A1M SOLUTIONS

Community organizations / Rural health / Elderly / Unhoused

Lessons from California's CalAIM program

Expanding Medicaid providers to advance health equity initiatives

Case Study

A housing provider is a community lifeline after health services vanish

Welcome to...

Butte County, California

Known for its natural beauty and low cost of living, for decades rural Butte County was a haven for retirees — especially the town of Paradise. Wildfires, COVID, and skyrocketing housing costs have battered the community in recent years. Health services, already stretched thin over a large area and isolated population, have closed their doors. In a recent survey by the Butte County Health and Human Services Department, 34.1% of adult respondents reported having no primary health care provider.

Lost in the fires

Housing and services for a vulnerable older population

Butte is known as the home to California State University Chico, but housing loss and displacement from the Camp Fire disproportionately affected those 65 and older, especially those who had resided in the town of Paradise, now destroyed.

26%
Of unhoused people in Butte are over 55

+3X
More unhoused elderly counted since 2018

23.5%
Skilled nursing facility beds lost

57.1%
Intermediate care facility beds lost

-1
1 of 3 hospital systems destroyed

Sources: *Butte County 2019 – 2022 Community Health Assessment and Butte County Homeless Continuum of Care 2022 point-in-Time Community Report*

Kristine Nixon and Elizabeth Goodman
www.a1msolutions.com

The role of rural Community Based Organizations (CBOs) in health equity

Geographic isolation is growing in rural communities. As well, there are fewer healthcare providers nearby, especially for the elderly. That means many groups are harder to reach through traditional health care providers

In rural communities like those of Butte County, CBOS:

- Help to retain housing or connect homeless to permanent housing
- eProvide supplemental food to address food insecuritiese or food desertse
- Provide transportation to critical services (jobe healthcare visits, etse)
- Use existing relationships toe connect people to supporte services such as mentale and behavioral healthe services, substance abusee counseling, support fore enrollment in variouse benefits, vocational traininge and more.e

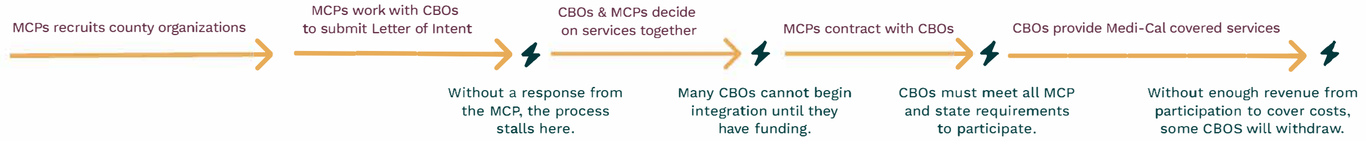
Case study methods

This poster draws insights from a partnership with a CBO in Butte County, where A1M is located. While assisting the CBO, A1M also reviewed webinars and attended regional CBO forums.

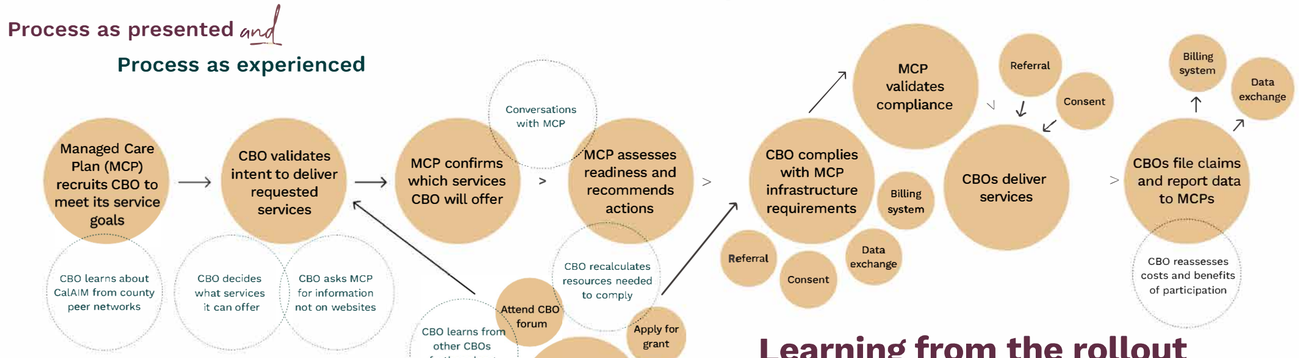
A1M also carried out content analysis of publicly available documents and data from the State of California, MCPs, state vendors, and healthcare foundations.

The rollout

State, health plans, and community organizations learn as they go



Process as presented and Process as experienced



"I don't know where I am in the process. There's so much to read and I don't have the time."
— Tina*, housing CBO director

High hopes for CalAIM... and many questions

For 25 years, the non-profit "Mountain Housing"* has run one of the largest homeless shelters in the county. As well, it provides comprehensive navigational services, rapid rehousing, mental health support services, and street outreach. Many of its clients are Medicare and Medicaid beneficiaries, but the CBO has never engaged with either program.

Though successful with grants and local donations, Mountain Housing needs more reliable revenue to survive. Donations and sporadic grants can't keep pace with rising needs.

* "Tina" and "Mountain Housing" are pseudonyms.

Tina's hopes for CalAIM:

- Stable year-over-year revenue
- Support for expanding medical respite and other services

Tina's challenges:

- Daily management crises keep her from devoting time to the process regularly.
- Deciding to apply without knowing compliance costs and reimbursement rates.
- Personal contact with MCP representatives is required to complete the process — but Tina had trouble finding hers.

Learning from the rollout

Formalize access

CBOs who had forged relationships with their MCPs in pre-CalAIM pilots could access unpublished information about requirements and reimbursement more easily than new-to-CalAIM providers.

Reduce dependency on informal relationships and networks for access to information.

Unify guidance

There is a wealth of information about CalAIM's goals and requirements available online. However, some of it is contradictory, and no one document explains the whole process.

Create a central, authoritative source for step-by-step guidance on how to participate.

Lower the barrier to Medicaid compliance

CalAIM represents a radical reimagining of community health. That means the housing- and food-oriented CBOs closest to hard-to-reach populations are unlikely to have Medicaid-standard billing tools, HIPAA-compliant systems, or prior experience implementing either of them. With extremely limited budgets, they may not be able to invest in compliance without upfront support.

Consider specifying a "standard toolkit" of infrastructure for data exchange, data collection, and billing.

Guarantee funding for administrative staff to establish compliant business processes and practices.