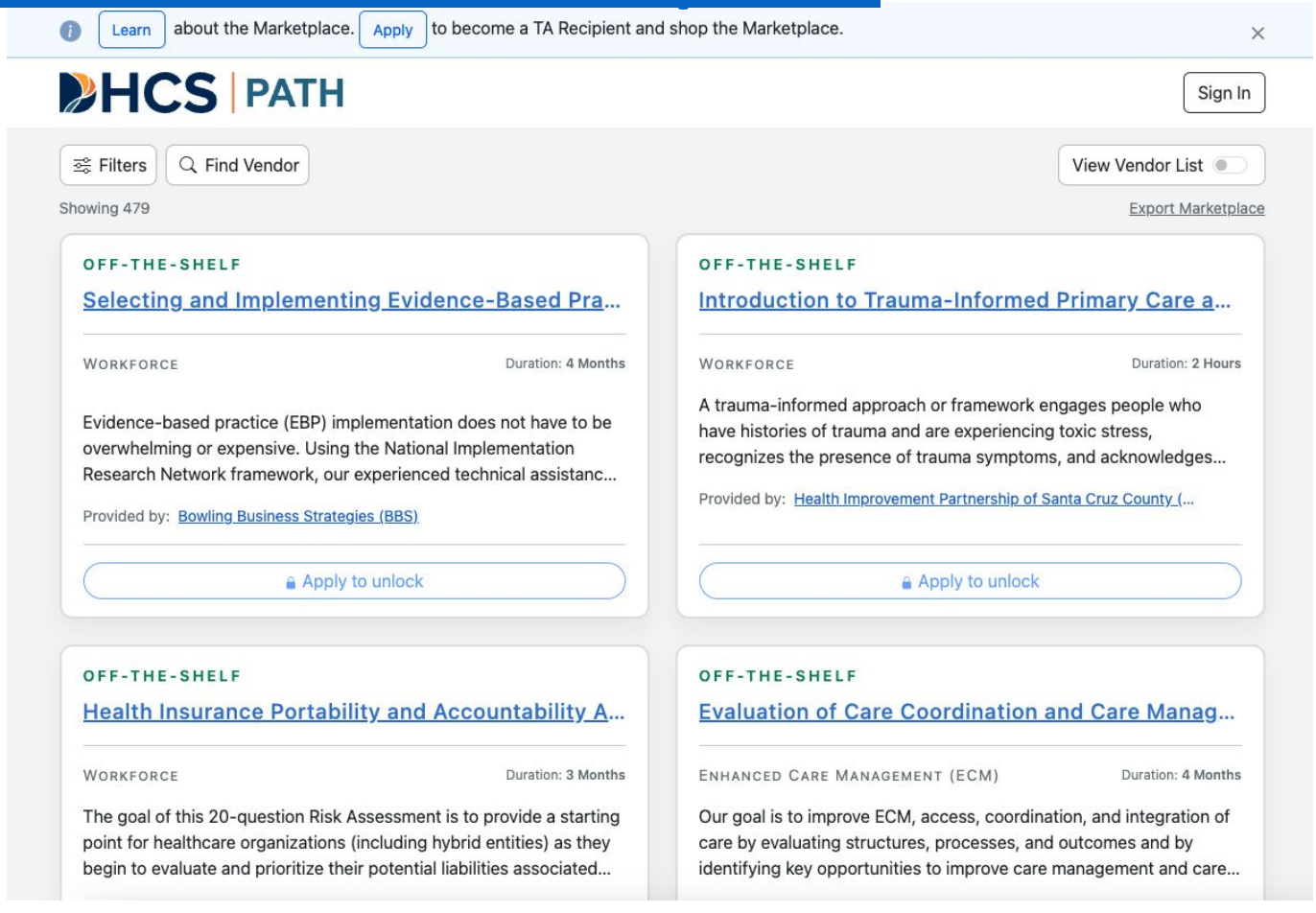
Time	Topic
10:10am	Welcome, agenda, and housekeeping
10:20am	Follow-ups from March
10:25am	MCP Updates
10:45am	PoF Spotlight: At risk for LTC institutionalization and NF residents transitioning to the community
10:55am	New Community Supports: Transition and Diversion
11:20am	Updates: Data, Resources, and Training
11:35am	Lunch, Networking, Office Hours

Housekeeping

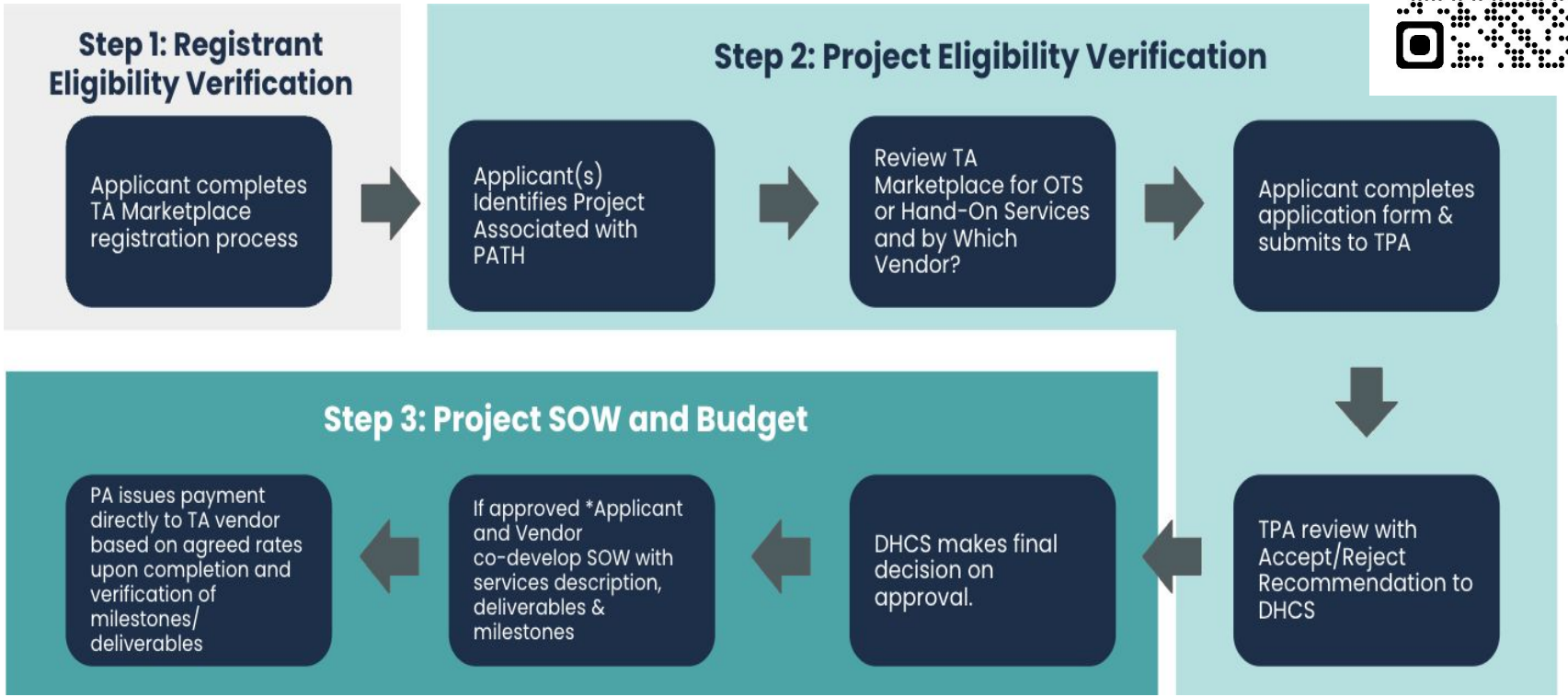
Updates: Data, Trainings, and Resources

- New Quarterly Implementation Report
- Upcoming trainings from ACTDU
- PATH Technical Assistance Marketplace
- Updated Provider List

Check out the TA Marketplace!



