DRAFT

AGENDA

Technical Advisory Committee (TAC) Meeting

Thursday, August 8, 2024 at 2:00 P.M.
L.A. Care Health Plan
1055 W. 7th Street, 1st Floor, CR 100, Los Angeles, CA 90017

Members of the committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m154caca4acafbf69715b43db4c8e9d21

Teleconference Call Information: Dial: 1-213-306-3065
Meeting number: 2485 463 0270 **Password:** lacare

Teleconference Site

Elaine Batchlor, MD, MPH
Martin Luther King, Jr. Community Hospital
12012 Compton Ave.
4th Floor 4-118
Los Angeles, CA90059

Paul Chung, MD, MS
Kaiser Permanente School of Medicine
98 S. Los Robles Ave.
Pasadena, CA 91101

Muntu Davis, MD, MPH
Los Angeles County Department of Public Health
313 N Figueroa St #804
Los Angeles, CA 90012

Rishi Manchanda, MD, MPH
Health Begins
2600 W. Olive Ave.
Suite 500
Burbank, CA 91505

Elan Shultz
Los Angeles County Department of Mental Health
510 S. Vermont Ave.
Los Angeles , CA 90020

For those not attending the meeting in person, public comments on Agenda items can be submitted prior to the start of the meeting in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Due to time constraints, we are not able to transcribe and read public comment received by voice mail during the meeting. Public comment submitted by voice messages after the start of the meeting will be included in writing at the end of the meeting minutes.

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

	Welcome	Alex Li, *MD,* *Chief Health Equity Officer, Chairperson*
1.	Approve today's meeting agenda	*Chairperson*
2.	Public Comment	*Chairperson*
3.	Approve April 11, 2024 Meeting Minutes P.3	*Chairperson*

8/5/2024 11:21 AM

DRAFT

4. Chairperson Report — *Chairperson*
- Chief Health Equity Officer Update

5. L.A. Care's Program Impact Assessment Practice P.11 — Francisco Perez-Chavez, *Data Scientist III, Advanced Analytics Lab*; Brandon Shelton, *Senior Director, Advanced Analytics Lab*

6. L.A. Care's Strategic Plan P.22 — Wendy Schiffer, *Senior Director, Strategic Planning, Strategy*

7. Approach on Race and Ethnicity Data P.29 — Melina Mata, *Clinical Data Analyst III, Health Equity*

Adjournment

The next meeting is scheduled on October 10, 2024.
Public comments will be read for up to three minutes.

The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE TECHNICAL ADVISORY COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.
NOTE: THE TECHNICAL ADVISORY COMMITTEE CURRENTLY MEETS ON THE THIRD TUESDAY OF THE MEETING MONTH AT 8:30 A.M.
AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT the Reception area off the main lobby at 1055 W 7th Street, Los Angeles, CA, or online at http://www.lacare.org/about-us/public-meetings/board-meetings and by email request to BoardServices@lacare.org

Any documents distributed to a majority of Committee Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at https://www.lacare.org/about-us/public-meetings/public-advisory-committee-meetings and can be requested by email to BoardServices@lacare.org. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT the Reception area off the main lobby at 1055 W 7th Street, Los Angeles, CA.
An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Summary – April 11, 2024

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*
Todd Gower, *Chief Compliance Officer*

** 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 2:03 p.m. without a quorum. *The committee reached a quorum at 2:09 p.m.*	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved Unanimously by roll call. 6 AYES (Amin, Chung, Davis, Li, Manchanda, Shultz)**
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	The January 11, 2024 meeting minutes were approved as submitted.	**Approved Unanimously by roll call. 6 AYES**

DRAFT

<table>
<tr><th>AGENDA ITEM/
PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td>CHAIRPERSON'S REPORT
• Chief Health Equity Update</td><td>Member Alex Li, MD, Chief Health Equity Officer, gave a Chief Health Equity Officer Update as part of the Chairperson's Report (a copy of the report can be obtained from Board services).

<u>Cyber Attack-Change Healthcare</u>
In late February, Change Healthcare, a subsidiary of UnitedHealth Group was hacked. Change Healthcare not only offers providers and payors an Information Technology (IT) solution to submit and receive claims, it is also greatly impacted pharmacies ability to check co-pay when they went to pick up their medications from pharmacies. Due to Change Healthcare's large market presence, this attack was significant and impacted nearly every sector of the health care ecosystem. Unfortunately, L.A. Care used Change Healthcare as its tool to receive claims from providers. For the most parts, providers who receive capitation payments were not impacted. However, for hospitals, skilled nursing facilities (SNFs), durable medical equipment (DME) suppliers and other health care providers who bill L.A. Care through the fee for service format, were impacted by this attack. L.A. Care's team have been working diligently with UnitedHealth Group to stand up an alternative process. In the meantime, the provider network team have sent out regular communications and conducted town hall meetings to keep the network appraised. L.A. Care has also advanced over $20 million to those providers who expressed hardship. Moving forward, L.A. Carewill modify its business processes to increase resiliency and redundancy.

<u>National Commission on Quality Assurance (NCQA) Health Equity Accreditation</u>
On March 11, 2024, L.A. Care received a notification from NCQA that it achieved the NCQA Health Equity Accreditation status, with a score of 98% or 86.5 out of 88 possible points. L.A. Care is extremely proud of its work in health equity and achieving this status. Nationally, there were around 170+ health plans out of around 1,100 health plans nationally that have received the NCQA Health Equity Accreditation status.

<u>Equity Practice Transformation Program Update</u>
The Department of Health Care Services (DHCS) Equity and Practice Transformation (EPT) program announced that 46 practices selected to L.A. Care as their managed care plan sponsor. 211 out of 700+ practices were selected to participate in the program.

