Plan Management Advisory Workgroup

August 14, 2025

AGENDA

Time	Topic	Presenter
10:05 – 10:15	2027 QHP and QDP Contract Amendment Updates and Public Comment Period - PMD	Tara Di Ponti
10:15 – 10:30	Qualified Dental Plan 2027 Attachment 2 Amendment	EQT Team
10:30 – 10:45	Hospital Quality Project	Peg Carpenter
10:45 – 11:00	Plan Performance Report Release Year 2025	Chelsea Hart-Connor
11:00 – 11:30	Update on 2025 Population Health Investments	Joy Dionisio
11:30 – 11:50	Proposed 2026 Population Health Investments	Dr. Soni

2027 PLAN YEAR AMENDMENT TO THE 2026-2028 CONTRACTS

Plan Management Division
Health Equity & Quality Transformation Division

COVERED CALIFORNIA

2027 PLAN YEAR AMENDMENTS

The Plan Management Division and Health Equity & Quality Transformation Division are working together to amend the Qualified Health Plan (QHP) Issuer Contracts for the Individual and Covered California for Small Business (CCSB) markets for the contract duration of 2026-2028, as well as amending the 2024-2027 Qualified Dental Plan (QDP) Issuer Contract for the Individual and CCSB markets.

- Minimal content updates to all Model Contracts
  - 2026-2028 QHP Individual Issuer Model Contract
  - 2026-2028 QHP CCSB Issuer Model Contract
  - 2024-2027 QDP Issuer Model Contract
- Minimal to no content updates for below Model Contract Attachments
  - QHP Individual, Attachments 1-4
  - QHP CCSB, Attachments 1, 2(placeholder), 3, & 5
  - QDP, Attachments 1, 3, & 5

SUMMARY OF PROPOSED 2027 AMENDMENT UPDATES

- Minimal updates have been made for the 2027 QHP and QDP Amendments.
  - General updates throughout contract documents have been made for clarity, accuracy, and alignment where applicable.
  - See below for a summary of updates to contract content or requirements:

Update Summary	2027 Proposed Updates
QHP, QDP **Article 10 – Privacy and Security** **10.1 b) ii. 7. Safeguards** Provision updated to align with the National Institute of Standards and Technology (NIST).	**QHP, QDP** **Article 10 – Privacy and Security** **10.1 b) ii. 7. Safeguards** Safeguards. Contractor must have in place administrative, physical, and technical safeguards that meet or exceed the standards published in the National Institute of Standards and Technology (NIST), Special Publication 800-53 rev 5, or in the ISO/IEC 27001 to ~~Contractor shall have in place administrative, physical, and technical safeguards that reasonably and~~ appropriately protect the confidentiality, integrity, and availability of the ~~Protected Health Information~~ PHI and ~~Personally Identifiable Information~~ PII that it creates, receives, maintains, or transmits pursuant to the Agreement and to prevent the use or disclosure of ~~Protected Health Information~~ PHI and/or ~~Personally Identifiable Information~~ PII other than as provided for in this Agreement, or as required by law…
QHP, QDP **Article 10 – Privacy and Security** **10.1 b) ii. 7. a. Safeguards** Encryption of Protected Health Information (PHI) and Personally Identifiable Information (PII) updated to align with the current Federal Information Processing Standards (FIPS).	**QHP, QDP** **10.1 b) ii. 7. a. Safeguards** a. Encrypt all ~~Protected Health Information~~ PHI and/or ~~Personally Identifiable Information~~ PII that is in motion ~~or~~ and at rest, including data on portable media devices, ~~using commercially reasonable means,~~ consistent with the current Federal Information Processing Standards (FIPS) Publication 140 encryption standards ~~applicable Federal and State laws, regulations and agency guidance, including the U.S. Department of Health and Human Services Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements or issued by the National Institute for Standards and Technology ("NIST") concerning the protection of identifiable data such as Protected Health Information and/or Personally Identifiable Information. Data centers shall be encrypted or shall otherwise comply with industry data security best practices~~;

SUMMARY OF PROPOSED 2026-28 QHP MODEL CONTRACT UPDATES

Update Summary	2027 Proposed Updates
QHP, QDP **Article 10 – Privacy and Security** **10.1 b) ii. 7. b. – f. Safeguards** Provisions updated for conciseness and to require that a contingency plan for responding to emergencies and disruptions to business without degradation of PHI and PII security and Security Incident Response Plans be tested at least annually.	**QHP, QDP** **Article 10 – Privacy and Security** **10.1 b) ii. 7. b. Safeguards** b. Implement a contingency plan for responding to emergencies and/or disruptions to business or systems used to deliver services pursuant to this Agreement without degradation of the PHI and/or PII security, and is tested at least annually ~~that in any way affect the use, access, disclosure, or other handling of Protected Health Information and/or Personally Identifiable Information~~; c. Maintain a Security an Incident response plan; Mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to PHI and/or PII or of any use or disclosure of PHI and/or PII by Contractor or its Subcontractors or Agents in violation of the requirements of this Agreement or applicable privacy and security laws and regulations and agency guidance;
QHP, QDP **Article 10 – Privacy and Security** **10.1 b) ii. 7. g. Safeguards** Contract language updated to better reflect current provisioning process for access permissions to accounts with authorized use of PHI and/or PII.	**QHP, QDP** **Article 10 – Privacy and Security** **10.1 b) ii. 7. g. Safeguards** ~~g.~~d. Ensure that each individual user, including ~~any~~ Contractor's employees, ~~sub~~ Sub contractors, ~~agents~~ Agents or other such individuals, of any Covered California computer system through which ~~Protected Health Information~~ PHI and/or ~~Personally-Identifiable Information~~ PII is accessed be assigned and maintain ~~his or her~~ their own unique user-id and password. Contractor shall immediately notify Covered California via the current provisioning process for access permissions ~~e-mail through an e-mail address~~ provided by Covered California once any such employees, ~~sub~~ Sub-contractors, ~~agents~~ Agents or other such individuals are no longer employed, ~~or~~ retained, or acting in a role that does not require access to PHI and/or PII by Contractor. Contractor shall likewise cooperate in good faith to ensure the accounts of any such individuals are de-activated to prevent unauthorized access to ~~Protected Health Information~~ PHI and/or ~~Personally-Identifiable Information~~ PII through any such Covered California computer system; and

SUMMARY OF PROPOSED 2026-28 QHP MODEL CONTRACT UPDATES

Update Summary	2027 Proposed Updates
QHP, QDP **Article 10 – Privacy and Security** **10.1 c) i. Compliance with California Requirements** Further clarity was added to the requirement to comply with the Information Practices Act (IPA).	**QHP, QDP** **Article 10 – Privacy and Security** **10.1 c) i. Compliance with California Requirements** i. With respect to the IPA, Contractor agrees to adhere to the standards and requirements of the IPA as if Contractor were Covered California itself. Contractor is therefore required to meet the same standards of privacy and information handling as Covered California and must comply with all applicable sections of the IPA related to the collection, use, storage, security, and disclosure of personal information as applicable and when handling any PII received from, or collected on behalf of, Covered California.

2027 CONTRACT AMENDMENT DRAFTS & PUBLIC COMMENT

- 2027 QHP and QDP Contract Amendment Drafts and Comment Templates will be posted to HBEX Friday, August 15, 2025: https://hbex.coveredca.com/stakeholders/plan-management/contract-listings/2027/
- Stakeholders will have until COB, **Monday, September 15, 2025** to provide comments on all contract documents.