CalAIM TA Marketplace



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Upcoming Office Hours:
Learn about the TA Marketplace!

Friday, May 3 | 11am - 12pm

On Zoom

TA Marketplace 101 and Application Process

Register Here

Available now: ECM and CS Provider List

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CalAIM PATH Care Coordination Provider List
ECM and Community Supports Providers
March 2024

Community Supports Providers: Quick Reference

	Alameda Alliance	Kaiser
Asthma Remediation		
• Alameda County Public Health ASTHMA START	X	
• Breathe California		X
• Evolve Emod		X
• Roots Community Health Center	X	
Community Transition Services/Facility Transition to Home		
• East Bay Innovations	X	
• Independent Living Systems		X
• Omatochi	X	
• Serene Health		X
• Star Nursing		X
Day Habilitation Programs		
• Serene Health		X
Environmental Accessibility Adaptations (Home Modifications)		
• Assured Independence		X
• Connect America West		X
• Lifeline Systems Company		X
• LifewiseCHM		X
• East Bay Innovations	X	

	EAST BAY INNOVATIONS
About	East Bay Innovations (EBI) is a private non-profit organization providing services to people throughout Alameda County. EBI offers a variety of services supporting more than 500 individuals with disabilities to live as independently as possible in their own homes, to be successfully employed, and to feel a sense of membership in their community.
Location	2450 Washington Avenue, Suite 240 San Leandro, CA 94577
Website	https://www.eastbayinnovations.org/
Main Line	510.618.1580
Provider Type	Enhanced Care Management
Population of Focus	Adults At Risk for Hospital or ED Utilization |Adults/Families experiencing Homelessness | Adults At Risk for LTC Institutionalization | Adult SNF Residents Transitioning to the Community

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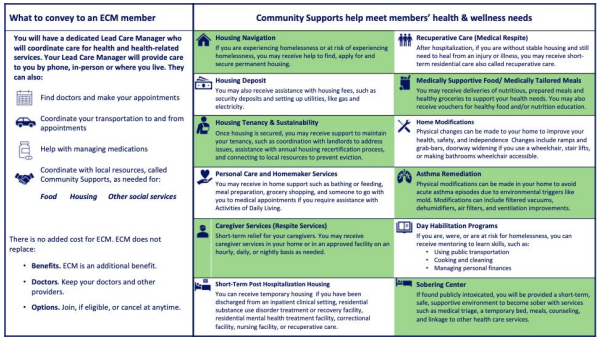
Don’t forget about our resource center!

BluePath HEALTH



What to convey to an ECM member

You will have a dedicated Lead Care Manager who will coordinate care for health and health-related services. Your Lead Care Manager will provide care to you by phone, in-person or where you live. They can also:

- Find doctors and make your appointments
- Coordinate your transportation to and from appointments
- Help with managing medications
- Coordinate with local resources, called Community Supports, as needed for:

Food Housing Other social services

There is no added cost for ECM. ECM does not replace:

- **Benefits.** ECM is an additional benefit.
- **Doctors.** Keep your doctors and other providers.
- **Options.** Join, if eligible, or cancel at anytime.

Community Supports help meet members’ health & wellness needs

Housing Navigation
If you are experiencing homelessness or at risk of experiencing homelessness, you may receive help to find, apply for and secure permanent housing.

Housing Deposit
You may also receive assistance with housing fees, such as security deposits and setting up utilities, like gas and electricity.

Housing Tenancy & Sustainability
Once housing is secured, you may receive support to maintain your tenancy, such as coordination with landlords to address issues, assistance with annual housing recertification process, and connecting to local resources to prevent eviction.

Personal Care and Homemaker Services
You may receive in home support such as bathing or feeding, meal preparation, grocery shopping, and someone to go with you to medical appointments if you require assistance with Activities of Daily Living.

Caregiver Services (Respite Services)
Short-term relief for your caregivers. You may receive caregiver services in your home or in an approved facility on an hourly, daily, or nightly basis as needed.

Short-Term Post Hospitalization Housing
You can receive temporary housing if you have been discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.

Recuperative Care (Medical Respite)
After hospitalization, if you are without stable housing and still need to heal from an injury or illness, you may receive short-term residential care also called recuperative care.

Medically Supportive Food/ Medically Tailored Meals
You may receive deliveries of nutritious, prepared meals and healthy groceries to support your health needs. You may also receive vouchers for healthy food and/or nutrition education.

Home Modifications
Physical changes can be made to your home to improve your health, safety, and independence. Changes include ramps and grab-bars, doorway widening if you use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.

Asthma Remediation
Physical modifications can be made in your home to avoid acute asthma episodes due to environmental triggers like mold. Modifications can include filtered vacuums, dehumidifiers, air filters, and ventilation improvements.

Day Habilitation Programs
If you are, were, or are at risk for homelessness, you can receive mentoring to learn skills, such as:
- Using public transportation
- Cooking and cleaning
- Managing personal finances

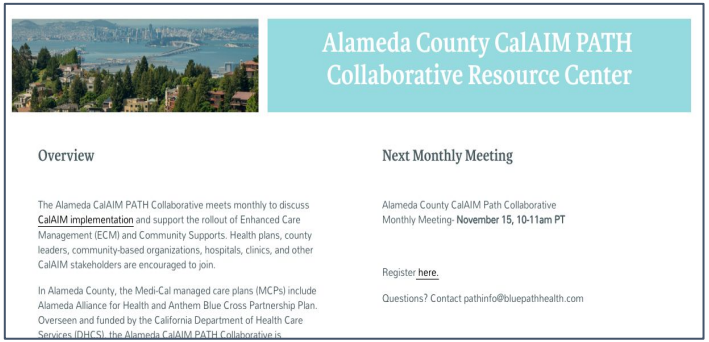
Sobering Center
If found publicly intoxicated, you will be provided a short-term, safe, supportive environment to become sober with services such as medical triage, a temporary bed, meals, counseling, and linkage to other health care services.