On March 7, 2024, L.A. Care hosted its first session.
<table>
<tr><th>Type of Practice</th><th>Total Number of Practices</th><th>Total in Direct Network</th><th>Medi-Cal Members (LA Care and HealthNet) Impacted</th></tr>
<tr><td>Private</td><td>24</td><td>8</td><td>100,938</td></tr>
</table>
</td><td></td></tr>
</table>

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

FQHCs	22	5	488,981
Totals	46	13	589,919

DHCS 2024 Quality Withhold and Incentive Program (QWIP)

On March 11, 2024, DHCS shared with the managed care plans their preliminary proposal for their new QWIP. The QWIP is intended to be a program where a small percentage of the managed care plan's revenue is withheld and then earned back based on the 8 managed care accountability set (MCAS) and consumer and provider survey responses. The new modification of the program is to have a health equity framework and seeks to require health plans to address sub-populations that perform poorly in the MCAS measures.

ARTIFICIAL INTELLIGENCE AND HEALTH EQUITY

Ankoor Shah, *MD, MBA, MPH, Chief Medical Officer, Radiant Services, Principal Director, Healthcare Strategy & Consulting Accenture,* and Brandon Shelton, *Senior Director, Advanced Analytics Lab,* provided a presentation on Artificial Intelligence (AI) and Health Equity.

Dr. Shah's report on AI in healthcare addresses several key points regarding the current state and future implications of AI in the healthcare industry. He highlighted the fundamental supply and demand mismatch in healthcare, with an aging population and fewer workers, particularly physicians and nurses, projected for the future. This creates pressure on the healthcare system, necessitating the exploration of technological solutions to augment human capabilities. Dr. Shah discussed rising consumer expectations, with patients expecting more from healthcare providers, leading to increased pressure on the system. This occurs within the context of escalating healthcare costs, further complicating the delivery of care. He delved into the role of AI in healthcare and questions whether it has effectively reduced disparities and advanced health equity at scale.

Dr. Shah cited examples from the past two decades, such as electronic health records (EHRs) and wearable technology, highlighting their limitations and unintended consequences, including physician burnout and disparities in risk scoring algorithms. Dr. Shah noted the impact of AI on care management solutions, noting instances where algorithms have disproportionately affected certain patient populations, exacerbating disparities in care delivery. He discussed the concept of generative AI, which focuses on output creation without necessarily understanding the underlying logic. Dr. Shah emphasized the potential of generative AI but also underscored its significant limitations and risks, including the creation of inaccurate recommendations and concerns about data security and privacy. Dr. Shah encouraged critical reflection on the risks and concerns associated with AI in healthcare, seeking input from the audience to understand their