Any questions please email PMDContractsUnit@covered.ca.gov

QUALIFIED DENTAL PLAN 2027
ATTACHMENT 2 AMENDMENT

EQT Team

SUMMARY OF 2024-2026 QDP ATTACHMENT 2

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2024	Percent of At-Risk Amount 2025	Percent of At-Risk Amount 2026
Data Submission 50%	1. Healthcare Evidence Initiative (HEI) Data Submission	45%	45%	45%
	2. Provider Directory Submission	5%	5%	5%
Oral Health 50%	3. Pediatric Oral Evaluation, Dental Services	5%	5%	5%
	4. Pediatric Topical Fluoride for Children, Dental Services	5%	5%	5%
	5. Pediatric Sealant Receipt on Permanent First Molars	5%	5%	5%
	6. Adult Preventive Services Utilization	35%	35%	35%

PROPOSED 2027 QDP ATTACHMENT 2 CHANGES

Notable Changes to Draft IND QDP Attachment 2	Rationale
Performance Standard 1 - Data Submission Specific to HEI Alternate Standard – Contractor must adhere to data submission standards outlined in Attachment 1, Articles 5.02.1 and 1.02.1, participate in data quality meetings during the first MY, and complete full and regular data submissions according to the same standards during the second MY	In alignment with QHP Issuer Model Contract Attachment 2, implements applicable requirements and timeline for QDP Issuer Contractors who execute contracts after the first year of the contract term.
Performance Standard 2 - Provider Directory Submission No changes proposed	

PROPOSED 2027 QDP ATTACHMENT 2 CHANGES

Notable Changes to Draft IND QDP Attachment 2	Rationale
Performance Standard 3 – Pediatric Oral Evaluation, Dental Services	
▪ Contractor face a 5% penalty for DHMO products if the increase is under 20% and for DPPO products if the increase is under 10%, with no penalty applied for increases equal to or exceeding these thresholds.	▪ The very low DHMO baseline performance rates result in a much lower improvement expectation compared to DPPOs if the same year over year percentage improvement target is used, widening the disparity already seen.
▪ Alternate Standard – Contractor must submit pediatric dental data in the first MY, establish a baseline in the second MY, and demonstrate compliance with data submissions at least once during the first Assessment Year.	▪ In alignment with QHP Issuer Model Contract Attachment 2, implements applicable requirements and timeline for QDP Issuer Contractors who execute contracts after the first year of the contract term.

PROPOSED 2027 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND QDP Attachment 2	Rationale
Performance Standard 4 – Pediatric Topical Fluoride for Children, Dental Services	
▪ Contractor face a 5% penalty for DHMO products if the increase is under 20% and for DPPO products if the increase is under 10%, with no penalty applied for increases equal to or exceeding these thresholds.	▪ The very low DHMO baseline performance rates result in a much lower improvement expectation compared to DPPOs if the same year over year percentage improvement target is used, widening the disparity already seen.
▪ Alternate Standard – Contractor must submit pediatric dental data in the first MY, establish a baseline in the second MY, and demonstrate compliance with data submissions at least once during the first Assessment Year.	▪ In alignment with QHP Issuer Model Contract Attachment 2, implements applicable requirements and timeline for QDP Issuer Contractors who execute contracts after the first year of the contract term.

PROPOSED 2027 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND QDP Attachment 2	Rationale
Performance Standard 5 – Pediatric Sealant Receipt on Permanent First Molars	
▪ Contractor face a 5% penalty for DHMO products if the increase is under 20% and for DPPO products if the increase is under 10%, with no penalty applied for increases equal to or exceeding these thresholds.	▪ The very low DHMO baseline performance rates result in a much lower improvement expectation compared to DPPOs if the same year over year percentage improvement target is used, widening the disparity already seen.
▪ Alternate Standard – Contractor must submit pediatric dental data in the first MY, establish a baseline in the second MY, and demonstrate compliance with data submissions at least once during the first Assessment Year.	▪ In alignment with QHP Issuer Model Contract Attachment 2, implements applicable requirements and timeline for QDP Issuer Contractors who execute contracts after the first year of the contract term.

PROPOSED 2027 ATTACHMENT 2 CHANGES

Notable Changes to Draft IND QDP Attachment 2	Rationale
Performance Standard 6 – Adult Preventive Services Utilization	
▪ Contractor face a 5% penalty for DHMO products if the increase is under 20% and for DPPO products if the increase is under 10%, with no penalty applied for increases equal to or exceeding these thresholds.	▪ The very low DHMO baseline performance rates result in a much lower improvement expectation compared to DPPOs if the same year over year percentage improvement target is used, widening the disparity already seen.
▪ Alternate Standard – Contractor must submit pediatric dental data in the first MY, establish a baseline in the second MY, and demonstrate compliance with data submissions at least once during the first Assessment Year.	▪ In alignment with QHP Issuer Model Contract Attachment 2, implements applicable requirements and timeline for QDP Issuer Contractors who execute contracts after the first year of the contract term.

SUMMARY OF PROPOSED 2027 QDP ATTACHMENT 2 PERFORMANCE STANDARDS & PERCENT AT RISK

Performance Area	Performance Standards with Penalties	Percent of At-Risk Amount 2024-2026	Percent of At-Risk Amount 2027
Data Submission 50%	1. Healthcare Evidence Initiative (HEI) Data Submission	45%	45%
	2. Provider Directory Submission	5%	5%
Oral Health 50%	3. Pediatric Oral Evaluation, Dental Services	5%	5%
	4. Pediatric Topical Fluoride for Children, Dental Services	5%	5%
	5. Pediatric Sealant Receipt on Permanent First Molars	5%	5%
	6. Adult Preventive Services Utilization	35%	35%

HOSPITAL QUALITY IMPROVEMENT

Peg Carpenter

Senior Equity and Quality Specialist

HOSPITAL QUALITY ALIGNMENT: EARLY MOMENTUM

We've begun meeting with key Quality Improvement leaders across our Qualified Health Plan Issuers.

Early Insights:

"*Let's focus on measures that matter to patients and plans*"

"*We want to learn from high performers, not just fix low performers*"

"*Let's get all hospitals to the table with the right data and support*"

Our ask of you: **Come co-design with us!**

What would success look like for your organization?

What milestones would excite your teams?

What support would make this sustainable?

All Interested Stakeholders:
Email us: eqt@covered.ca.gov

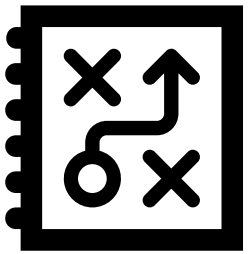
HOSPITAL QUALITY ALIGNMENT: NEXT STEPS

This roadmap reflects our shared commitment to improving hospital quality across California. By starting with focused alignment and building on what works, we aim to create a scalable, data-driven model that delivers better outcomes, greater value, and lasting impact for the communities we serve.

Build the Framework:
- Build infrastructure to align hospital performance
- Identify measure(s) for testing
- Establish proof of concept

Iterate:
- Create pathway to achieve statewide goals
- Learn from high performers
- Support early adopters
- Accelerate digital measure collection

Innovate
- Expand measures of focus
- Data transparency
- Sustainment activities



Priorities:
- Identify a focused set of measures
- Engage all hospitals across the state
- Tiered strategy by hospital performance
- Align with CA purchasers, agencies, and stakeholders
- Align with regional health plan efforts

PLAN PERFORMANCE REPORT
RELEASE YEAR 2025

Chelsea Hart-Connor

Health Informatics Lead, EQT

QUALITY OVERSIGHT THROUGH TRANSPARENT, ACTIONABLE DATA

Quality Care

We ensure consumers consistently receive accessible, equitable, high-quality care.

1. Produce measurable, equitable improvements in health outcomes.
2. Hold Qualified Health Plan (QHP) and Qualified Dental Plan (QDP) issuers accountable for consistent, standard levels of quality.
3. Increase access to and support of high quality, diverse providers who practice with cultural humility.
4. Make demonstrable progress in addressing health disparities and increasing health equity.
5. Increase access to and quality of behavioral health care.

ASSEMBLY BILL 929 (2019): ANNUAL PPR PUBLICATION

*"...ensure[s] that Covered California is able to obtain from health plans and insurers **information on cost, quality, and disparities useful in evaluating the impact of Covered California** on the health delivery system and health coverage in California..."*

Protects the personal **identifiable information** of enrollees but **enables comparison across QHPs**

Requires Covered California to publish a **report at least annually** the areas of quality, cost, and disparities reduction

Cites disparities reduction across population groups by age, geography, language, race, ethnicity, sexual orientation, gender identity, disability status

GUIDING PRINCIPLES FOR EQT'S PLAN PERFORMANCE REPORT

A BRIEF HISTORY OF AB929 & PPR

AB929 passed in 2019

Covered California has the authority to collect and publish data to hold health plans accountable to improve quality and reduce disparities.

Requires Covered California to annually release report on cost, quality, and disparities.

