BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Summary – November 9, 2023

1055 W. Seventh Street, Los Angeles, CA 90017

Members

Alex Li, *MD, Chief Health Equity Officer*, *Chairperson*
Sameer Amin, *MD*, *Chief Medical Officer* *
John Baackes, *Chief Executive Officer**
Elaine Batchlor, *MD, MPH*
Paul Chung, *MD, MS*
Muntu Davis, *MD, MPH*,
Rishi Manchanda, *MD, MPH*
Santiago Munoz*
Elan Shultz
Stephanie Taylor, *PhD**

Management

Noah Paley, *Chief of Staff, Executive Services*
Acacia Reed, *Chief Operating Officer, Managed Care Services*
Phinney Ahn, *Executive Director, Medi-Cal Product Management*
Karla Lee Romero, *Director, Medi-Cal Product Management*
Brandon Shelton, *Senior Director, Advanced Analytics Lab*
Jordan Limperis, *Data Scientist II, Advanced Analytics Lab*

** Absent ***Present (Does not count towards Quorum)*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alex Li, *MD*, *Chief Health Equity Officer,* called the meeting to order at 2:05 p.m.	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved Unanimously. 6 AYES (Batchlor, Chung, Davis, Li, Manchanda, Shultz)**
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	The February 9, 2023 meeting minutes, May 11, 2023 Meeting Summary, August 24, 2023 were approved as submitted.	**APPROVED. 5 AYES (Batchlor, Chung, Li, Manchanda, Shultz)** **1 ABSTENTION Davis**

APPROVED

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CHAIR AND VICE CHAIR ELECTION	Member Li nominated himself as Chair. No other nominations were made. **Member Alex Li, MD, was approved as Chair of the Technical Advisory Committee.** Member Chung himself as Vice Chair of the committee. No other nominations were made. **Member Paul Chung, MD, was approved as Vice Chair of the Technical Advisory Committee.**	 **Approved Unanimously. 6 AYES** **Approved Unanimously. 6 AYES**
CHIEF HEALTH EQUITY UPDATE	Member Alex Li, *MD*, gave a Chief Health Equity Officer Update. He noted that one of the major organizational initiative is centered around Medi-Cal redetermination. Our Medi-Cal redetermination efforts are led by Ms. Ahn and Ms. Romero. They will provide a more detailed report in today's meeting. He mentioned that L.A. Care will soon submit a completed NCQA Health Equity accreditation application. He is confident that L.A. Care will achieve the Health Equity Accreditation status. Dr. Li also shared that he and Member Manchanda recently participated in the National Academy of Sciences' health equity round table. They observed a couple of noteworthy themes that were repeated throughout the day. First, history of racial and class-based health inequities has been well-documented, but the momentum around the health equity movement is relatively new. Concurrently, there is a strong anti-diversity, equity and inclusion movement across the United States. Dr. Li announced that he and Dr. Mona Patel from CHLA have co-organized a L.A. County focused children's health disparities summit. The four focus areas are: 1) , on building resiliency for school children staff, 2) addressing child welfare gaps, 3) fighting against vaccine mis-information and 4) transitioning youth with complex health care needs to adult systems of care. He emphasized the significance of their focus on children's health and youth wellness in the context of the pandemic. Dr. Li also informed that L.A. Care has been actively engaged in the Department of Health Care Services's Equity Practice Transformation Program. He will have this on	

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	the agenda at the next meeting as the deadline for practices and clinics to participate in the program will close on November 29. Finally, Dr. Li expressed gratitude to Members Chung, Taylor and Manchanda for their input on today's geo-spatial presentation as well as help on L.A. Care's health equity impact assessment tool and the format of the TAC meeting.	
TAC CHARTER, APPROACH, MEMBERS, FUTURE ITEMS	*(Member Batchlor joined the meeting. The committee reached quorum at 2:30 P.M.)* Member Li discussed the suggested changes to the TAC Charter. He asked the committee to review and provide any feedback they have. He stated that the Technical Advisory Committee is an advisory committee on various subjects and areas and as chair, he will also bring a greater health equity focus on our meeting items while ensuring that the committee is aware and have the opportunity to weigh in on major L.A. Care priorities and initiatives.	
MEDI_CAL REDETERMINTATION UPDATE	Ms. Ahn and Ms. Romero gave a Medi-Cal Redetermination Update *(a copy of the presentation can be obtained from Board Services)*. Redetermination Experience – November 2023 reflects Medi-Cal redeterminations for members with October renewal month. Below highlights the general process and activities: • November 1, 2023 - Action taken on fifth cohort of beneficiaries - Auto renewal using existing info in DPSS systems started in August • Pass = renewed! • Fail – Beneficiaries mailed renewal packet in late August ▫ ~126,000 L.A. Care members were mailed a packet ▫ L.A. Care began a call campaign for these members in late September ▫ Monthly data file of members who were mailed a packet shared with groups/Independent Physician Associations (IPA) • If no response to packet/request for info, beneficiary lost coverage effective November 1 and entered the 90-day cure period (procedural term/on hold) • L.A. Care is calling and mailing postcards to these "on hold" members • Monthly on-hold data file shared with groups/IPAs • November 2023 disenrollment and on-hold counts - ~77.5K total disenrollments	