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	perspectives and considerations regarding AI implementation and its implications for health equity. Member Chung raised several concerns regarding security risks and intellectual property (IP) protection in the context of AI technology in healthcare. He noted that security risks tend to rise to the top of discussions, particularly issues related to protecting both model inputs and outputs. Member Chung highlighted the importance of discussing the basic aspect, which involves the degree to which globally applicable tools can be customized at individual or institutional levels. He questioned who owns the customization rights and how customization occurs on top of existing platforms. Member Chung acknowledged the challenges surrounding training and customization in the rapidly evolving field of AI in healthcare, noting that many are "making it up as they go along." He mentioned concerns about model hallucinations but emphasizes that those working with AI understand that models simply execute their programming based on the quality of the underlying data and prompts. Despite potentially alarming outputs from AI models, Member Chung suggested that the focus should be on the quality of data and interrogation rather than solely on the outputs themselves. He indicated that most people are likely focusing on the latter three concerns raised, although he acknowledged some uncertainty in this assumption. Mr. Limperis draws parallels between the historical adoption of electronic health records (EHRs) and the current trajectory of AI in healthcare. He highlighted the early adoption by institutions like Kaiser Permanente in 2002, noting that the floodgates truly opened in 2009 with the passage of the High Tech Act, which accelerated the modernization and widespread implementation of EHR systems. Mr. Limperis inquired whether Dr. Shah sees a similar path for AI in healthcare and how government regulation might influence this trajectory, particularly in the context of how EHRs were integrated into the industry. By referencing the regulatory framework that accompanied the adoption of EHRs, Mr. Limperis prompted Dr. Shah to consider how regulatory measures may shape the implementation and evolution of AI technologies in healthcare. Dr. Shah acknowledged the significant regulatory changes underway, emphasizing the need for both regulatory adaptation and innovative solutions beyond regulatory frameworks. He drew a parallel between the proliferation of electronic health records (EHRs) following the High Tech Act and the potential trajectory of AI in healthcare, highlighting interoperability as a crucial aspect that could either facilitate or hinder progress. Dr. Shah expressed optimism about the transformative potential of AI in addressing healthcare challenges, particularly in diagnosis, drug discovery, and addressing disparities. He cited examples such as AI-aided detection of	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	precancerous conditions and ambient listening technology for administrative tasks, which could enhance efficiency and expand capacity in healthcare delivery. Addressing concerns about fairness and transparency in AI deployment, Dr. Shah outlined principles for responsible AI use, including human-centered design, fairness, transparency, and accountability. He stressed the importance of continuous monitoring and audit systems to address biases that may emerge over time. Regarding regulation, Dr. Shah highlighted various initiatives aimed at defining core principles and criteria for AI developers and users. He emphasized the complexity of the regulatory landscape, with multiple agencies and organizations contributing to rulemaking and compliance standards. Dr. Shah advised organizations to establish governance structures, conduct risk assessments, and prioritize responsible AI practices to navigate the evolving regulatory environment effectively. He also provided four key questions for organizations to assess their readiness and accountability in implementing responsible AI practices. Sameer Amin, MD, *Chief Medical Officer*,expressed concern regarding the discourse surrounding AI in healthcare, noting that much of the discussion has focused on branding rather than practical applications. He highlighted the confusion between predictive AI and generative AI and the need for clarity on how AI will be utilized in healthcare. Dr. Amin raised skepticism about the success of AI initiatives, citing past experiences where technological promises failed to materialize. He referenced instances such as clinical decision-making tools built into glasses and natural language software, which ultimately resulted in cumbersome pop-up screens rather than meaningful advancements. Drawing parallels to science fiction portrayals of AI, Dr. Amin emphasized the importance of realistic expectations and timelines for AI implementation. He urged caution in discussing AI and advocated for a more pragmatic approach to assessing its potential benefits and usability in clinical settings. Dr. Shah acknowledged Dr. Amin's concerns about the branding-centric discourse surrounding AI in healthcare, noting the prevalence of startups using AI as a buzzword without clear application. He highlighted the need for a more thoughtful approach, focusing on identifying real problems that AI can effectively address rather than pursuing flashy but superficial solutions. Dr. Shah emphasized the importance of deploying AI in back-office administrative tasks to reduce burdens and demonstrate tangible value to healthcare organizations. He stressed the significance of systematic deployment strategies to ensure meaningful integration and avoid superficial implementations driven solely by marketing appeal. Acknowledging the diversity of approaches across the market, Dr. Shah expressed agreement with Dr. Amin's concerns and offered to continue the discussion on this topic.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In response to Member Batchlor's question about principals, Dr. Shah responded by emphasizing the importance of integrating technology to enhance rather than replace human tasks, advocating for a "human plus machine" approach. He underscored the need to prioritize human-centric goals in the design and deployment of technology, such as enabling more meaningful interactions between healthcare providers and patients. Dr. Shah urged a mindset shift towards building solutions around human needs and functions, rather than pursuing technology for its own sake. Member Batchlor enquired whether the human-centric approach advocated for in their discussion was a novel concept gaining traction. Member Batchlor acknowledged the historical emphasis on technology over human considerations and shared a personal anecdote about their son pursuing a graduate program in human factor engineering, indicating a personal interest in understanding the concept better. Dr. Shah noted that the current emphasis on human-centric approaches in AI implementation differs from previous waves, largely due to past experience with less thoughtful implementations. He observed a recent increase in discussion around ethical AI and responsible use, but noted that practical implementation still lags behind the discourse. Member Manchanda commented with three interrelated points regarding AI implementation: use cases, approach, and accountability. He applauded the acknowledgment of potential harms associated with AI, particularly from an equity standpoint, emphasizing the importance of considering harm as a default assumption in use case prioritization. Member Manchanda noted AI-enabled prior authorization and utilization management as an example of a use case with inherent risks. Member Manchanda spoke about the approach aspect, noting that while terms like "fairness" and "inclusiveness" are positive, they can be ambiguous and subject to co-optation. He advocated for explicit and inclusive framework that involves community and patient engagement from the outset, rather than as an afterthought. Member Manchanda discussed the necessity of ethical oversight throughout the implementation process, drawing parallels to the film industry's use of advisors for sensitive scenes. He stressed the need for ethical observers to ensure equitable application and mitigate the heightened risk of harm, particularly due to potential biases in large language models and datasets. Member Manchanda also underscored the importance of accountability and governance structures, pointing out the challenge faced by many plans in aligning internal systems with equity goals. He emphasized the need for involvement from those most impacted by AI implementation and highlighted the risk of bias in large datasets. Member Manchanda expressed curiosity about how the presented strategies would translate into actionable healthcare strategies.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Shah responded with several considerations regarding the discussion on AI implementation and its potential harms. He expressed agreement with Member Manchanda while highlighting the opportunity costs of inaction. Dr. Shah acknowledged the risk of harm but emphasized comparing it to the alternative of human-only approaches, which have their own shortcomings. Dr. Shah stressed the importance of considering scalability in mitigating harm, particularly in solutions like care management. He suggested that smaller-scale iterative approaches could allow for better harm mitigation and responsible scaling compared to traditional methods reliant solely on human resources. Regarding prior authorization systems, Dr. Shah indicated his limited involvement in that area but noted the regulatory safeguards in place, such as requiring medical approval for care denials. He expressed hope that regulatory barriers would prevent the misuse of technology to deny care, although he acknowledged the potential for circumvention. Member Manchanda emphasized the importance of acknowledging the high risk of harm associated with AI, comparing it to drugs with a narrow therapeutic window. He clarified that recognizing this risk does not negate the consideration of potential benefits, which vary depending on specific use cases. Member Manchanda highlighted the discrepancy between the comprehensive expertise and strategic overview provided in the discussion and the more limited approaches taken by point solution vendors. He noted that many vendors pitch their technologies to healthcare plans without adequately addressing potential harms or providing necessary safeguards, thereby increasing overall risk.	
APPROVE THE TECHNICAL ADVISORY COMMITTEE CHARTER (TAC 100)	Chairperson Li, presented the following motion *(a copy of the materials can be obtained from Board Services)*: **To approve the revised Technical Advisory Committee Charter.** Member Manchanda moved to approve the committee charter with requested changes. He stated that while the Charter is well-crafted and logical, it lacks clarity on how the Technical Advisory Committee will enhance the existing work in engaging members and patients, such as community advisory committees. He suggested that the Charter should explicitly include ways to incorporate member voices and community engagement efforts. Member Manchanda noted the importance of integrating technical expertise on community engagement within the committee and stressed the need for communication to be a focal point in these discussions. Chairperson Li responded that that language can be included in the Charter. He added that the approval of the Charter can be postponed for another meeting. Member Manchanda responded that the Charter can be approved as long as there is a vehicle to elevate communication with	**proved Unanimously by roll call. 6 AYES (Amin, Chung, Davis, Li, Manchanda, Shultz)**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	technical expertise. He trusted Chairperson Li to guide the committee and elevate that process and moved to approve the Charter as is. Member Davis seconded the motion, but asked that the committee incorporate other work and how the community will be involved.	
MEDI-CAL REDETERMINATIONS UPDATE	Karla Lee Romero, *Director, Medi-Cal Product Management,* gave an update on Medi-Cal Redetermination of eligibility *(a copy of the presentation can be obtained from Board Services).* Ms. Romero reviewed the end of the continuous coverage requirement in March 2023 and the subsequent unwinding period starting in April 2023, affecting beneficiaries with eligibility renewals in June and terminations beginning in July. Ms. Romero noted California's flexible approach during the unwinding, which improved engagement rates. She discussed a recent DHCS survey showing significant gaps in member awareness and engagement, with many members unaware of the renewal requirements or the process to restart coverage. She spoke about the need for continued outreach, noting that 32% of those who lost coverage were unaware of the renewal necessity, 37% wanted to restart coverage but did not know how, and 45% claimed they never received the renewal packet. As the unwinding period concludes in May, L.A. Care estimates about 330,000 members still need redetermination. Despite the unwinding ending, monthly redeterminations will continue. Ms. Romero noted that close to 2 million members have undergone renewal processing, with 73% maintaining coverage. She stressed the importance of consistent messaging to ensure members complete their renewal packets and maintain coverage. The update included details on L.A. Care's ongoing and planned outreach efforts to support members through the redetermination process.	
ADJOURNMENT	The meeting was adjourned at 4:01 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: _____
Alex Li, MD, *Chairperson*