PPR published in 2021

Includes data from MY2017 to MY2019, focusing on quality measures at the QHP level.

Select QHP level metrics stratified by race and ethnicity.

PPR published in 2023

Includes data from MY2020 to MY2021.

QHP-level data stratified by race and ethnicity.

PPR published in 2024 with a renewed focus on actionable data

Renewed focus galvanized by alignment with Covered California's new strategic plan & Contract Refresh.

Improved analytic abilities & additional stratifications.

Measure selection criteria was further refined.

WHAT'S NEW IN PPR FOR RELEASE YEAR 2025

	Continued from 2024		*New in 2025*
Data Sources	Healthcare Evidence Initiative (claims) CMS' Quality Ratings System Patient Level Data files Plan self-reported data	&	Publicly available data (CMS.gov -Medical Loss Ratio)
Measures	Breast Cancer Screening Child & Adolescent Well Care Visits ER Utilization Preventive Visit Utilization Primary Care & PC Telehealth Utilization BH and BH Telehealth Utilization No Utilization of Care Use of High Dose Opioids, Concurrent Use of Opioids, Pharmacotherapy for opioid use disorder *All QRS Measures*	&	25/2/2 results MLR trend by QHP Dental quality measures Out-of-pocket spend (*aggregate only*) % of Medicare pricing (*aggregate only*)
Measure Stratifications	Race/ethnicity, subpopulation Preferred language Income Rural v Urban	&	Rating region Age Metal tier Gender

WHAT'S NEW IN PPR: USER CENTERED DESIGN

Delivery Systems and Payment Strategies to Drive Quality

Access to Care

Measure Description: The Access to Care measure is the percentage of adult members who, when surveyed, reported that they got treatments, tests, and other care and appointments as soon as they needed in the last six months.

Notable Trend: In both MY2022 to MY2023, 0 plan products performed at or above the 66th national percentile.

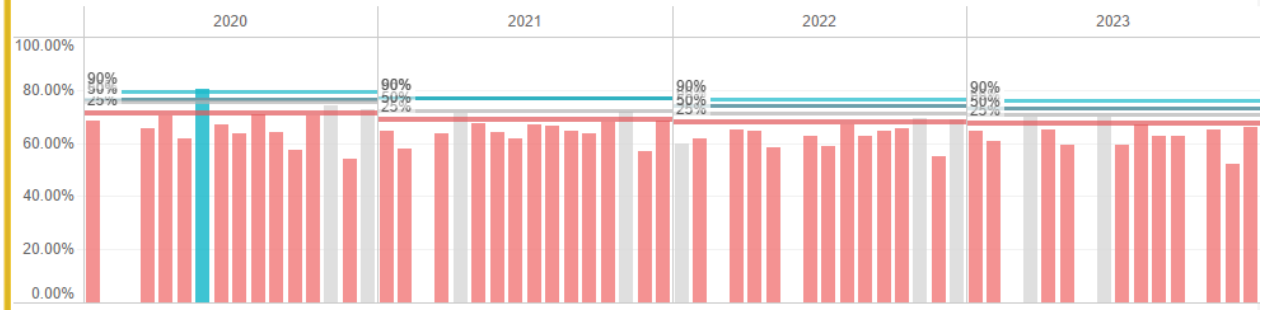
High Performance: In MY2023, no plan products scored at or above the 66th national percentile.

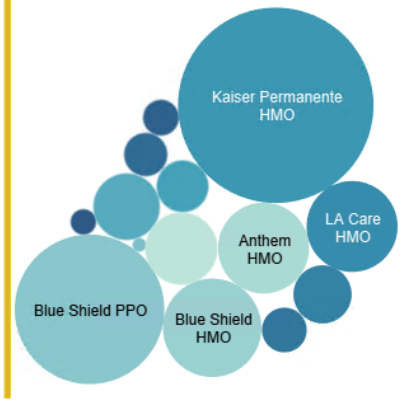
Low Performance: In MY2023, 11 out of 11 plan products scored below the 50th national percentile, which accounts for the entire measured population.

Health Plan Ratings
Quality Rating System
Access to Care

No Score Available | Plans at or Above 90% | Plans between 66% & 90% | Plans between 50% & 66% | Under 25%

Measure Year	Anthem EPO	Anthem HMO	Anthem PPO	Blue Shield H..	Blue Shield P..	CCHP HMO	Health Net EPO	Health Net HMO	Health Net PPO	Kaiser Permanent..	LA Care HMO	Molina Healthcar..	Oscar Health P..	Sharp Health P..	Valley Health P..
2020	68.30%			65.41%	70.26%	61.66%	80.17%	66.90%	63.62%	70.89%	64.02%	57.33%	70.20%	73.98%	54.17%
2021	64.70%	57.70%		63.72%	71.34%	67.68%	63.95%	61.76%	66.97%	66.71%	64.64%	63.62%	67.77%	71.71%	56.83%
2022	59.85%	61.80%		65.20%	64.70%	58.60%		62.90%	59.00%	67.00%	62.50%	64.80%	65.70%	69.50%	54.90%
2023	64.70%	60.60%		69.92%	65.24%	59.29%		69.74%	59.21%	67.08%	62.91%	62.50%		64.86%	52.00%





Qualified Health Plans Over the 66th Percentile in MY2023

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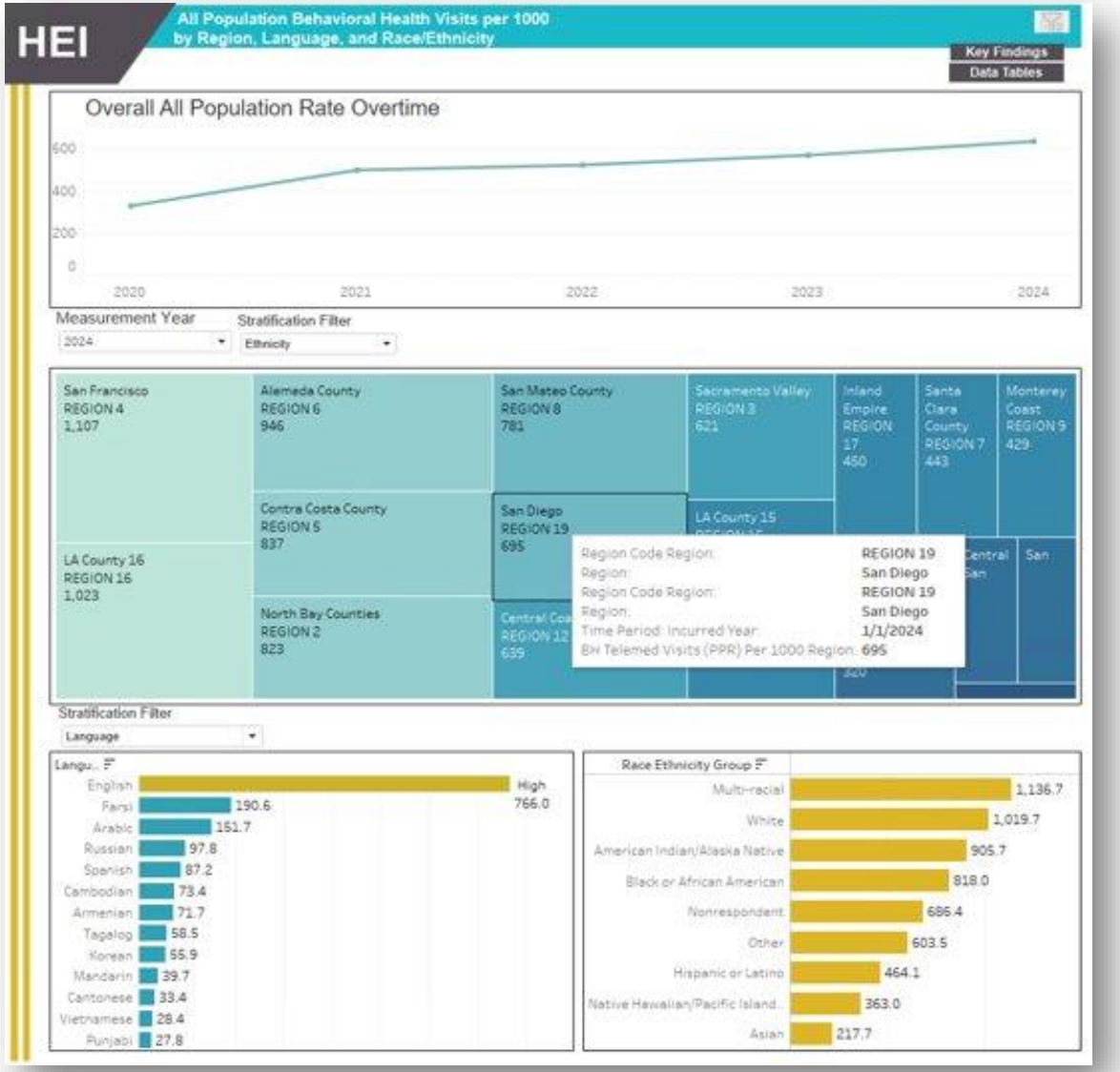
Issuer	2020	2021	2022	2023	2024
Aetna Health HMO	0.00%	0.00%	0.00%	1.20%	0.86%
Anthem EPO	4.93%	4.53%	4.68%	4.73%	5.25%
Anthem HMO	0.67%	1.86%	4.72%	7.57%	8.02%
Blue Shield HMO	5.41%	7.44%	8.13%	8.82%	8.12%
Blue Shield PPO	20.15%	20.57%	20.97%	20.35%	18.36%
CCHP HMO	0.42%	0.30%	0.21%	0.17%	0.19%
Health Net EPO	0.08%	0.05%	0.03%	0.00%	0.00%
Health Net HMO	12.41%	8.28%	5.76%	4.03%	4.22%
Health Net PPO	3.14%	2.66%	2.31%	2.44%	2.79%
Inland Empire Health Plan..					1.16%
Kaiser Permanente HMO	36.34%	36.95%	35.91%	34.75%	33.61%
LA Care HMO	5.44%	6.07%	6.79%	7.53%	10.47%
Molina Healthcare HMO	2.97%	3.53%	3.84%	3.09%	3.04%
Oscar Health Plan EPO	4.64%	4.26%	2.96%	1.83%	0.00%
Sharp Health Plan HMO	1.37%	1.50%	1.90%	1.72%	1.55%
Valley Health Plan HMO	1.45%	1.39%	1.22%	1.18%	1.57%
Western Health Advantag..	0.57%	0.60%	0.57%	0.59%	0.80%

