

Five-part guide to advancing and innovating Medi-Cal with analytics

Mede/Analytics®



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1 Introducing CalAIM

What is CalAIM?

California Advancing and Innovating Medi-Cal, known as CalAIM — is a far-reaching, multiyear plan to transform California's Medi-Cal program and integrate it more seamlessly with other social services. Led by California's Department of Health Care Services, the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, especially those with the most complex needs.





3 primary goals of CalAIM

Drive whole-person care

Identify and manage member risk and need through whole person care approaches and addressing social determinants of health.

Be consistent and seamless

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

Transform access and quality

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

A photograph of a healthcare professional, a young woman with dark hair in a blue scrubs uniform, smiling and assisting an elderly man. The man has white hair, a beard, and glasses, and is wearing a grey cardigan over a blue button-down shirt. He is using a silver walker. They are in a modern, well-lit room with a large window in the background showing a potted plant on the sill. A dark grey sofa is visible in the lower right.

2 Impact of CalAIM

New programs under CalAIM

Under CalAIM, the Department of Health Care Services would create several new Medi-Cal programs intended to improve care for populations with complex health needs. **The following programs build on the Whole Person Care Pilots and Health Homes Program, which are ending in 2021:**

Enhanced care management: Person-centered care management provided to the highest-need Medi-Cal enrollees, primarily through in-person engagement

Community supports: Includes housing supports and medically tailored meals, which will play a fundamental role in meeting enrollees' needs for health and health-related services that address social drivers of health

Short-term recovery supports: Includes short-term, post-hospitalization housing, recuperative care, respite services for caregivers and sobering centers

Independent living supports: Provides for day habilitation programs, nursing facility transition to assisted living facilities, community transition services, personal care/homemaker services, environmental accessibility adaptations, medically tailored meals and asthma remediation

Prerelease/in-reach care for people who are incarcerated: Expands coverage for key Medi-Cal services in the 90 days prior to release from jail to ensure adequate planning for a smooth transition

Providing Access and Transforming Health (PATH): Federal support for the data infrastructure and coordination needed between the managed care plans and the community-based providers and correctional facilities

Population health management: Encompasses a whole-system, person-centered strategy that includes assessments of each enrollee's health risks and health-related social needs, focuses on wellness and prevention, and provides care management and care transitions across delivery systems and settings

Updates to current Medi-Cal programs

CalAIM would also usher in key changes to current programs within Medi-Cal, including:

- Behavioral health reforms
- Aligned incentives and integrated care for seniors and people with disabilities
- Standardized and enhanced requirements for managed care
- More flexible payment for public hospitals that care for the uninsured
- Enhanced oversight of county eligibility and enrollment processes
- Enhanced oversight of county California Children's Services programs
- Model of care for foster youth

3 major ways CalAIM influences managed care organizations

The CalAIM initiative is poised to create a significant impact on managed care organizations (MCOs). To keep up, MCOs will need to:

A:

Focus on population health

Match the right patients to the right services at the right time to increase equity.

B:

Implement payment reform

Lay the foundation for paying physical and behavioral health providers based on outcomes rather than services.

C:

Ensure greater accountability

Adapt to new requirements by coordinating access to services provided by counties and community-based organizations.



3 How to succeed under CalAIM

Three key strategies

A:

Lead with data

To successfully adapt to the changes and new requirements laid out under CalAIM, MCOs must have robust, accurate data. Access to strong reporting and thorough analysis is essential for MCOs to successfully improve the equity, completeness, and quality of care for Medi-Cal beneficiaries.

B:

Find a strong partner

Building and executing all the necessary reporting and analytic tools in-house is rarely feasible—so pick a partner that will support and grow with you throughout the transition to CalAIM.

Our dedicated, experienced team at MedeAnalytics can provide the foundation you need to align patient care across the continuum; identify and reduce health disparities, ease administrative burden and waste, and improve data-driven decision-making on population health strategy.

C:

Establish pathways for transparency

Collaboration and clarity are keys to sustainability—especially when adapting to new regulations and requirements. Ensure your teams are prepared to work together closely to accomplish these goals. Organize operations around transparency to ensure compliance and understanding.

A photograph of a male and female healthcare professional in white lab coats sitting at a desk. The male professional, on the right, is gesturing with his right hand towards a computer monitor. The female professional, on the left, is looking at the monitor with her hand resting on her chin. The background shows a typical office environment with a computer monitor displaying a medical image and a small potted plant.