_____
Date Signed

Impact Assessment Practice: Systemic Review of LA Care Programs with Causal Analysis

August 8, 2024

L.A. Care HEALTH PLAN®
For All of L.A.

Advanced Analytics Lab
Delivering quantifiable business value through analytics

Road Map

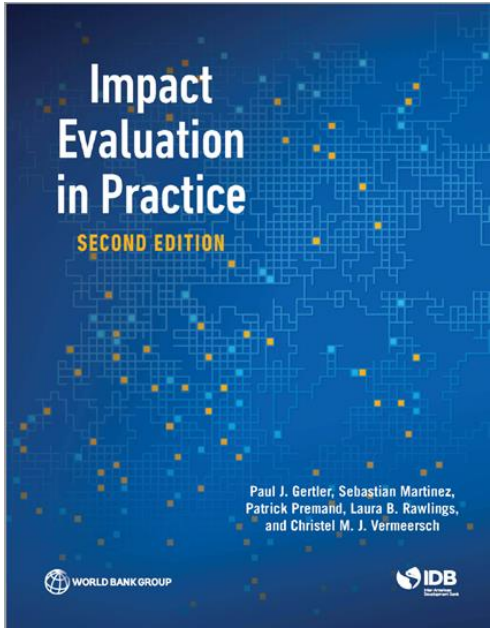
1. Why Impact Assessments
2. Impact Assessment Practice
3. Causal Analysis
4. Discussion

Why Impact Assessments?

How do we evaluate a program's impact with a focus on evidence based policies?

***Key Idea:* What is the impact (or causal effect) of a program on a specific outcome of interest?**

- Impact assessments are a particular type of evaluation that seeks to answer **cause-and-effect** questions
  - Use statistical tools and methods to account for other factors to that impact the observed outcome
- A periodic assessment of the effectiveness, relevance and sustainability of a program or policy



Why Impact Assessments?

Program Evaluations:

A complementary suite of evaluations both qualitative and quantitative needed for
“demonstrating the results of resource investments”:

- Needs assessment
- Process evaluation and monitoring
- Design and theory assessment
- Efficiency evaluation (cost benefit analysis)

Centers for Disease Control and Prevention. Framework for program evaluation in public health. MMWR 1999;48 (No. RR-11)

Why Impact Assessments?

How the IAP was designed?

Final Evaluation of California's Whole Person Care (WPC) Program (December 2022)

- WPC was a $3 Billion 5 year statewide pilot with ~250k participants
- UCLA Center for Health Policy Research was selected to evaluate WPC
- Developed a conceptual framework for evaluation with a mixed methods approach
- An impact assessment is part of a very thorough full program evaluation

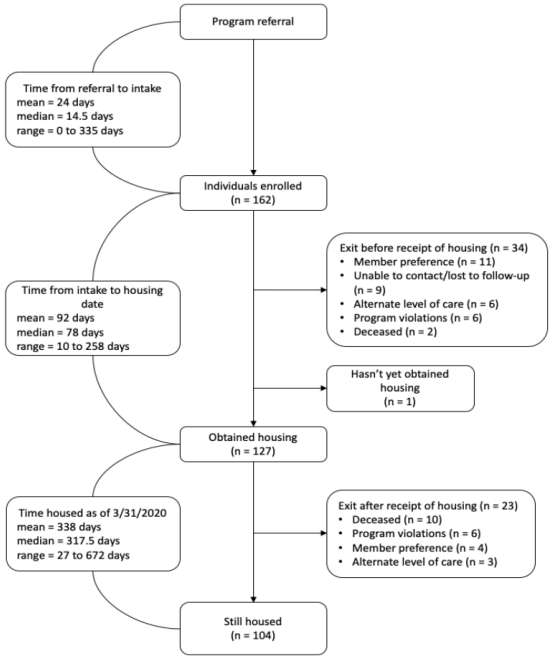
CalAIM | DHCS

UCLA Fielding School of Public Health

The Impact Assessment Practice

What is the IAP [**Consultation**, Code, Documentation]