Draft view for illustrative purposes only

WHAT'S NEW IN PPR: USER CENTERED, INTERACTIVE DESIGN

- Interactive dashboard with filters
- More visualizations
- Use of narrative description and key findings to highlight important trends or outliers
- Comprehensive and multidimensional report



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NEXT STEPS

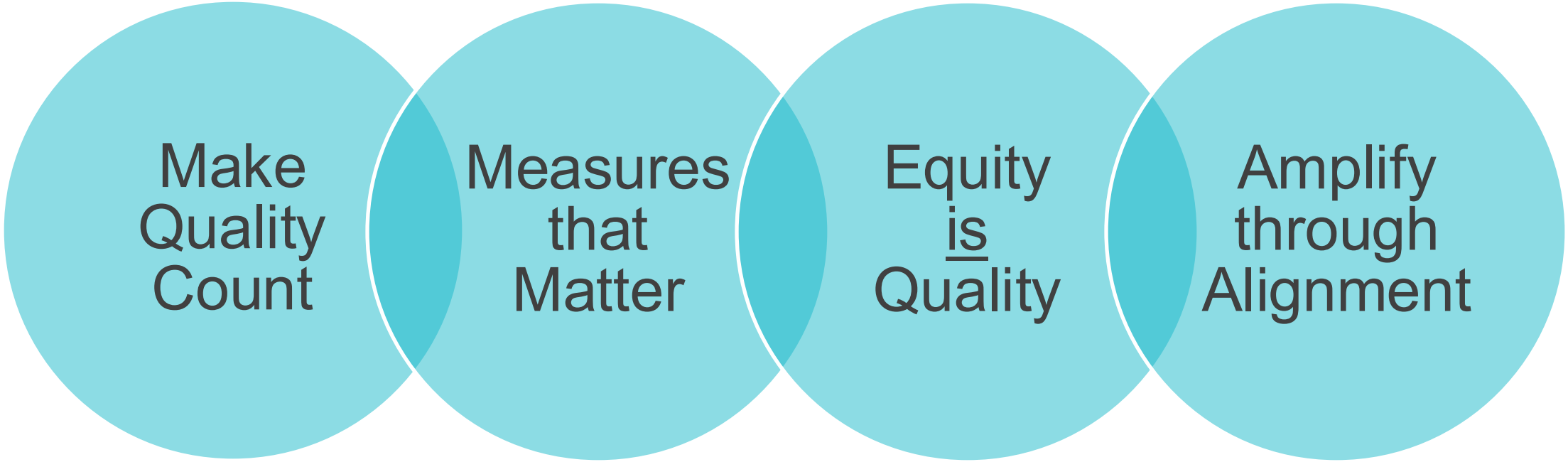
- First Plan Preview Period that includes HEI MY2020-MY2024 data end of August
  - Will last for ~3 weeks
  - First part of PPR Release Year 2025 to be published in early Q4 2025
- Second Plan Preview Period that includes QRS MY2024 data, HEI cost data, publicly available data, & plan self-reported measures to begin in November
  - Second part of PPR Release Year 2025 to be published in late Q4 2025

UPDATE ON 2025 POPULATION HEALTH INVESTMENTS

Joy Dionisio

Senior Equity and Quality Specialist

QUALITY TRANSFORMATION INITIATIVE



0.8% to 4% premium at risk for

a small set of clinically important measures

stratified by race/ethnicity

selected in concert with other public purchasers*

*Public purchasers includes CalPERS and DHCS/Medi-Cal

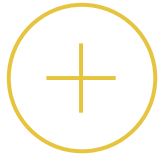
GUIDING PRINCIPLES: USE OF FUNDS

Centered on goal to improve health outcomes for Covered California enrollees

Equity First: funds should preferentially focus on geographic regions or communities with the largest identified gaps in health and quality among California subpopulations

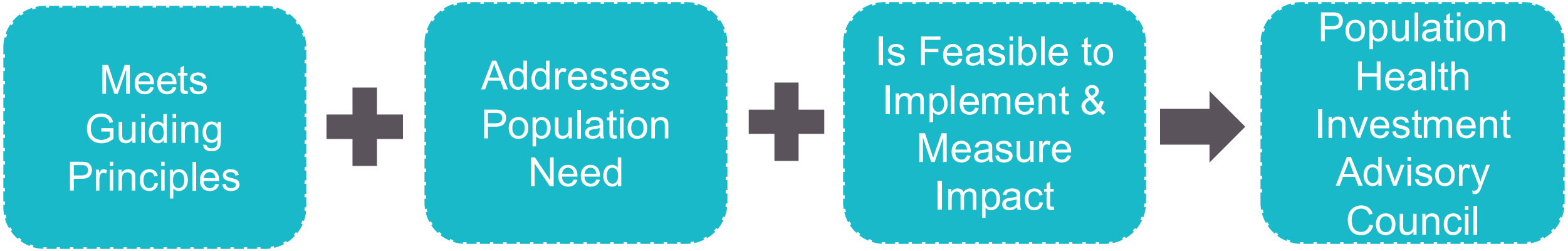
Direct: use of funds should lead to measurable improvements in quality and outcomes for enrollees that are related to QTI Core Measure performance

Evidence-based: use of funds should be grounded in approaches that have established evidence of success in driving improvements in quality or outcomes