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	• 70,700 procedural terminations / on-holds • 6,800 disenrollments / no longer eligible Medi-Cal redeterminations continue to be in flight and the next cohort of beneficiaries impacted are those with a November 2023 renewal month (6th cohort): • Renewal processing for beneficiaries with a November renewal month began in September • Paper packets for the 120,000 individuals who failed auto renewal were mailed around September 17 • L.A. Care conducted target outreach to these individuals ▫ Call campaign ▫ Data sharing with participating provider groups/IPAs and Plan Partners • Disenrollments will occur on December 1 for beneficiaries who do not respond to the county and for those who are determined ineligible *Medi-Cal redetermination will continue annually for all beneficiaries.* Key messages that we are actively sharing with beneficiaries: • Update your contact information - Make sure the county has your current contact information, if it has changed. This way, the county can contact you about your Medi-Cal. If your information has changed, you can update it online at benefitscal.com or by calling DPSS at 1-866-613-3777. • Create or check your online account - You can sign up to receive alerts on your case. Create or log into your BenefitsCal account to get these alerts. You may submit renewals or requested information online. • Check your mail - The county will mail you a letter about you Medi-Cal eligibility. You may need to complete a renewal form. • Complete your renewal form (if you get one) - If you receive a renewal form in the mail, submit your information by mail, phone, in person, or online so you do not lose your coverage. • Watch out for scammers - There is no cost to renew your Medi-Cal	

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	Member Shultz asked if there will be an increase in the number of beneficiaries that are placed on hold. Ms. Romero shared that it was challenging to identify a specific trend at this time. She mentioned that the best information she could provide was related to the processing of packets. In June, the county did not process all the packets they received, affecting approximately 167,000 individuals with maintained coverage. Ms. Romero suggested that there might be a significant volume of people in this category whose packets were not processed. She acknowledged the uncertainty and explained that if these packets were processed in the following month or months, it could contribute to the observed increase. Ms. Romero expressed her inability to provide a conclusive answer and stated that she was closely monitoring the numbers to assess the situation in the coming months, noting that they were currently at the halfway point in their evaluation. Member Manchanda inquired about the presented data on members placed on hold, specifically focusing on the new on-hold members each month within the renewal process. He asked for clarification, noting that the data represented the on-hold status within their renewal month. Member Manchanda clarified that the data did not show the cumulative number of members on hold due to a 90-day window. Thus, he questioned whether the overall number of members on hold in a given month was higher than what was presented in the current data. Member Manchanda expressed a desire to understand the broader context of the overall number of members on hold, suggesting that the figures shown might not capture the complete picture of the on-hold status for the entire time. Member Chung followed up with a question regarding nationwide disparities in enrollment, highlighting significant variations among states, ranging from 10% to 80% enrollment. He inquired about the comparison of counties, seeking to understand how the organization assesses its performance relative to other similar counties or locations facing similar situations. Member Chung aimed to gain insights into whether their enrollment rates were comparatively better or worse than those of comparable entities, acknowledging the need to consider variations across different regions. Ms. Romero responded by mentioning that she actively tracks the data on another chart against the date and the organization's enrollment rate. She stated that the data aligns quite closely with the figures discussed earlier. The procedural term rate is around 39%, and the disenrollment rate is around 30%. Ms. Romero noted that these rates don't include members to be released from hold. The state has estimated a release from hold	

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	rate to be around 44% in California. She expressed hope that they would observe a similar trend but acknowledged that it would become clearer with time.	
USE OF GEO-SPATIAL RESOURCE TO IDENTIFY AND TARGET L.A. CARE SOCIAL SERVICE NEEDS	Mr. Shelton and Mr. Limperis gave a presentation about Use of Geo-Spatial Resource to Identify and Target L.A. Care Social Service Needs *(a copy of the presentation can be obtained from Board Services)*. Research have clearly shown that disadvantaged neighborhoods suffer worse health outcomes than their counterparts in more affluent communities. Below highlight some of the clear association: • Poor and minority populations often live in socioeconomically disadvantaged neighborhoods, which directly affects access to food, safety, education, health behaviors and stress [1-5]. • Living in a disadvantaged neighborhood has been linked to higher rates of diabetes, cardiovascular disease, morbidity, and many other diseases [1-5]. • Studies have shown that poor people who live in wealthier neighborhoods have better health outcomes than poor people in disadvantaged neighborhoods [2,5] Examples of the clinical impact include: 1. Diabetes education programs will do little to reduce disparities if participants live in an area with substandard housing and lack access to a refrigerator for insulin storage [1]. 2. Being in a disadvantaged neighborhood is an equitable re-hospitalization risk as if you were living with Chronic Pulmonary Disease [2] An example with using geospatial tool is to review our geographic coverage with clinical resources. For example, certain areas like Antelope Valley have sparse clinical resources. Consequently, this has lead to a discussion by L.A. Care on whether our Community Resource Centers (CRCs) can supplement and provide some basic clinical services (e.g. health assessment screening) and preventative care (e.g. vaccines and basic testing colon cancer screening) t. There are certain areas with limited resources and we want to find where those services would have the greatest impact. Exploration of different indexes and L.A. Care member needs. • CMS recently mandated that provider (ACO REACH) reimbursement would be risk adjusted nationally using an Exposome (Area Deprivation Index, ADI), which was a very controversial change. They are looking at doing the same for STARs.	