- The goal is to apply an iterative and systematic accounting, with a focus on results, that can help inform policy and program guidelines.
- Consultative process to help define the operational characteristics of the program with the institutional knowledge of the people administering the program
  - Empower program managers to help define parameters of the study
  - It is our job to help them define the problem so that it can be examined with these tools
- The specific outcomes are changes in adverse utilization as well as the costs associated with those changes
  - Translate these parameters into statistical outcomes

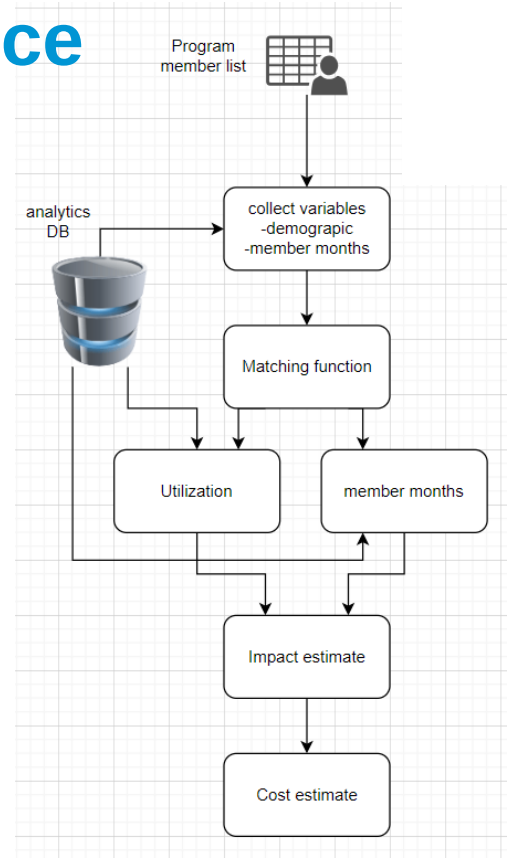


Sample Program Workflow

The Impact Assessment Practice

What is the IAP [Consultation – **Code** - Documentation]

- The code is the definitive source of the methodology
  - Outcomes are determined and reviewed by the code
- Software design principals
  - Computational statistics
  - Efficient, scalable, and reproducible code

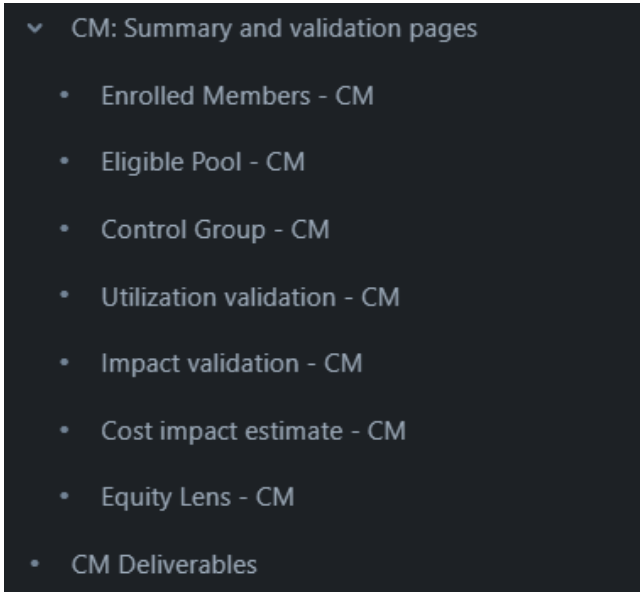


IAP software diagram

The Impact Assessment Practice

What is the IAP [Consultation – Code - **Documentation**]

- We must transform statistical outcomes into a language that is accessible and intuitive so that stakeholders understand and feel empowered to participate
  - Outcomes from the studies are typically in a very specific specialized language.
- Communicate the process and the outcomes in a way that is transparent, accessible and effective
  - Helps our customers in building confidence in our outcomes
  - Encourages building meaningful 2-way discussion

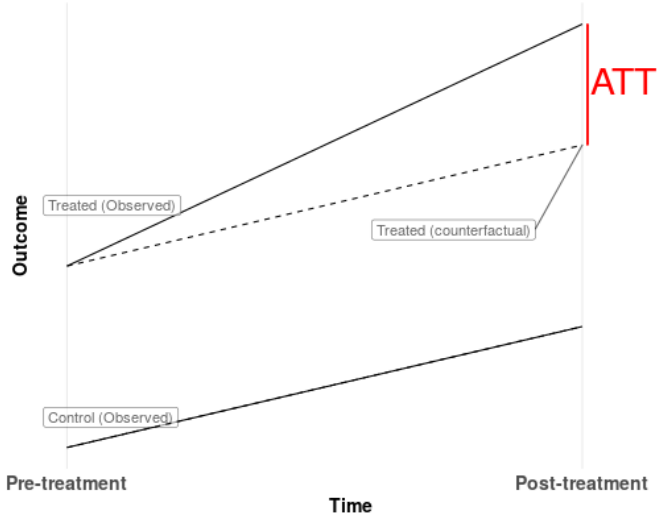


Outcome pages

Causal Analysis

Methodology

- Estimating a counterfactual
  - RCTs in medical literature
  - Natural experiments in econometrics
  - Quasi-experimental in social sciences
- Design based approaches
  - Difference in differences
  - Regression discontinuity