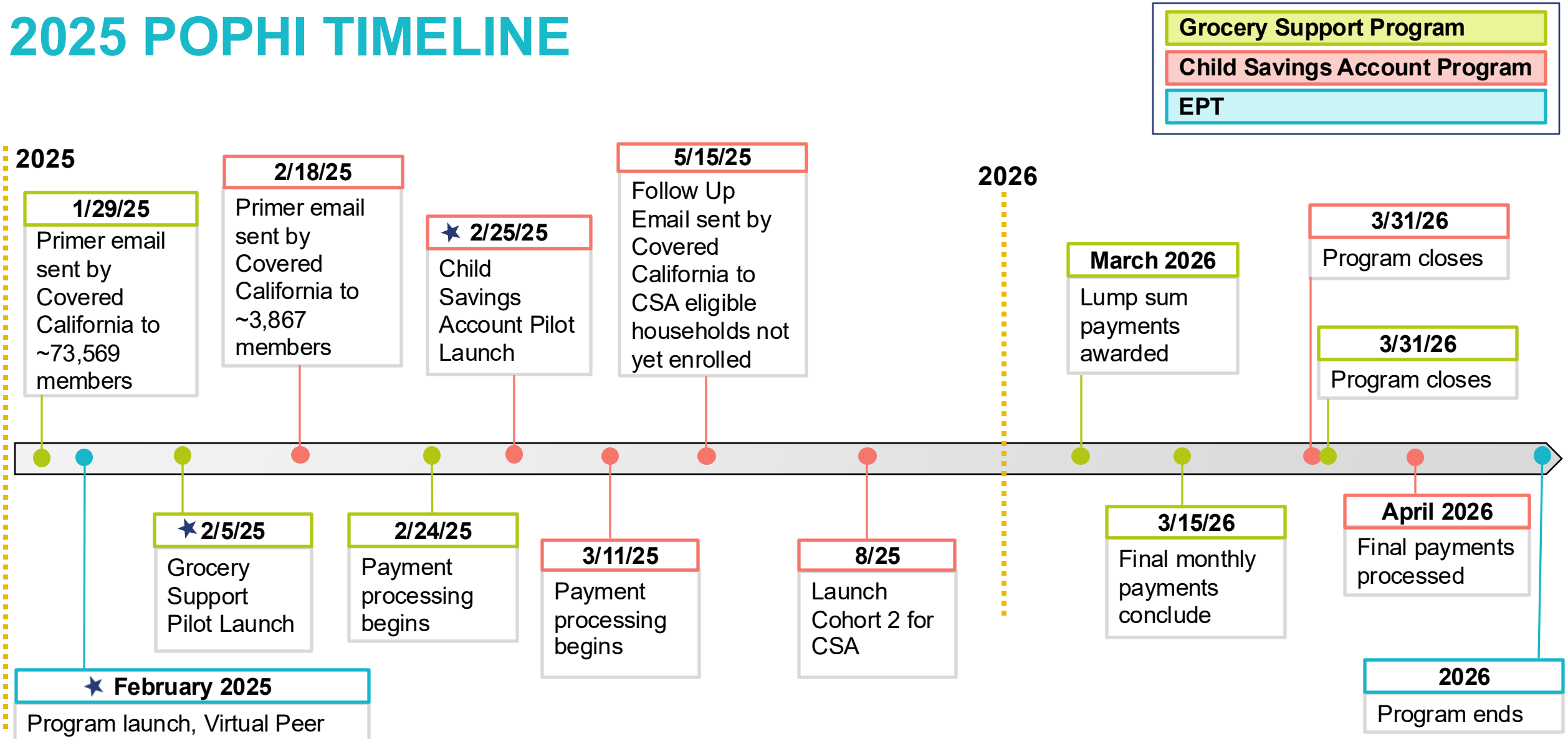


Additive: funds should be used to advance quality in a currently underfunded arena.

POPULATION HEALTH INVESTMENTS: SELECTION CRITERIA



2025 POPHI TIMELINE



GROCERY SUPPORT PROGRAM • GO LIVE 2/5/25

Purpose

The **Beyond Covered by Covered California: Grocery Support Program** is designed to help Covered California members facing chronic health conditions and financial challenges access nutritious food to help improve food security and health outcomes.

Eligibility

Covered California members who:

1. Have a household income up to 250% of FPL
2. Have a chronic health issue
3. Are experiencing food insecurity

Benefit

A reloadable debit card to purchase food, and either:

- Monthly payments will be loaded onto the debit card for 12 months, OR
- A lump sum payment will be loaded onto the debit card at the end of 12 months (equal to 12 monthly payments)

Funds are based on household size reported to Covered California at time of enrollment and may only be used to purchase fresh food, packaged food, baby food and non-alcoholic drinks.

IMPLEMENTATION OBSTACLE #1 AND AGILE ADJUSTMENTS

Program Facts	• 2,168 landline only members • 25,546 non-English speakers (Spanish, Korean, Vietnamese, Cantonese, Chinese or unknown)
Challenge	• **Support enrollment of members with additional challenges – members only reachable by landline and non-English speaking members**
Pre-Launch Strategies	• Prioritize landline-only members in the first outreach cohort, offering mailed consent forms for those unable to engage with the digital platform • Translate outreach communication into five most common member languages
Real Time Adjustments	• **Sent additional email outreach to non-English speakers before initiating outreach to a new cohort** • **Emphasized the "last chance" for members to enroll in last outreach messaging** • **Added text outreach for landline-only members with Voice Over Internet Protocol (VOICE) numbers**
Impact of Adjustments	• These adjustments increased members' enrollment rate from 5.75% to 6.4%

IMPLEMENTATION OBSTACLE #2 AND AGILE ADJUSTMENTS

Program Facts	• 94,502 eligible members • Projected about 6,051 households could be enrolled
Challenge	• **Minimizing applicant denials while ensuring timely program take-up**
Pre-Launch Strategies	• Organize pool of eligible members into seven cohorts and conduct outreach on rolling schedule to create opportunities to delay, limit, or stop outreach to a new cohort
Real Time Adjustments	• **Reviewed program take-up/encumbrance* before initiating outreach to each cohort to make go/no-go decision** • **Delayed initiating outreach 8 days to final 3 cohorts to allow more time for members in earlier cohorts to respond**
Impact of Adjustments	• Prevented outreach to an estimated 17,821 members when funding was exhausted • Postponing scheduled outreach to the fifth cohort enabled 375 additional members from the first four cohorts to enroll

COVERED CALIFORNIA

*PopHI funds considered encumbered when they are “owed” to an enrollee (i.e., the full benefit is encumbered even if an enrollee has only received 3 of 12 monthly payments)

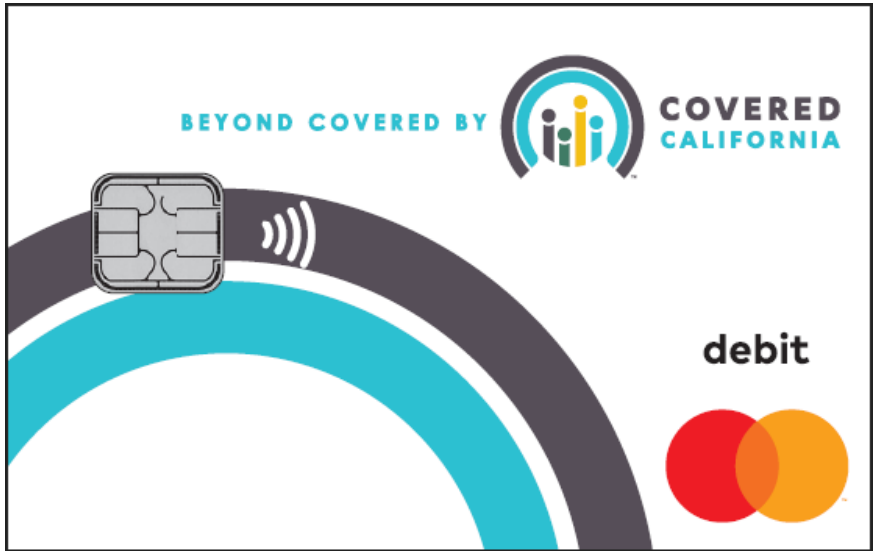
IMPLEMENTATION OBSTACLE #3 AND AGILE ADJUSTMENTS

Program Facts	• The pool of eligible members represented all 12 Issuers, including 4 not required to fund the program • The number of eligible members per Issuer varied widely, from 28,210 to less than 1,000
Challenge	• **Balancing two competing goals: timely full encumbrance and supporting the opportunity for enrollment across all Issuers**
Pre-Launch Strategies	• Define target enrollment/spending goal amounts/fund allocations for each Issuer • Leverage the outreach approach of staggered cohorts to ensure balanced representation from all Issuers • Monitor enrollment and fund allocations against targets daily
Real Time Adjustments	• **Sent additional email outreach to members of 3 small QHPs that had not yet reached their target enrollment before initiating outreach to a new cohort** • **Adjusted QHP targets as needed to balance both goals** • **Reallocated funds to applicants awaiting funds when possible**
Impact of Adjustments	• Without deploying and monitoring enrollment targets, the program would have likely fully encumbered approximately 4 weeks earlier with representation from only the largest QHPs

GROCERY SUPPORT PROGRAM: EARLY SUCCESSES

Enrollment Highlights

- Households Invited: 76,681
- Households Enrolled: 6,975
- Household Members Impacted: 13,090
- Budgeted Amount Encumbered: 99.9%
- Average Award Per Household $1,646
- 75.2% of approved applicants completed the baseline survey



Early Feedback

“To whom it may concern: I would like to be considered for this program. We do not eat healthy and I have heart disease. Please let me know what is required to qualify. Best regards. Thank you!”