ECM/CS Provider Job Aid

2024 version available in
English and Spanish
Accompanying PoF 1-pager in progress

Alameda PATH Resource Center

updates & adding more resources



Alameda County CalAIM PATH Collaborative Resource Center

Overview

The Alameda CalAIM PATH Collaborative meets monthly to discuss CalAIM implementation and support the rollout of Enhanced Care Management (ECM) and Community Supports. Health plans, county leaders, community-based organizations, hospitals, clinics, and other CalAIM stakeholders are encouraged to join.

In Alameda County, the Medi-Cal managed care plans (MCPs) include Alameda Alliance for Health and Anthem Blue Cross Partnership Plan. Overseen and funded by the California Department of Health Care Services (DHCS), the Alameda CalAIM PATH Collaborative is

Next Monthly Meeting

Alameda County CalAIM Path Collaborative Monthly Meeting- **November 15, 10-11am PT**

Register here.

Questions? Contact pathinfo@bluepathhealth.com

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DHCS ECM and Community Supports Data

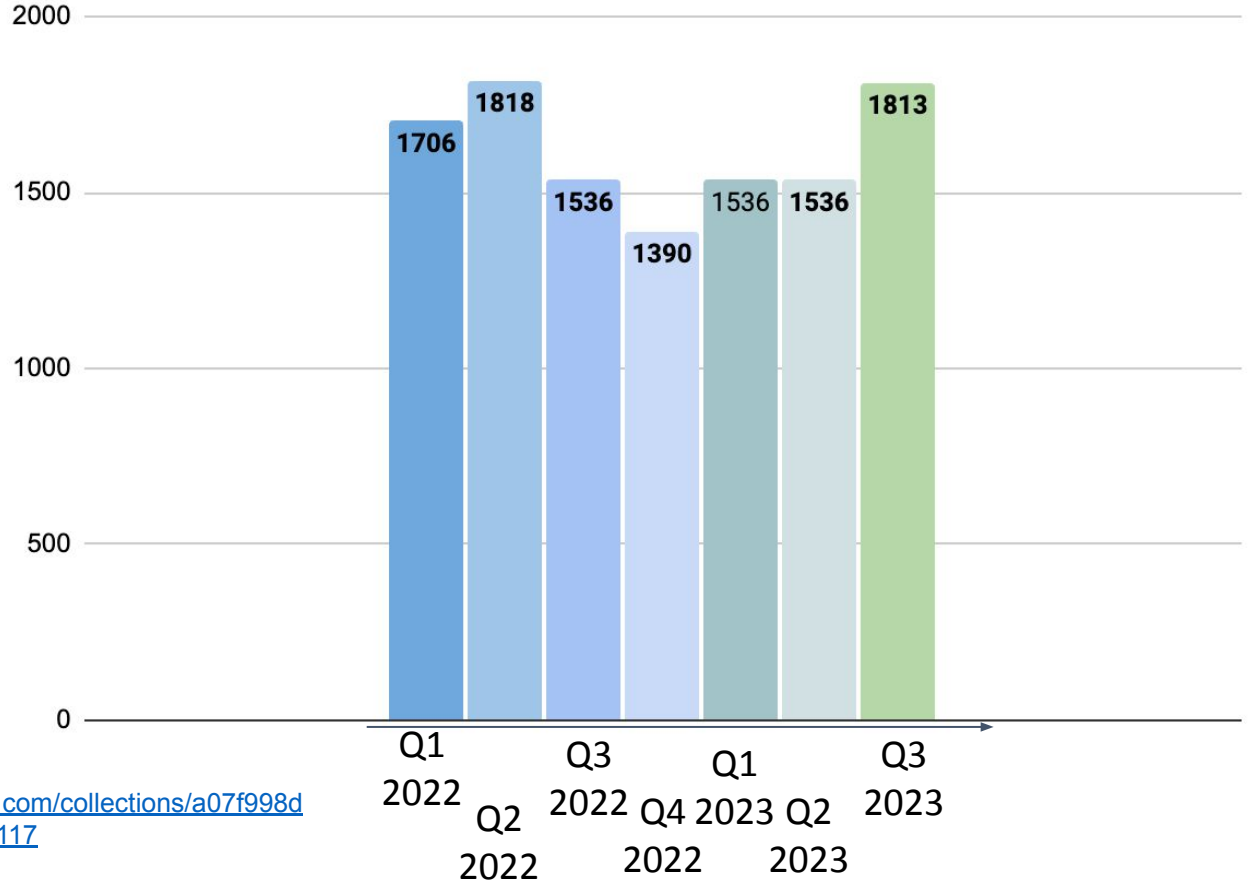
- **ECM and Community Supports Quarterly Implementation Report updated by DHCS, with data through Quarter 3 (July-September), 2023**

160.3K	123.1K	85.73K
unique members received ECM **since ECM launched** to the end of the reporting period.	unique members received ECM **in the last 12 months** of the reporting period.	unique members received ECM in the **most recent quarter** of the reporting period.

102.9K	95.14K	61.74K
unique members received Community Supports **since Community Supports launched** to the end of the reporting period.	unique members received Community Supports **in the last 12 months** of the reporting period.	unique members received Community Supports **in the most recent quarter** of the reporting period.

View the full report here

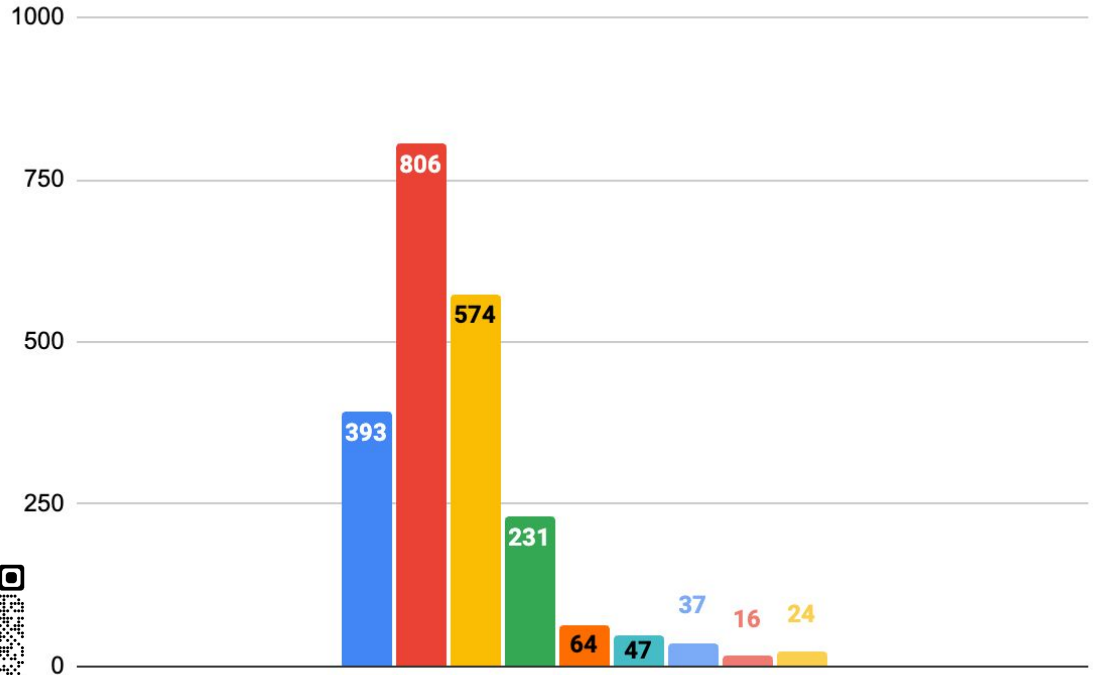
Alameda County, ECM Enrollment by Quarter