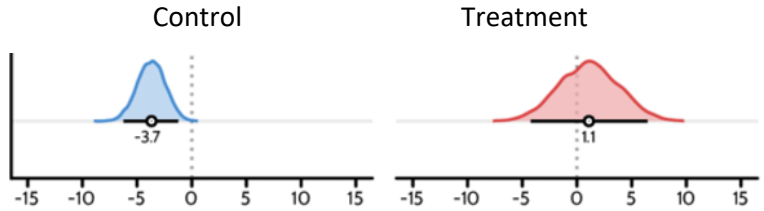


Parallel Trends in Diff-in-Diff

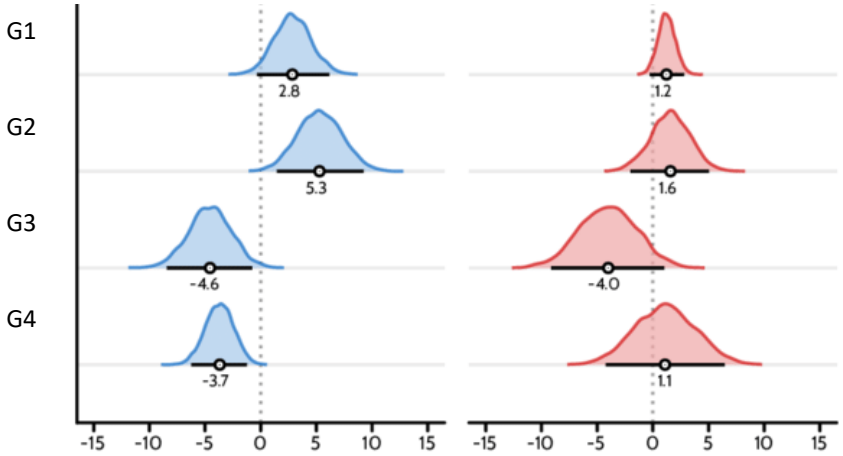
Causal Analysis

Heterogeneous Treatment Effects

- "Individuals differ not only in their background characteristics but also in how they respond to a particular treatment"
- How effects vary based on a member's background characteristics
  - What groups see greater effect
  - Useful for equity analysis



Treatment Effects Overall



by Group

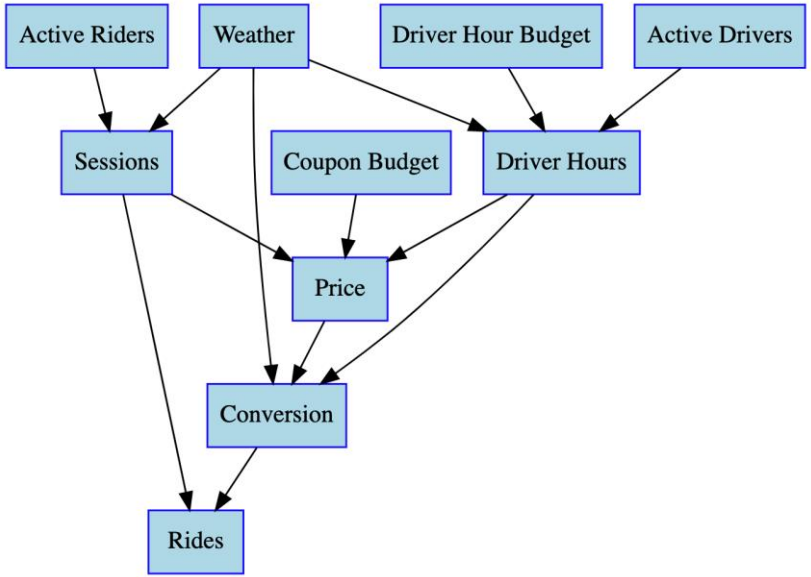
Causal Analysis

Methodology

- Structural Causal Modeling
  - Cause and effect
  - Represent a more logical flow for business processes

- Making the assumptions very clear, explicit and transparent
  - Validating those assumptions with SME
  - Testing those assumptions

- Helps identify:
  - Downstream impacts
  - Confounding variables



Causal model at Lyft

Strategic Vision 2024/25 – 2026/27

L.A. Care HEALTH PLAN
For All of L.A.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY
SINCE 1997

Wendy Schiffer, MSPH
Senior Director, Strategic Planning

Our Mission

L.A. Care's mission is to provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents and to support the safety net required to achieve that purpose.

Our Vision

A healthy community in which all have access to the health care they need.

Strategic Directions

- Improve **operational efficiency**.
- Support a robust **provider and partner network** to ensure their capacity to address our members' health and social needs.
- Improve the **member experience** with L.A. Care and the **quality** of care members receive.
- Serve as a **national leader** in promoting equitable health care to our members and the community and act as a catalyst for community change.

Operational Efficiency

- Develop and retain strong leaders
- Systems improvements for all core functional areas
- Customer relationship platform
- Provider workflow platform
- Cloud-based data ecosystem

Provider and Partner Capacity

- Provider portal
- Plan Partner collaboration
- Direct Network growth and support
- Field medicine
- Enhanced Care Management and Community Supports (CalAIM)

Member Experience and Quality

- Expand capacity and capabilities of Community Resource Centers
- First call resolution for Customer Service representatives
- Launch MAPD
- Grow and retain membership in all lines of business
- Touchpoint reform
- Quality performance for all lines of business

National Leader

- Culture of equity and diverse workforce
- Advocate for equitable and sustainable funding
- Promote equity and health equity
- Intentional AI development
- Elevating the Safety Net and other community investments

Approach to Categorize and Report on Race and Ethnicity Data at L.A. Care

Melina Mata
Clinical Data Analyst III
Health Equity

Agenda

1. Federal Office of Management and Budget's (OMB) Race/Ethnicity (r/e) Standards Overview
2. OMB Presentation Recommendations
3. Approach LA Care is Considering
4. Potential Limitations and Opportunities
5. Framing Questions and Technical Advice

OMB's R/E Standards Overview

Office of Management and Budget way to Collect Race/Ethnicity is Changing!