"Wow! What an incredible program… I guess we are just waiting for a representative from Forward to reach out? Via Email? How will we know we’ve been offered this opportunity? I want to be sure not to miss any announcements, requests for information, etc.…”

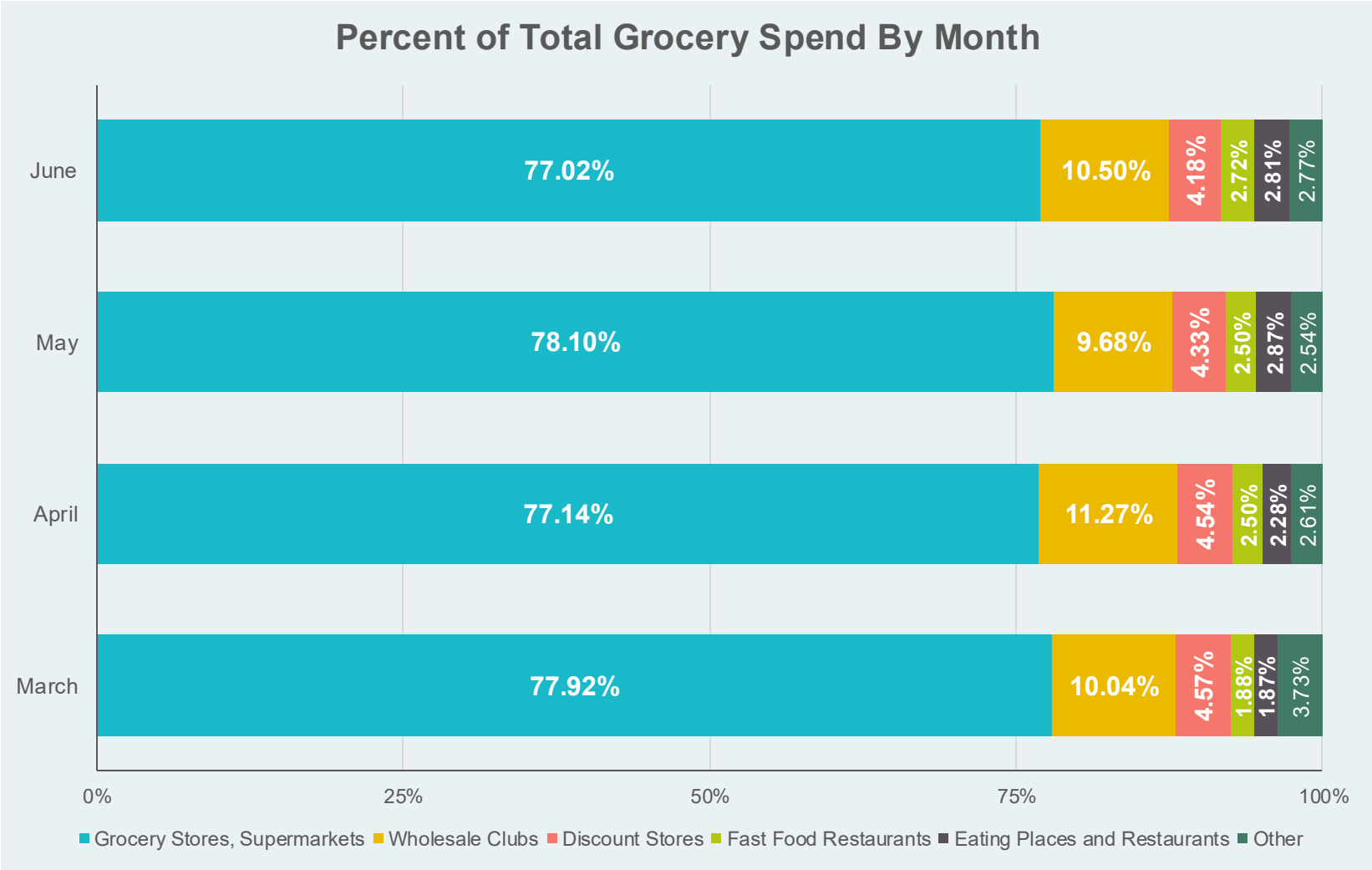
PREVIEW OF GROCERY SUPPORT PROGRAM MEMBER SPENDING

Top 3 Categories for Spending month over month from March 2025 – June 2025:

1. **Grocery Stores, Supermarkets**
2. **Wholesale Clubs**
3. **Discount Stores**

Top 3 Categories:

- Make up **92.28%** of **total funds** spent
- Account for **$1,423,170** in **member spending**



COVERED CALIFORNIA

Data as of 7/21/2025

GROCERY SUPPORT PROGRAM EVALUATION

Study Design and Participant Assignment:
To assess the impact of grocery support on food security and spending habits participants randomly assigned to one of two groups:

- Treatment Group (50%) – Receives monthly grocery payments for 12 months.
- Control Group (50%) – Receives the total benefit amount as a lump sum at the end of 12 months.

Baseline Survey:
Before receiving payments, participants will complete a survey evaluating:

- Health & Well-Being: Self-rated health, mental health, quality of life, fatigue, pain.
- Food Access & Nutrition: Difficulty affording/obtaining healthy foods, dietary habits.
- Financial & Housing Stability: Income, benefits, housing security, utility shutoffs.
- Healthcare Access & Barriers: Doctor visits, medication adherence, transportation issues.

Incentives for Survey Participation:
To encourage participation, respondents will be entered into a lottery for a **$50 prepaid card**.

Data Collection– Monthly Check-Ins:
Participants receiving monthly grocery support will complete brief surveys to measure:

- Timing of food purchases.
- Whether the program has improved their ability to afford food

Evaluation Focus:
This program will aim to assess the impact of Grocery store support will have on food security, nutritious eating, financial trade-offs, and health outcomes.

CHILD SAVINGS ACCOUNT PROGRAM • GO LIVE 2/25/25

Purpose

The **Beyond Covered by Covered California: Child Savings Account Program** aims improve well-child visits and childhood immunization rates for children under the age of two enrolled in Covered California, while helping families invest in their child's future.

Eligibility

Children under 2 years old who are:

1. Enrolled in a Covered California Health Plan
2. Born in California
3. Registered for a CalKIDS account*

Benefit

Families can earn up to $1,000 for their CalKIDS savings account, which can be used for educational expenses.