Source: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

Alameda County, ECM Enrollment by PoF

Q3 2023



- Adults experiencing homelessness
- Adults at risk for avoidable hospitalization
- Adults with SMI or SUD
- Adults at risk for long term care
- Children and youth experiencing homelessness
- Children and youth at risk for avoidable hospitalization
- Children and youth with SMI or SUD
- Children enrolled in CCS
- Children involved in child welfare

Total: 1813

There were fewer than 21 enrollees in the following PoFs:

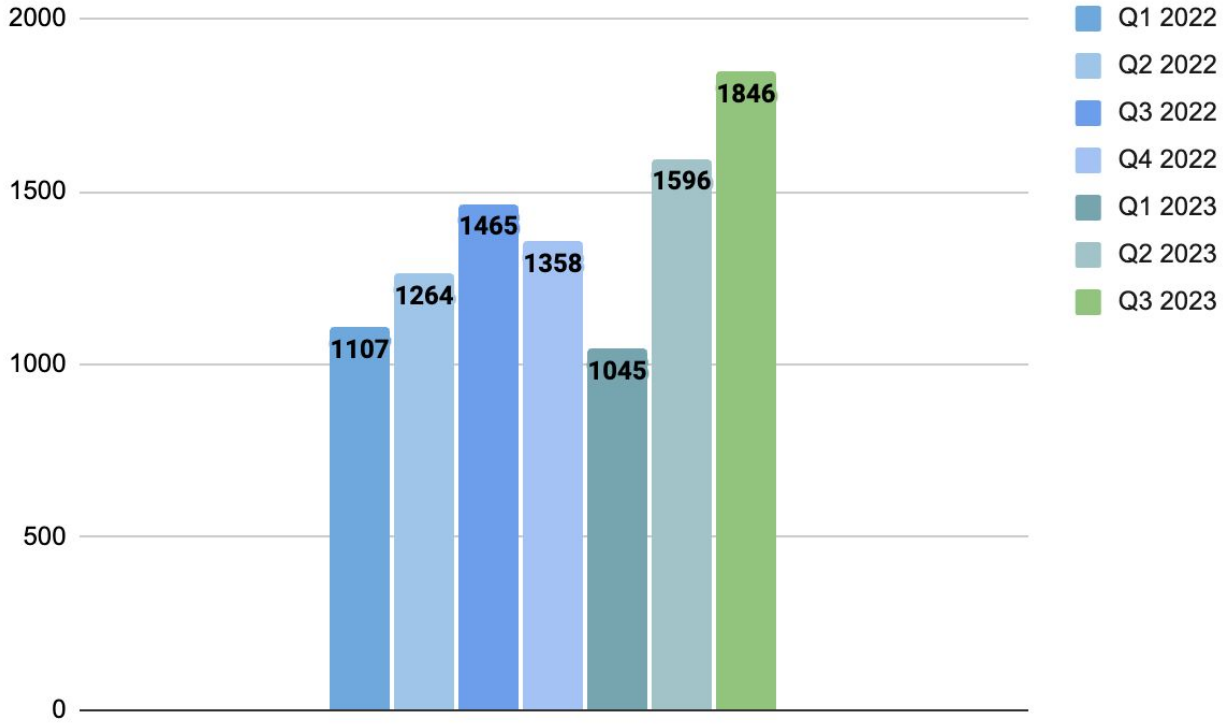
-Adults transitioning from incarceration

-Adult nursing facility residents transitioning to the community

Unique members may be included in multiple PoFs

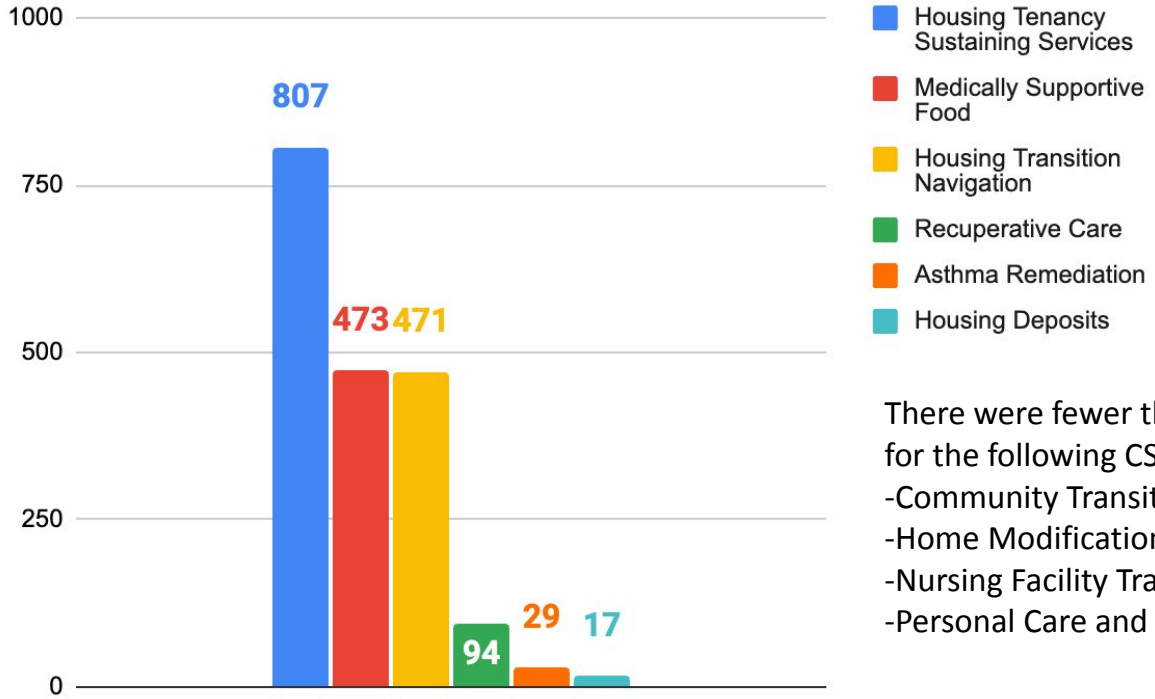
Source: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