- The OMB Statistical Policy Directive No. 15 (SPD 15) guidance has not changed since 1997.

- Since 1997 there has been [1]:
  - Increasing racial and ethnic diversity and rise in number of people who identify as more than one race and/or ethnicity.

- **This requires data to be accurately captured which can lead to more opportunities to reflect communities with diverse experiences and needs.**

Overview of Changes for SPD 15

- SPD 15 recent revisions include:
  - Using a **single combined race and ethnicity question** for data collection.
  - Allowing respondents to have **multiple responses** in that single question.
  - Adding the **Middle Eastern or North African** (MENA) category, as a minimum reporting category
    - Separate and distinct from the White category
  - Requiring the collection of **more detail** beyond the minimum race and ethnicity reporting categories.
  - Updated **terminology**.
  - Requiring agency **Action Plans** on Race and Ethnicity Data and timely compliance with revisions.

OMB's R/E Standards Overview

What is the expected result of these revisions?

The goals of SPD 15 remain unchanged: to ensure the comparability of race and ethnicity across Federal datasets and to maximize the quality of these data by ensuring the format, language, and procedures for collecting the data are consistent. [1]

High Level Expectations

- Encourage respondents to select as many categories as apply to them.
- Reduce the number of respondents who skip the race or ethnicity question.
- Reduce the number of respondents who select the "some other race" category.

Transition to the Combined One-Question Format

Are you Hispanic or Latino?

☐ No, not Hispanic or Latino

☐ Yes, Hispanic or Latino

What is your race? *Select one or more.*

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

1997 SPD 15's Two-Questions Format [2]

What is your race and/or ethnicity?

Select all that apply and enter additional details in the spaces below.

☐ **American Indian or Alaska Native –** *Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.*

☐ **Asian –** *Provide details below.*

☐ Chinese ☐ Asian Indian ☐ Filipino
☐ Vietnamese ☐ Korean ☐ Japanese

Enter, for example, Pakistani, Hmong, Afghan, etc.

☐ **Black or African American –** *Provide details below.*

☐ African American ☐ Jamaican ☐ Haitian
☐ Nigerian ☐ Ethiopian ☐ Somali

Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.

☐ **Hispanic or Latino –** *Provide details below.*

☐ Mexican ☐ Puerto Rican ☐ Salvadoran
☐ Cuban ☐ Dominican ☐ Guatemalan

Enter, for example, Colombian, Honduran, Spaniard, etc.

☐ **Middle Eastern or North African –** *Provide details below.*

☐ Lebanese ☐ Iranian ☐ Egyptian
☐ Syrian ☐ Iraqi ☐ Israeli

Enter, for example, Moroccan, Yemeni, Kurdish, etc.

☐ **Native Hawaiian or Pacific Islander –** *Provide details below.*

☐ Native Hawaiian ☐ Samoan ☐ Chamorro
☐ Tongan ☐ Fijian ☐ Marshallese

Enter, for example, Chuukese, Palauan, Tahitian, etc.

☐ **White –** *Provide details below.*

☐ English ☐ German ☐ Irish
☐ Italian ☐ Polish ☐ Scottish

Enter, for example, French, Swedish, Norwegian, etc.

2024 SPD 15's One-Question Format [1]

OMB's Guidance on R/E Categorization

Approach #1	Approach #2	Approach #3
Approach consists of **double counting** respondents in several categories depending on what they report.	Approach defines a category as **every possible combination** of Race and Ethnicity.	Approach aggregates to the **Multiracial and Multiethnic** category which obscures specific race and ethnicity details.
Percentages do **not** sum to **100%**	Percentages sum to **100%**	Percentages sum to **100%**
Example: If respondent reported being both 'Black or African American' and 'White' then they would fall into both the '**Black or African American alone or in combination**' category and the '**White alone or in combination**' category.	*Example:* If respondent reported being both 'Black or African American' and 'White' then they would fall into the '**Black or African American and White**' category.	*Example:* If respondent reported being both 'Black or African American' and 'White' then they would fall into the '**Multiracial**' category.

Approach LA Care is Considering

Consideration for Tabulation:

- L.A. Care is considering a combination of OMB's suggested **Approach #2** and **Approach #3.**
- Implement this approach with the understanding that we may want to shift more toward Approach #2 if the data supports this.
  - As we learn more about our member population we may want to include additional categories (similar to the permutations seen in Approach #2) such as 'Hispanic or Latino and Black or African American and White'.
- Percentages sum to 100 percent.
- Response categories to be mutually exclusive.

L.A. Care's Consideration for Tabulation – 1 Question Roll Up

Ethnicity	Race	OMB One-Question Roll-up Draft
Not Hispanic or Latino	American Indian or Alaska Native	Not Hispanic or Latino *and* American Indian or Alaska Native
	Asian	Not Hispanic or Latino *and* Asian
	Black or African American	Not Hispanic or Latino *and* Black or African American
	Native Hawaiian or Other Pacific Islander	Not Hispanic or Latino *and* Native Hawaiian or Other Pacific Islander
	White	Not Hispanic or Latino *and* White
	Two or more races *(If a respondent has any combinations of the five race categories:* ***American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White*** *)*	Not Hispanic or Latino *and* Two or more races *Must maintain the ability to drill into two or more races.*
	Other	Not Hispanic or Latino *and* Other Race
	Asked but no answer	Not Hispanic or Latino *and* Unknown
	Unknown	Not Hispanic or Latino *and* Unknown
Hispanic or Latino	American Indian or Alaska Native	Hispanic or Latino *and* American Indian or Alaska Native
	Asian	Hispanic or Latino *and* Asian
	Black or African American	Hispanic or Latino *and* Black or African American
	Native Hawaiian or Other Pacific Islander	Hispanic or Latino *and* Native Hawaiian or Other Pacific Islander
	White	Hispanic or Latino *and* White
	Two or more races *(If a respondent has any combinations of the five race categories:* ***American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White*** *)*	Hispanic or Latino *and* Two or more races *Must maintain the ability to drill into two or more races.*
	Other	Hispanic or Latino *and* Other Race
	Asked but no answer	Hispanic or Latino *and* Unknown
	Unknown	Hispanic or Latino *and* Unknown