Steps

1: $150 Program Consent & CalKIDS Registration
2 - 6: $100 Per PC Visit & Vaccine(s) at Specified Age
7 - 9: $150 Per Flu Shot During Specified Time

COVERED CALIFORNIA

*Beyond Covered program is designed to assist parents/guardians with CalKIDS account registration

IMPLEMENTATION OBSTACLE #4 AND AGILE ADJUSTMENTS

Program Facts	• 4,037 eligible members • 176 landline only members received live calls
Challenge	• **Ensure member centric outreach that respects member priorities**
Pre-Launch Strategies	• Leverage multiple outreach modalities per member, based on available member information: mobile phone, text, email and/or landline • Conduct live calls to members with no email address • Prioritize non-English speakers and families with members 0-3 months old in first cohort • Maintain all household members within one outreach cohort
Real Time Adjustments	• **Added additional round of 6 outreach attempts to increase enrollment** • **Follow up email sent from Covered California to unenrolled members on 5/15**
Impact of Adjustments	• Follow up email from Covered California for first cohort yielded 8 new enrollees in the first 3 days post email

CHILD SAVINGS ACCOUNT (CSA) PROGRAM: EARLY SUCCESSES

Enrollment Highlights

- Households Invited: 4,037
- Households Enrolled: 269
- Children Impacted: 274
- Budgeted Amount Encumbered: 27.41%
- 42.8% of approved applicants completed baseline survey
- Program Steps Completed by Members: 609
- 46.15% of enrollees newly claimed their CalKIDS account
- A total of $74,000 newly deposited in member CalKIDS accounts in the months from March through June between completion of program steps and initial enrollment claim bonus provided by CalKIDS

CalKIDS
The first step toward college

Early Feedback

"Vaccination is for your child's future, so are the funds - and it's important"

*All data as of 7/21/2025 except * as of 6/13/2025*

CSA PROGRAM EVALUATION

Study Design and Participant Assignment:
As part of Covered California's commitment to improving financial stability among families, participants will be randomly assigned to one of two groups:

- Treatment Group (75%) – received a reminder to sign up after 72 hours of being contacted, encouraging prompt enrollment
- Control Group (25%) – received a reminder to sign up after 90 days.

Baseline Survey:
Upon enrollment, participants will complete a survey evaluating:

- Health & Well-being: Parent and child's health, mental well-being, and quality of life.
- Family & Finances: Household resilience, financial concerns, and saving habits for the education.
- Child Development: Motor skills, communication, and social behaviors (for ages 5-25 months).

Data Collection

- Participant interviews conducted for deeper Insights

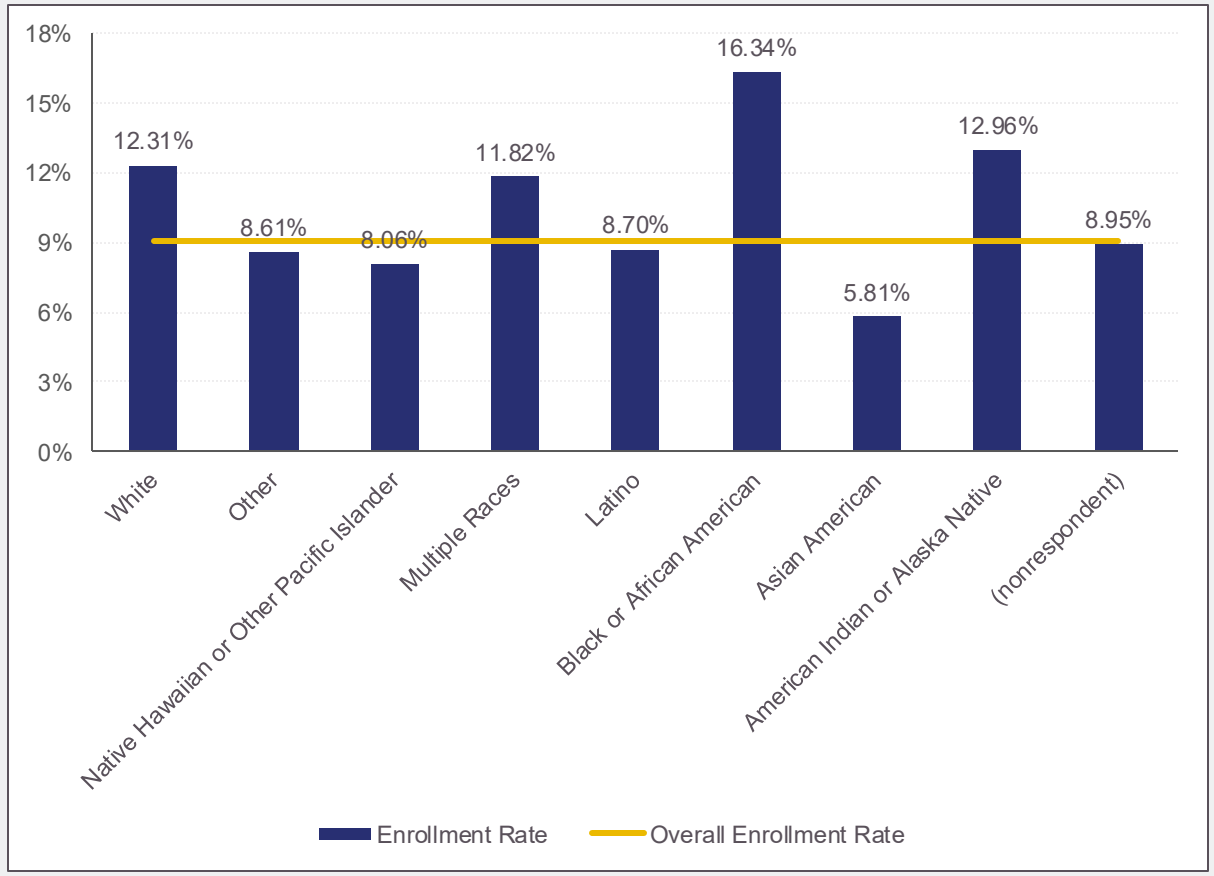
Incentives for Survey Participation:
To encourage participation, surveys will be incentivized with a **$20 prepaid card** per completed survey.

Evaluation Focus: Assess assess how college savings incentives impact pediatric care and vaccinations. Additionally, will evaluate effects on parental health, child development and education expectations