4 MedeAnalytics approach to CalAIM

Key benefits

With MedeAnalytics, MCOs gain many benefits, including:



Data integration
and transparency



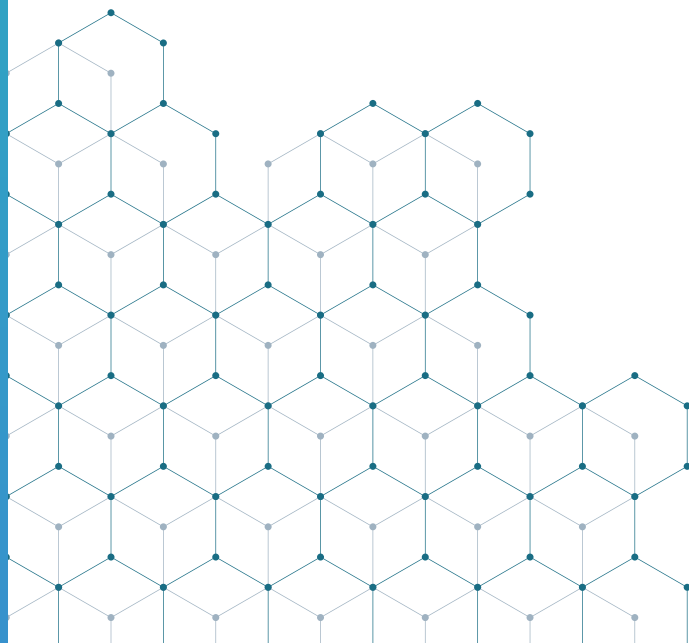
Identification and
stratification of populations



Quality measurement and
performance reporting



Data security and
role-based access



Use case: Social determinants of health

A:

Robust SDOH dashboards:

- Enable a detailed look at socioeconomic impacts on member care
- Understand the environmental factors that most impact outcomes and/or access to care to inform outreach campaigns and care plans

Social Determinants of Health (SDOH) Dashboard

★ Favorite 📄 Export ⚙️ Options

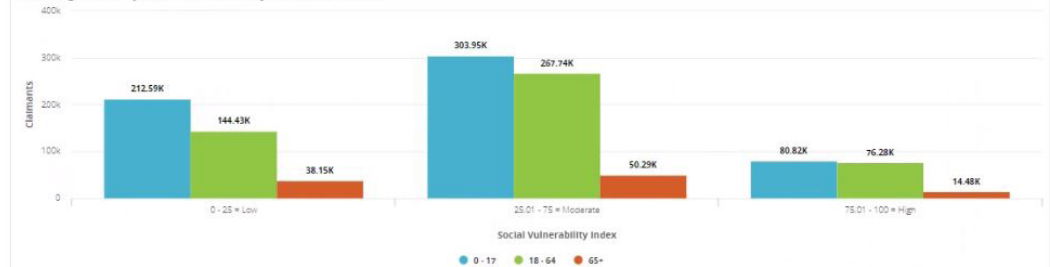
SDOH Summary

This value indicates the Social Vulnerability Index (SVI) of the FIPS area identified by the CDC where the claimant resides and DOES NOT represent the SVI of the unique claimant. The SVI is the overall percentile ranking of all themes (household composition, socioeconomic, housing/transportation, and minority/language).

SDOH Summary

Social Vulnerability Index	Claimants	30 Day Mortality Rate	Observed Readmission Rate	Unplanned Readmissions	ER Visits	IP Admissions	Preventable %	Non Preventable %
0 - 25 = Low	371,125	0.36%	6.3%	1,339	78,983	24,349	5.9%	11.1%
25.01 - 75 = Moderate	582,544	0.39%	7.1%	5,536	347,732	90,645	6.3%	10.7%
75.01 - 100 = High	164,390	0.24%	8.6%	721	28,213	9,481	5.5%	13.4%
Total : Selected Filter(s)								

SDOH Age Band by Social Vulnerability Index (Claimants)



Claimants by Theme: Overall Socioeconomic Vulnerability Risk

The Claimants by Theme: Overall Socioeconomic Vulnerability Risk value indicates the risk level for the Socioeconomic Theme of the FIPS area. This value is the overall percentile ranking for poverty level, unemployment rate, income, and high school diploma.

Claimants by Theme: Overall Socioeconomic Vulnerability Risk

Overall Socioeconomic Vulnerability Risk	Claimants
0 - 25 = Low	534,665
25.01 - 75 = Moderate	414,379
75.01 - 100 = High	16,562
Total : All	692,968

Claimants by Theme: Overall Household Composition Vulnerability Risk

The Claimants by Theme: Overall Household Composition Vulnerability Risk value indicates the risk level for the Household Composition Theme of the FIPS area. This value is the overall percentile ranking for persons ages 65 and older, persons ages 17 and younger, persons older than 5 years with a disability, and single-parent households.