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	▫ Exposome is a geographic clustering of a multitude of non-healthcare-specific data that is linked to healthcare outcomes. These indices are broken down to the Census Tract Level to effectively capture Social Drivers of Health (SDOHs) and model the Neighborhood Disadvantage. ▫ There are individualized ways to calculate SDOH's for members, but this abstraction might provide a way to ensure we have this data over near-every member with a strong research backing. • Here are some prominent indexes that L.A. Care has reviewed: ▫ Healthy Places Index (HPI) – Made specifically for California. We have used this in the past and it has the best documentation and support. ▫ Area Deprivation Index (ADI) – Modified to the Census Tract Level by the University of Wisconsin ▫ Social Vulnerability Index (SVI) – Created by the CDC for natural disaster recovery • A number of comments around the strength and weakness of various indexes were made. In the end, there is a general agreement that HPI may best reflect the neighborhood assets since it is a California and regionally produced model.	
FOLLOW-UP HEALTH EQUITY IMPACT ASSESSMENT TOOL UPDATE	Marina Acosta, *Manager, Health Equity,* gave an update on the revised Health Equity Impact Assessment Tool *(a copy of the materials can be obtained from Board Services).* Ms. Acosta thanked member Taylor for providing a tremendous amount input to our assessment tool. She shared an update on L.A. Care Health Plan's Health Equity Impact Assessment Tool. The plan is for the project leads to use the tool when major projects are considered. Ms. Acosta highlighted that it aligns with L.A. Care's health equity disparities and mitigation plan. The tool is part of L.A. Care Health Plan's commitment to institutionalizing the consideration of health equity in all their initiative and our next step is to work with our Enterprise Project Management department to begin field testing this new tool.	

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ADJOURNMENT	The meeting was adjourned at 3:52 P.M.	

Respectfully submitted by:
Victor Rodriguez*, Board Specialist II, Board Services*
Malou Balones*, Board Specialist III, Board Services*
Linda Merkens*, Senior Manager, Board Services*

APPROVED BY: DocuSigned by: Alex Li FF33F5D33BFB4D4...
Alex Li, MD, *Chairperson* 1/25/2024 | 4:50 PM PST

Date Signed

The following comments were made via chat box:
from Rishi Manchanda MD MPH to everyone: 2:28 PM
Reviewing the TAC Charter draft edits. Under Committee responsibilities, I'd recommend editing item B. to state the following ------ "Provision of expert advice to the Chief Health Equity Officer, other LA Care senior leaders and managers, and L.A. Care Board of Governors concerning L.A. Care Health Plan proposals or activities impacting the provider community."

to Rishi Manchanda MD MPH (privately): 2:33 PM
Thank you, Dr. Manchanda. I've made a note of your recommened edits.

from Rishi Manchanda MD MPH to everyone: 2:42 PM
This is very helpful Karla. Building on my earlier question, I think it would be helpful to view and track the rolling average of on-hold members in order to track the mid/longer term impact of interventions to reduce the number of on-hold beneficiaries.

from Rishi Manchanda MD MPH to everyone: 2:54 PM
Thanks Phinney, this is great. Curious - to what extent have these redetermination flyers (+/- training/education) been provided to CalAIM ECM and CS providers? If so, are you seeing any traction based on CS provider outreach?

from Paul Chung to everyone: 3:18 PM
I agree. Custom aggregations are useful if what you're customizing to is the zone of intervention (e.g., the CRC catchment area).

from Paul Chung to everyone: 3:23 PM
Minor point, but I believe Neighborhood Deprivation Index is at the census tract level, while Area Deprivation Level goes down to the census block level?
from Paul Chung to everyone: 3:24 PM
Area Deprivation Index, sorry

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from Rishi Manchanda MD MPH to everyone: 3:43 PM
one other use case is the use of geomarkers to help understand drivers and target interventions to close racial inequities in performance measures. for example Andrew F. Beck et al., Mapping Neighborhood Health Geomarkers To Clinical Care Decisions To Promote Equity In Child Health. Health Affairs 36, no. 6.(June 2017): 999-1005 doi: 10.1377/hlthaff.2016.1425.

from Rishi Manchanda MD MPH to everyone: 3:44 PM
sharing a Toolkit that outlines some of these equity-related use cases for geospatial analysis (See pg 25 for example)
https://www.chcf.org/publication/toolkit-racial-equity-primary-care-improvement/

from Jordan Limperis to everyone: 3:49 PM
@Dr. Chung - You are correct. HPI is census tract level, while ADI is census block level. We do a lot of work to make sure we have the most up-to-date aggregations.

from Jordan Limperis to everyone: 3:50 PM
I believe cross-comparison of indices would require the same geographic aggregations.

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