Alameda County, Community Supports Utilization by Quarter



Source: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

Alameda County, Community Support Enrollment by Service, Q3 2023



Source: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

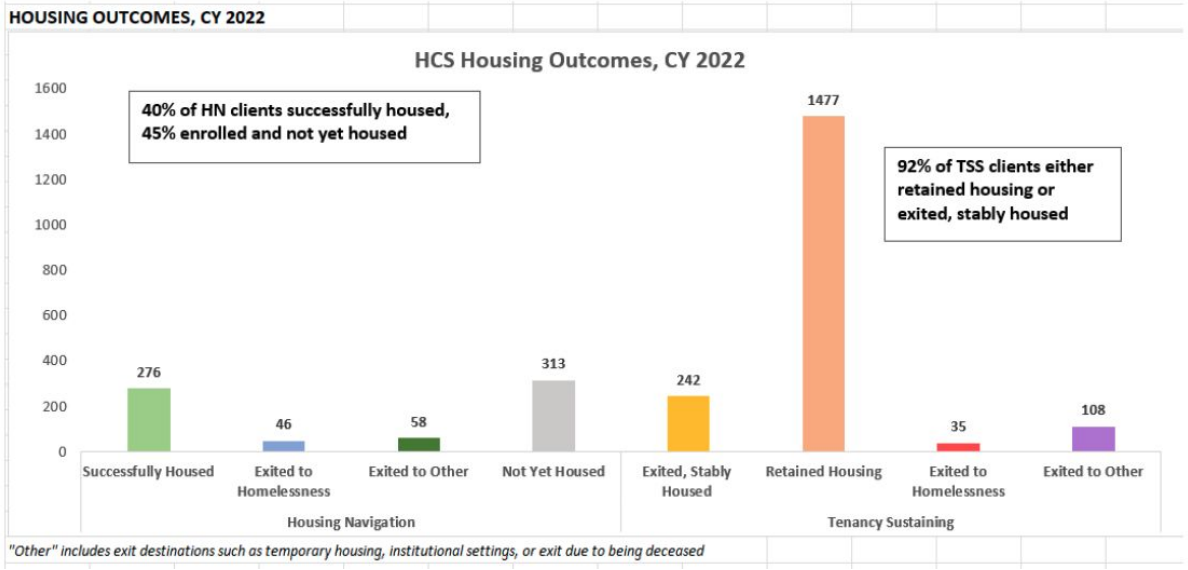
There were fewer than 21 authorizations for the following CS:
-Community Transition Services
-Home Modifications
-Nursing Facility Transition/Diversion
-Personal Care and Homemaker Services

March Follow-Ups

3/15 Collaborative Meeting: Individuals Experiencing Homelessness PoF

Next Steps:

- Alameda County Health will share 2023 data for Housing Community Supports outcomes when available

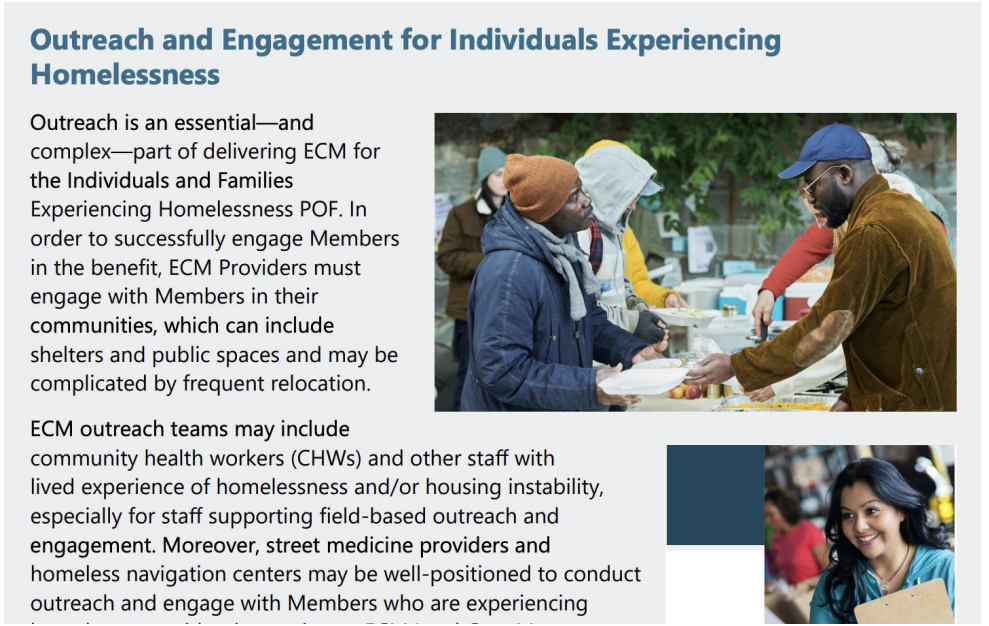


DHCS Spotlight on Individuals and Families Experiencing Homelessness

Highlights:

- ECM delivery strategies
- Approaches to outreach and engagement
- Example cases/vignettes

Access the resource here



Outreach and Engagement for Individuals Experiencing Homelessness

Outreach is an essential—and complex—part of delivering ECM for the Individuals and Families Experiencing Homelessness POF. In order to successfully engage Members in the benefit, ECM Providers must engage with Members in their communities, which can include shelters and public spaces and may be complicated by frequent relocation.

ECM outreach teams may include community health workers (CHWs) and other staff with lived experience of homelessness and/or housing instability, especially for staff supporting field-based outreach and engagement. Moreover, street medicine providers and homeless navigation centers may be well-positioned to conduct outreach and engage with Members who are experiencing

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ALAMEDA Alliance FOR HEALTH

KAISER PERMANENTE®

MCP updates

Kaiser Permanente

Alameda PATH CPI Meeting

April 2024

KAISER PERMANENTE®

How to Submit a Referral for ECM or Community Supports

KP has a no-wrong-door approach for referrals

- Referrals are accepted from any source (members, providers, family, community organizations, etc.)
- Use of the KP referral form is recommended; however, KP will accept any referral form created by another Medi-Cal plan. Simply send the completed form to the same KP email address noted below.
- Referrals may be placed via email or via phone.

	Sacramento/Central Valley	Rest of Northern California	Southern California
Cities	Amador, El Dorado, Fresno, Kings, Madera, Mariposa, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare*, Yolo, Yuba	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma,	Kern, Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare*, Ventura,
Phone	1-833-721-6012 (TTY 711) Monday-Friday (closed major holidays) 9:00 a.m. to 4:45 p.m.	1-833-952-1916 (TTY 711) Monday-Friday (closed major holidays) 9:00 a.m. to 4:45 p.m.	1-866-551-9619 (TTY 711) Monday-Friday (closed major holidays) 8:30 a.m. to 5:00 p.m.
Email	Send completed referral form to REGMCDURNs-KPNC@kp.org with the subject line “ECM Referral” or “CS Referral”		Send completed referral form to RegCareCoordCaseMgmt@kp.org with the subject line “ECM Referral” or “CS Referral”

*Tulare Central Valley: 93618, 93631, 93646, 93654, 93666, 93673; Tulare Southern CA: 93238, 93261.

How a community-based organization can serve KP members

KP is working with three Network Lead Entities (NLEs) to develop a network of community-based ECM, CS, and CHW providers.