Claimants by Theme: Overall Household Composition Vulnerability Risk

Overall Household Comp Vulnerability Risk	Claimants
0 - 25 = Low	484,559
25.01 - 75 = Moderate	469,533
75.01 - 100 = High	72,339
Total : All	692,968

Claimants by Theme: Overall Housing/Transportation Vulnerability Risk

The Claimants by Theme: Overall Housing/Transportation Vulnerability Risk value indicates the risk level for the Housing Type/Transportation Theme of the FIPS area. This value includes multi-unit structures, mobile homes, crowded houses, households without an available vehicle, and group intuitions/housing.

Claimants by Theme: Overall Housing/Transportation Vulnerability Risk

Overall Housing/Transportation Vulnerability Risk	Claimants
0 - 25 = Low	222,385
25.01 - 75 = Moderate	615,912
75.01 - 100 = High	276,045
Total : All	692,968

Claimants by Theme: Overall Minority/Language Vulnerability Risk

The Claimants by Theme: Overall Minority/Language Vulnerability Risk value indicates the risk level for the minority/language theme of the FIPS area. This value is the overall percentile ranking for persons who are considered a minority (not white or non Hispanic) and persons 5 years of age and older who do not speak English well.

Claimants by Theme: Overall Minority/Language Vulnerability Risk

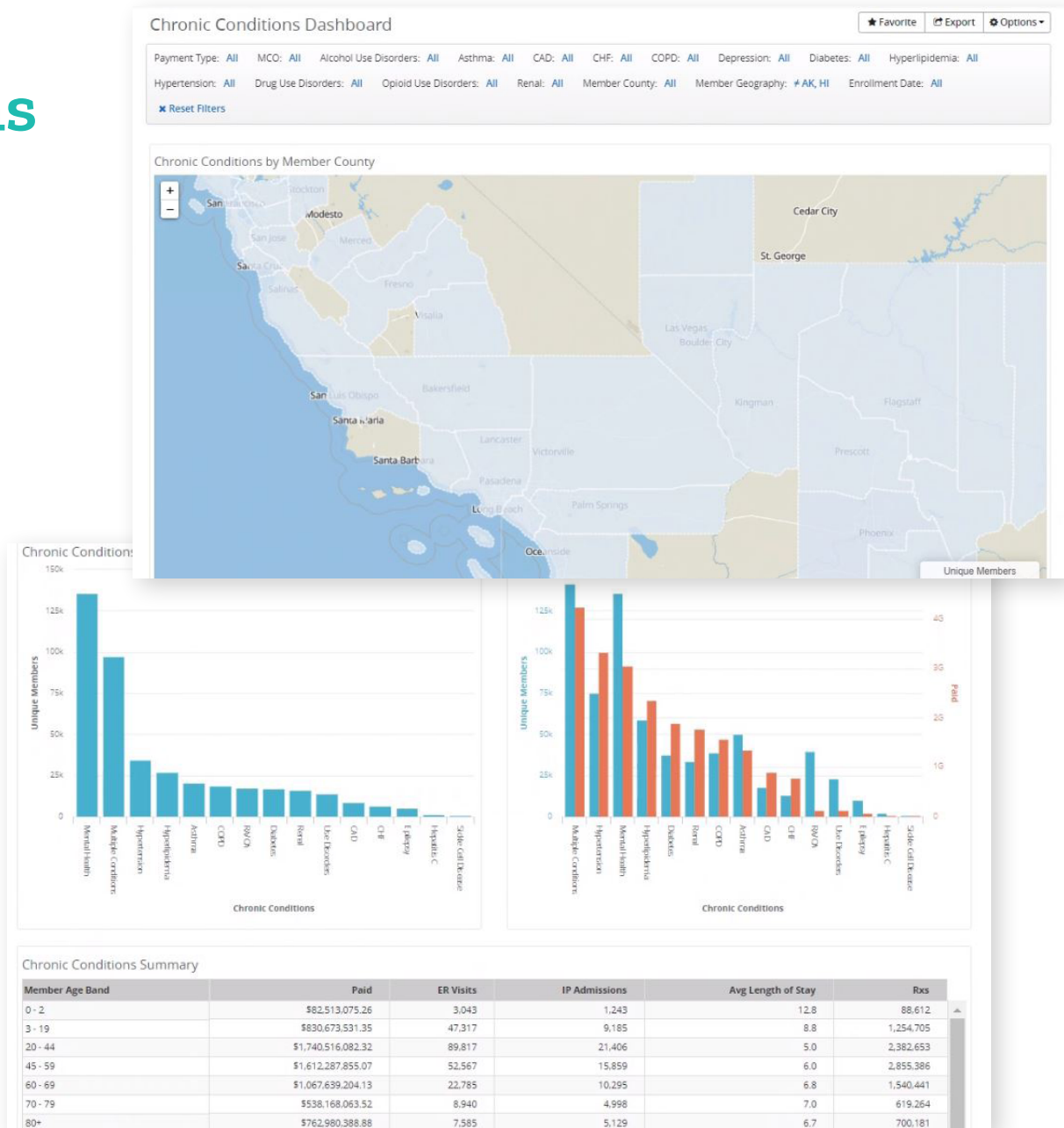
Overall Minority/Language Vulnerability Risk	Claimants
0 - 25 = Low	198,410
25.01 - 75 = Moderate	456,150
75.01 - 100 = High	498,486
Total : All	692,968