L.A. Care's Consideration for Tabulation – 2 Question Roll Up

Race (OMB Categories)	OMB Two-Question Roll-up Draft
American Indian or Alaska Native	American Indian or Alaska Native
Asian	One *or* any combinations of granular Asian categories: ***Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Other Asian***
Black or African American	Black or African American
Native Hawaiian or Other Pacific Islander	One *or* any combinations of granular Native Hawaiian or Other Pacific Islander categories: ***Native Hawaiian, Samoan, Guamanian or Chamorro, Other Pacific Islander***
White	White
Two or more races	Any combinations of the five race categories: ***American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White***
Asked but no answer	Asked but no answer
Unknown	Unknown

Ethnicity (OMB Categories)	OMB Two-Question Roll-up Draft
Hispanic or Latino	One *or* any combinations of granular Hispanic or Latino categories: ***Mexican, Guatemalan, Salvadoran, Puerto Rican, Cuban, Other Hispanic/Latino***
Not Hispanic or Latino	Not Hispanic or Latino
Asked but no answer	I choose not to answer
Unknown	Unknown

Potential Limitations and Opportunities

Potential Limitations

- 834 Files - Health Plan benefit enrollment files
  - Each Line of Business manages their own race and ethnicity codes.
  - Race and Ethnicity codes are not consistent across Line's of Business.

Potential Future Opportunities

- Health Information Exchange Data
- Call Center Data
  - Expand the race and ethnicity values to include the minimum 7 race and ethnicity categories as well as the minimum detailed race and ethnicity values.
  - Ensure we are capturing the both race and ethnicity details for our members. This may include additional detailed values than what is seen in the SPD 15.

Framing Questions and Technical Advice

- Are there any concerns with the approaches we are considerin?
- What have you seen work best for reporting?
- How best do we represent an individual who has two or more races?
- Any other resources we should be mindful of?

References

1. https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and
2. https://www.federalregister.gov/documents/2023/01/27/2023-01635/initial-proposals-for-updating-ombs-race-and-ethnicity-statistical-standards
3. https://spd15revision.gov/content/spd15revision/en/history.html

Appendix

History of SPD 15

- 1977 → OMB initially developed SPD 15 [1].
- 1997 → Since 1977, SPD 15 has been revised one time in 1997 [1].
- 2005 → The decennial census and American Community Survey (ACS) were required to include the SOR “Some Other Race” category. [2]
- 2014 – 2018 → Interagency working group reviewed SPD 15 [1].
- 2020 → This Census showed the increase in non-response and reporting of “Some Other Race” (SOR) which was one of the primary indicators to OMB that SPD 15 was no longer providing options that align with how respondents prefer to identify.[1]
- 2022 → OMB announced a formal review in June 2022 with the goal of updating SPD 15 to better reflect the diversity of the Nation [1].
- 2023 → Preliminary proposals and questions published to the public [2].
- 2024 →OMB released revisions to SPD 15 [1].

Appendix

OMB Guidance - Approach #1

- The alone or in combination approach.
- Respondents can be in several categories.
- Percentages across the categories sum to greater than 100%.

- Example
  - If respondent reported being both 'Black or African American' and 'White' then they would fall into both the 'Black or African American alone or in combination' category and the 'White alone or in combination' category.

- American Indian or Alaska Native alone or in combination
- Asian alone or in combination
- Black or African American alone or in combination
- Hispanic or Latino alone or in combination
- Middle Eastern or North African alone or in combination
- Native Hawaiian or Pacific Islander alone or in combination
- White alone or in combination

Appendix

OMB Guidance - Approach #2

- Defines a category as every possible combination of Race and Ethnicity.
- Percentages will sum to 100%.

- Example
  - If respondent reported being both 'Black or African American' and 'White' then they would fall into the 'Black or African American and White' category.
  - If respondent reported being both 'Hispanic or Latino' and 'White' then they would fall into the 'Hispanic or Latino and White' category.

- American Indian or Alaska Native alone
- Asian alone
- Black or African American alone
- Hispanic or Latino alone
- Middle Eastern or North African alone
- Native Hawaiian or Pacific Islander alone
- White alone

American Indian or Alaska Native*and* Hispanic or Latino

American Indian or Alaska Native*and* White

Asian*and* Native Hawaiian or Pacific Islander

Asian*and* White

Black or African American*and* Middle Eastern or North African

Black or African American*and* White

Hispanic or Latino*and* Black or African American

Appendix

OMB Guidance - Approach #3

- This approach aggregates the Multiracial and Multiethnic category which obscures specific race and ethnicity details.
- Percentages will sum to 100%.

- Example
  - If respondent reported being both 'Black or African American' and 'White' then they would fall into the 'Multiracial' category.

- American Indian or Alaska Native alone
- Asian alone
- Black or African American alone
- Hispanic or Latino alone
- Middle Eastern or North African alone
- Native Hawaiian or Pacific Islander alone
- White alone
- Multiracial and/or Multiethnic