If your organization wishes to become part of an NLE's network, you may send an email message to:

Full Circle Health Network

network@fullcirclehn.org
Phone number: 888-749-8877

Full Circle Health Network meets with prospective providers each week on Thursdays from 12-1pm PST
https://us06web.zoom.us/j/86507421534

INDEPENDENT Living System

ILSCAProviderRelations@ilshealth.com
Phone number: 305-262-1292

Partners in Care FOUNDATION

Hubinfo@picf.org
* Phone number: 818-837-3775

In your email, please specify the services your organization provides, geography serviced, and population expertise.

*Partners in Care only serves the Southern California region at this time.

KAISER PERMANENTE

Helpful Links and Contacts

KP 2024 Medi-Cal Direct Contract:	**KP.org/Medi-Cal2024**
KP Designated Medi-Cal Call Center:	**1-855-839-7613** Call to speak to a live Medi-Cal trained agent
KP Medi-Cal Programs (ECM, CS, CHW):	For current information, go to our website: **Link**
KP Medi-Cal Continuity of Care:	For current information, go to our website: **Link**
KP Self-Service Community Resource Directory:	**KP.org/communityresources** **1-800-443-6328** Toll-free number to speak with a resource specialist (M-F, 8a-5p local time)
KP Community Health Care Program:	Available to California residents without access to other health coverage. For current information, go to our website: **Link**
Medi-Cal Redeterminations Toolkit:	For current information, go to DHCS website: **Link**
Medi-Cal Rx:	**1-800-977-2273**
Medi-Cal Dental:	**1-800-322-6384**

Alameda Alliance Updates

ALAMEDA Alliance FOR HEALTH

Provider Network

- ECM
  - Network Expansion
    - July 1, 2024 – internal network to broaden/cover more PoF
    - January 1, 2024 – external network

- Community Supports
  - July 1, 2024
    - Sobering Centers
  - January 1, 2025
    - Short-Term Post-Hospitalization Housing
    - Day Habilitation Programs

Provider Network

- Interested in becoming a contracted Provider?
  - Submit Entity Interest Form to: CalAIMinfo@alamedaalliance.org

- Vetting process
  - Review Entity Interest Forms
  - Internal Committee Meeting to finalize list
  - Initial meeting to discuss program alignment

- Preparation to Go-Live
  - Weekly meetings to discuss:
    - Contracting
    - Credentialling, and
    - Provider certification

- Process takes 4-6 months prior to Go-Live
- Continued weekly meetings post-go-live

Thanks!
Questions?

You can contact us at:

For Community Supports:
CSDept@AlamedaAlliance.org

For ECM:
ECM@AlamedaAlliance.org

ECM – Populations of Focus:

Adults Living in the Community and At Risk for LTC Institutionalization

Adult Nursing Facility Residents Transitioning to the Community

ALAMEDA Alliance FOR HEALTH

Adults Living in the Community and At Risk for LTC Institutionalization

- Adults (A, B and C are required)

A.

i. Living in the community who meet SNF Level of Care (LOC) criteria, **OR**

ii. Require a lower-acuity skilled nursing (such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury

B.

Are actively experiencing one complex social or environmental factor influencing their health.

Including, but not limited to, needing assistance with ADLs, communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring

Adults Living in the Community and At Risk for LTC Institutionalization

- Adults (A, B and C are required)

C. Are able to reside continuously in the community with wraparound supports

i.e. some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns.

Adult Nursing Facility Residents Transitioning to the Community

- Adults nursing facility residents who (all 3 are required):

1. Are interested in moving out of the institution, **AND**
2. Are likely candidates to do so successfully, **AND**
3. Are able to reside continuously in the community

Corresponding Community Supports Services

- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Environmental Accessibility

Thanks!
Questions?

You can contact us at:

For Community Supports:
CSDept@AlamedaAlliance.org

For ECM:
ECM@AlamedaAlliance.org

Transition & Diversion Providers

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Alameda Alliance

East Bay Innovations

Omatochi

Kaiser Permanente

INDEPENDENT Living Systems

STAR NURSING
OUR SPECIALTY IS YOU.

serene
MENTAL & BEHAVIORAL HEALTH

Omatochi

We provide a smarter way for seniors to age in place.

We help aging adults meet their physical needs, combat social isolation, and stay connected with their families.

5 Populations Of Focus

- Personal Care & Homemaker Services
- Respite Services
- Home Modifications
- Nursing Facility Transition/Diverstion to ALFs
- Community Transfer Services/Nursing Facility Transfer to Home

What Omatochi Has to Offer:

Senior Centric Care

Our seniors are at the center of our care model. Holistic senior well-being and autonomy are the foundation of every decision we make, including our service structure, hiring and training processes, and innovation.

Personalized Support

We match each senior with an In-Home Health Aide based on their interests and lifestyle needs. We vet and interview each Aide to ensure they share our values and are invested in our core pillars of service beyond thorough background checks.

Social Companionship

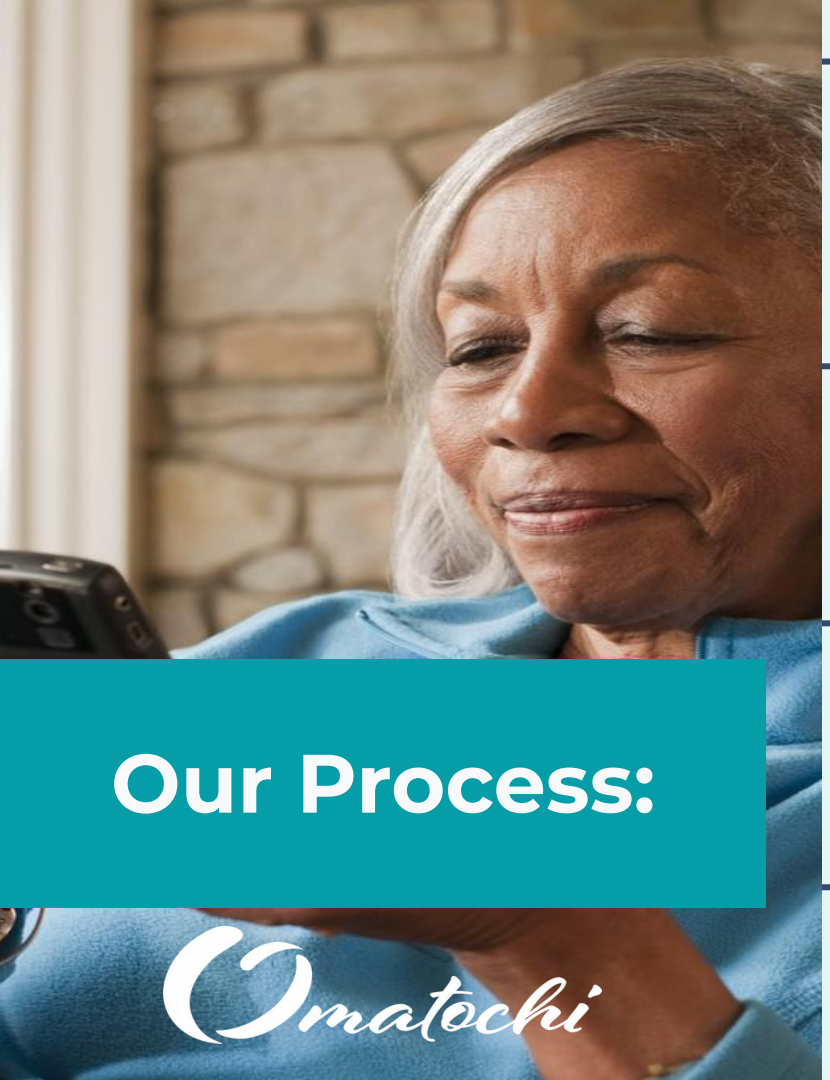
We create and organize custom social activities calendars to combat social isolation and enliven each senior's social life.