Use case: Chronic conditions

B:

Insights into patients with chronic conditions

- Give county visuals that enables cluster recognition
- Identify mental health members with co-morbidities to create comprehensive care plans
- Provide flexible filters and important demographic data for end users to dig into custom cohorts



Use case: Quality Payment Program

C.

Quality Payment Program dashboards:

- For states that have enacted Medicaid QPPs, provides MCOs the ability to track performance against key payment thresholds month over month for each measure identified
- Flexible platform allows MCOs to view performance (based on provider group or at a macro level) and collaborate with state agencies to view performance against other MCOs



ConcertoCare case study

Goals

ConcertoCare, headquartered in Aliso Viejo, CA, is a leading, risk-bearing provider of field-based complex care for vulnerable populations. ConcertoCare came to MedeAnalytics with a few central objectives:

- Address vulnerable populations
- Reduce hospitalizations for target groups
- Segment population groups for effective care management



Solution

ConcertoCare uses MedeAnalytics to identify high-risk and rising-risk patients for in-home care delivery and get the data necessary to address social determinants of health, including transportation, social isolation, cognitive impairment, behavioral health and palliative care. ConcertoCare is now successfully:

- Using predictive analytics to impact the most complex 5% of the population and address rising risk in up to 20% of the population.
- Proactively looking at 'Cost and Utilization' patterns to identify and prioritize care and interventions for the patients who are the most vulnerable and most at risk.
- Categorizing data by assigning Adjusted Clinical Groups (ACGs) to each patient based on morbidity, age and sex.

ConcertoCare case study

"We were able to significantly decrease unnecessary utilization for an entire population with MedeAnalytics' predictive analytics. The insights allow the ConcertoCare home-based care team to intervene with patients to slow down disease progression and keep them safely out of the hospital, while uniquely addressing their myriad of complex care needs."

Dr. Chris Dodd, Chief Clinical Officer at ConcertoCare



ConcertoCare case study

Results

16%

Reduction in ER visits

47%

Reduction in admissions

40%

Reduction in readmissions



A group of five healthcare professionals are gathered around a wooden table in a bright, modern office setting. A man in a dark suit and glasses is pointing at a tablet held by a woman in a white lab coat. Another woman in blue scrubs stands behind them, writing on a notepad. A man in a suit and glasses is looking at the tablet. A woman in a green top is partially visible on the left. On the table, there is a glass of water, a red mug, and a stethoscope.

5 Start executing on your CalAIM strategy

Where to go from here

The healthcare industry has only scratched the surface of what's possible with analytics. Moving ahead, look for these technologies to continue to improve. Advanced analytics has the potential to help health plans quickly adapt to this vast CalAIM plan by transforming data into actionable insights, driving administrative efficiency, improving the cost and quality of care, enhancing revenue growth, and moving the industry forward.

For more than 25 years, MedeAnalytics has been dedicated to helping healthcare organizations use their data to make a measurable impact. Now more than ever, it is critical for payers to utilize their data to its greatest potential. Payers leveraging MedeAnalytics will have the best advantage for tackling these challenges and capitalizing on the opportunities that are coming with CalAIM.

Our experts are equipped with the knowledge, experience and tools you need to navigate these changes in an advanced and cost-efficient manner. We are always innovating, ensuring our clients receive only the best service—so their members can get the best care.



To learn more about our comprehensive approach to CalAIM and how it can help you, [visit the CalAIM hub](#)