CS Eligibility

- Alameda Resident ?
- Alameda Alliance Member ?
- Low Income Individual ?
- Medi-Cal Eligible ?
- Aging Adults or Persons with Disabilities ?
- Approved/Pending IHHS Application ?

If you answered "Yes" to any of these questions, you and your family could benefit from assistance with this service

Use the above questions as a general guide for CS. Note that there are specific eligibility criteria for each population of focus.



Our Process:

1st Point of Contact

Our care managers first reach out to the referred member via phone call to introduce our services to them and also learn more about their needs and care goals.A then schedule an in-person home assessment to check for any safety hazards in the member's home and sign the Omatochi admission paperwork

Create a Customized Care Plan

Based on the home assessment, we tailor a unique care plan for your loved one and assign a caregiver that we think would be a great fit for your loved one's personality and needs.

Perform Home Assessment

Our care manager sees the member in person to evaluate the safety of their home and ensure it is a safe environment for both the member and our caregiver. The care manager also goes over all paperwork in-person before member signs

Matching Our Caregivers with the Member

Once the home assessment and paperwork are completed, we begin to match the member with the caregiver who would best meet their lifestyle and needs

Wellness Fair 2024

Location: Community Center (Exact Location TBD)

Date: June 1st

Get ready to celebrate the unique bond between different generations on Intergenerational Day on June 1!

Description

We aim to provide a monthly social engagement for our seniors to combat loneliness and inform them of the various ways they can maintain their physical, mental, and social well-being

Initiatives:

- Wellbeing Tables- Physical Health ex. Senior boxing exercises and activities promoting mindfulness
- Social-Emotional Session- Candidly Speaking: Conversations Across Cultures
- Craft Tables--Stop by and build a craft with new friends.
- Tech Tables-- Learn how to use your phone and applicable apps.
- Medi-Cal Education Table-- Learn more about YOUR benefits.
- Omatochi Boot-- Learn about Omatochi's offerings.
- Live Band-- Dance or sit with others while enjoying some music.

Complex Discharge Utilizing ECM & CS Services

East Bay Innovations

Situation:

- 55 year old male, re-admitted to a SNF in November.
- Client discharged from previous SNF in October after 6 year stay.
- 120 IHSS hours and 88 24 home care hours per month (Approx 7 hours per day)
- Caregiver setup was not sufficient to manage needs across the 24/7 period.
- Current caregivers (3) not all willing to transfer or do personal care
- This resulted in infection and sepsis leading to ER, Inpatient and then SNF admission.
- Some caregivers quit, messy situation with payment and accusations about behavior (both from caregivers and client).
- Client enrolled in ECM and CS-Diversion programs.

East Bay Innovations

Background:

- Dx Paraplegia, stage 4 wounds, bi-polar disorder, pain
- Dependent on transfers, personal care, bowel care, foley catheter care
- Recently discharged from SNF after long admission
- Several ER, Inpatient and SNF admissions in 1 month period since initial SNF discharge.
- Recent history of going AMA when hospitalized
- Newly connected to PCP in Dublin area
- No case management input prior to discharge, EBI involved once client was at home.
- Bariatric hospital bed and LAL mattress needed
- Housing and income stable
- Client knows the inpatient healthcare system. Understands his health - but has chosen not to engage with treatment plan at times.

East Bay Innovations

Assessment:

- High level of need and low level of engagement (example: refused PT, not willing to do leg work, meet/interview caregivers)
- Client personality, although challenging, good humoured, able to be realistic about situation and honest about what he could and would do.
- To remain safe at home client would robust care provider support. Client fully involved and aware of risks.
- Current number of care hours not sufficient (7 hours per day)
- Client unclear whether he would work with caregivers or wanted to be back home at all
- Boundaries and expectations for client in regards to maintaining caregivers - coaching required.
- Challenge of finding caregivers with skill set to manage needs and also in the area client new home is in.
- Caregivers will need to start on discharge. This will take considerable coordination.
- IHSS could not increase hours until after discharge - CM could only offer small hours to providers initially.
- 24 hour home care already in place and client had accrued a bulk of hours that had not been used during the authorization period.
- Pain management and institutionalization - factors in the client wanting to be home and being successful

East Bay Innovations

Actions:

- Assess what the caregiver set up needed to cover needs - develop ideal caregiver schedule and assess what the minimum would need to be for safe discharge and continued success.
- Interviewing caregivers - process, get the list from public authority etc
- Establishing rapport with caregivers, building trust, keeping everyone on the same page.
- Negotiating how the hours were used to meet client needs and aid caregiver retention.
- Set IHSS assessment at home - contact IHSS SW. Lots of advocacy.
- 24 home care - had hours were banked. Discussed future increase.
- DME - new bariatric hospital bed and LAL mattress ordered - RN advocacy
- Overnight urine canisters - to mitigate risk of catheter becoming backed up if a caregiver does not show. This had caused hospitalization. Not covered through insurance.
- Home mods: Bids sought for either ceiling hoyer or fixed hoyer - to make set up more appealing/safer to potential caregivers and improve chances of retention.
- Refer client Personal Emergency response system
- Referral for medically-tailored meals.

Outcome:

- Client discharged home.
- Care provider hours increased by both IHSS and 24 home care
- New caregivers interviewed and onboarded
- CM liaised with providers to coordinate and initiate caregiver support.
- Client home with safe care provider support that meets needs.
- Client with DME to manage previous situations that caused hospitalization
- Client aware of needs and limitations of his caregiver support.
- MTM inplace which also eases caregiver burden
- Client is willing to accept PERS following discharge and originally declining.
- Potential for home modifications fixed hoyer to ease carer burden and mitigate risk transferring.

East Bay Innovations

Learnings:

- Building rapport with client
- Coaching client to manage needs - particularly with caregivers
- Problem solving!
- Asking lots of questions to understand resources available and safe discharging
- Reaching out to previous providers to get background and updates
- IHSS caregivers complex dynamics
- Challenges of the system - eg. IHSS hours not increased until post DC
- Using available CS services to mitigate risk, provide caregiver support and improve caregiver retention.

Questions?

Training Development Unit

PATH Collaborative Meeting
April 19th, 2024

https://careconnect.ucsf.edu/ACTDU/index.html

TRAINING DEVELOPMENT UNIT

New Hire Academy!!

The New Hire Academy is a two-day in-person onboarding program designed to provide an extensive introduction to the California Advancing and Innovating Medi-Cal (CalAIM) environment and Alameda County Training Development Unit (ACTDU) training offerings.

https://careconnect.ucsf.edu/ACTDU/index.html

Navigating Services for Individuals with IDD in Alameda County

InSight sessions are designed to offer CalAIM providers an opportunity to have deeper conversations on select topics.

Date: **April 24th, 11 am - 1 pm**

Location: **Virtual/Zoom**

https://careconnect.ucsf.edu/ACTDU/index.html

Training Development Unit

Thank You!

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traininghealthequity.org

Next meeting:

May 17th, 10am - 12pm

On Zoom, Register here:

https://us02web.zoom.us/meeting/register/tZwuf-6trzgpHtxCQ1uxMMiv2xZiTS8yuLmA#/registration

See you for the 3rd Friday mornings each month in 2024!

Thank you for attending!
Please stick around for lunch and Office Hours!

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Providing Access & Transforming Health

BluePath HEALTH

Appendix

2024 Collaborative Aims and Objectives

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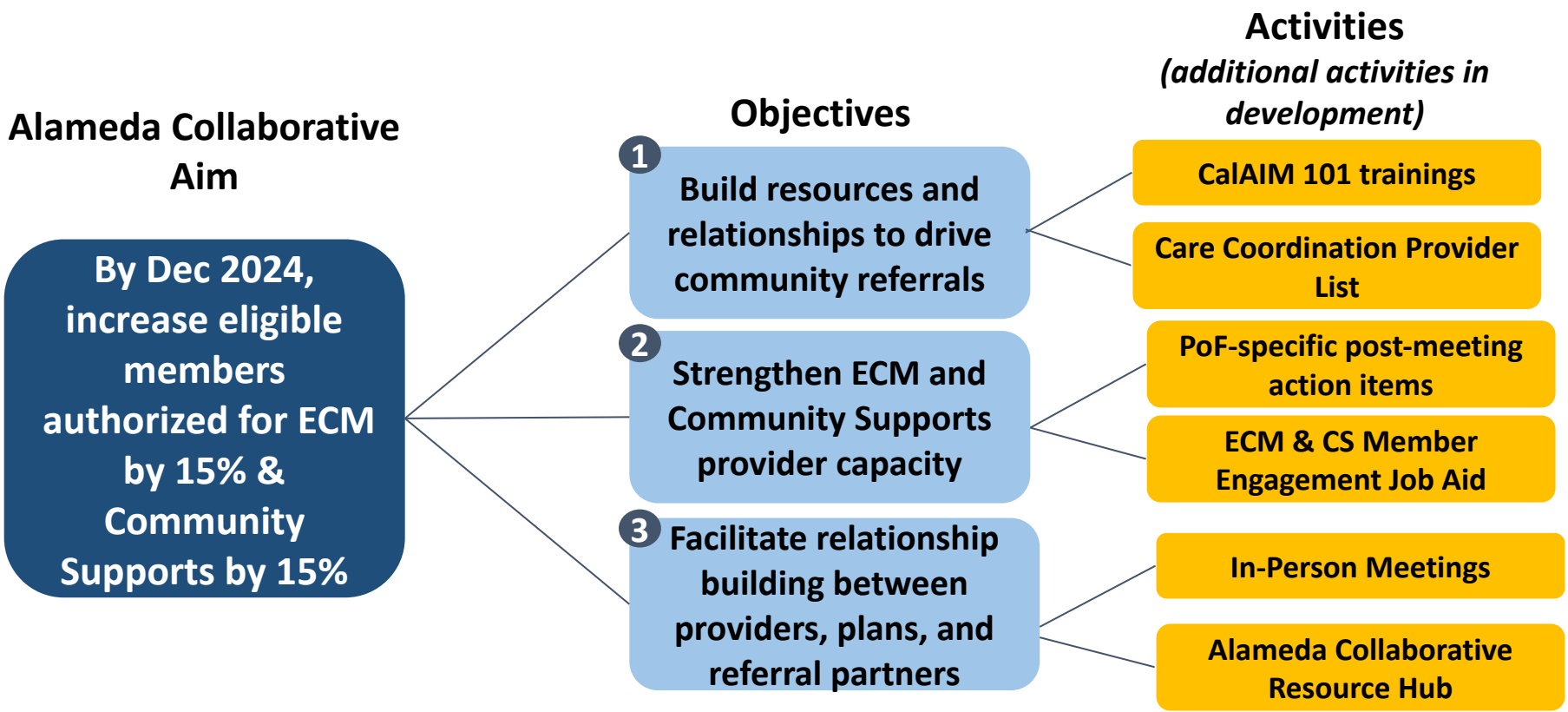
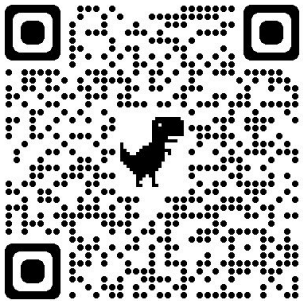


New Resource:

Alameda County MCP 2024 Transition FAQ



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Alameda County Medi-Cal Managed Care Plan 2024 Transition FAQ

Prepared by the Alameda CalAIM PATH Collaborative in December 2023[1]

This tool is intended for use by providers, not members or the general public. Public-facing resources are available from DHCS, Kaiser Permanente, Anthem Blue Cross, and Alameda Alliance for Health.

Overview

Q: What is the 2024 Medi-Cal Managed Care Plan, and how does it impact Alameda County?
A: In 2024, some counties will experience changes in their designated Medi-Cal Managed Care Plans (MCPs). As of January 1, 2024, Anthem Blue Cross will no longer operate as a MCP in Alameda County, and Kaiser Permanente will become an MCP. The Alameda Alliance for Health will remain an MCP for Medi-Cal members in Alameda County.

Q: What will happen to members who are currently enrolled in Anthem Blue Cross?
A: As of January 1, 2024, Anthem Medi-Cal members will automatically transition to another MCP. The majority of transitioning members will be enrolled in the Alameda Alliance for Health.

Q: Do members know whether or not they will be experiencing a change in their health plan?
A: Communications have been sent to affected members beginning in October. See Appendix for the member notification letter sent to Anthem members.

Kaiser Permanente in Alameda County

Q: How will 2024 be different from 2023 with regards to Kaiser Permanente?
A: In 2023, Kaiser Permanente was operating as a plan partner in Alameda County, meaning

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Upcoming trainings

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Alameda County Training and Development Unit (ACTDU) regularly offers valuable virtual trainings for local providers:

- Navigating Services for Individuals with Intellectual and Developmental Disability in Alameda County (Apr. 24, 11am-1pm, In-Person)
- **New Hire Academy (Apr. 30 - May 1, In-Person)**
- Conflict Management and De-Escalation (May 9, 10am-12pm, Virtual)

To check out these offerings and more, register here:
https://bit.ly/ACTDU-Portal

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