2025 DIRECT TO MEMBER POPHI ENROLLMENT TRENDS

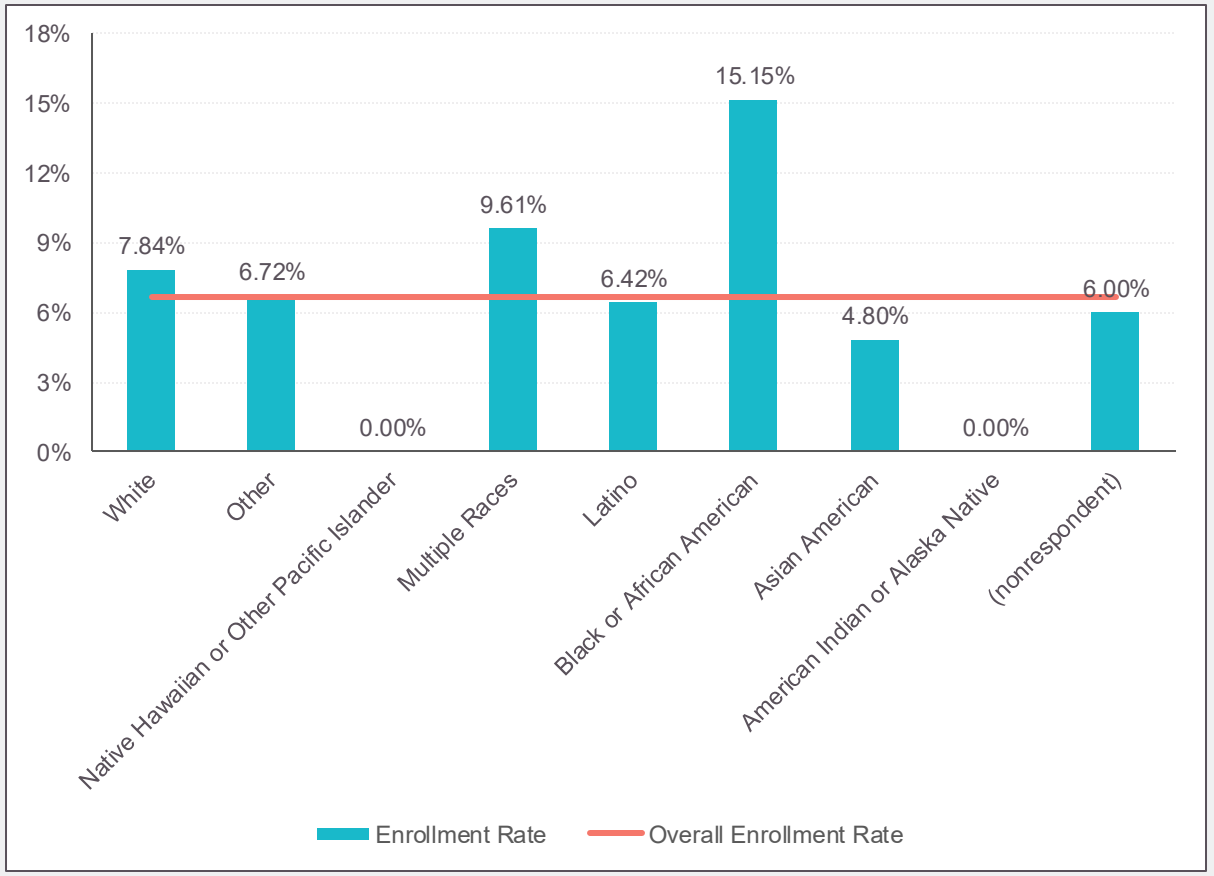
Grocery Support Program Enrollment Rate

Overall Enrollment Rate: 9.10%



Child Saving's Account Program Enrollment Rate

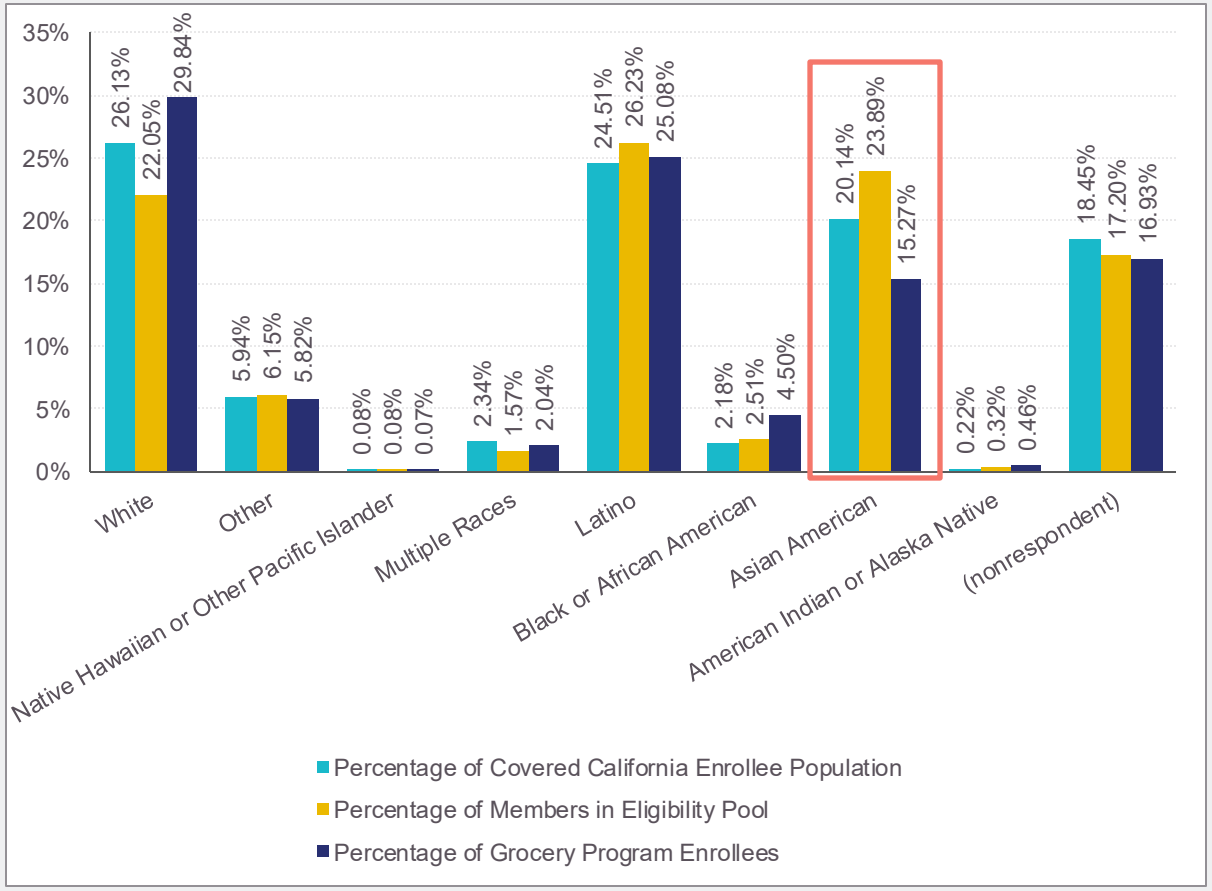
Overall Enrollment Rate: 6.66%



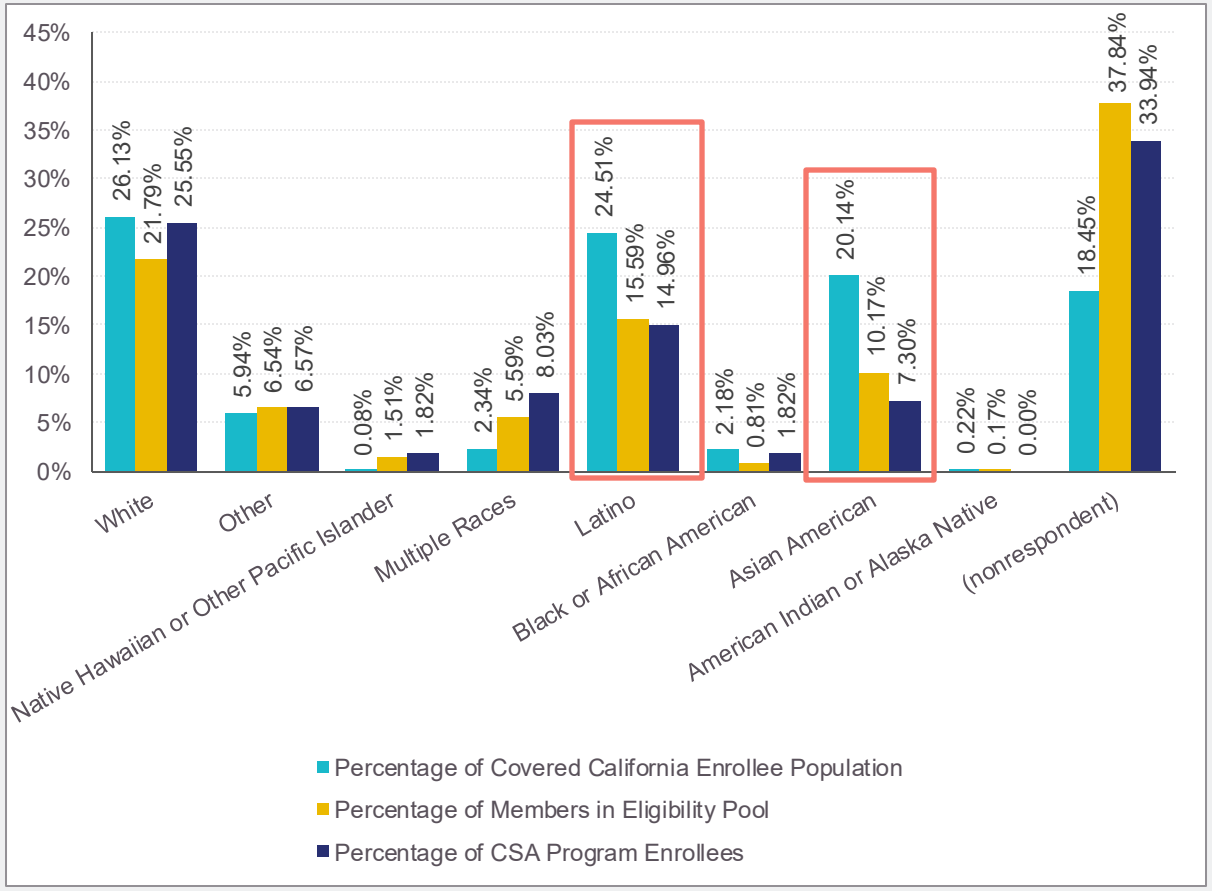
POPHI ENROLLMENT BY DEMOGRAPHIC

While enrollment mostly matches the demographics of Covered California's overall enrollee population, PopHIs are tracked closely, and future adjustments will continue to center equity

Grocery Support Program



Child Saving's Account Program



Covered California enrollee data from 2025 March Membership Profile

EQUITY & PRACTICE TRANSFORMATION • GO LIVE 2/2025

Purpose

Covered California's investment is aimed at leveraging Equity and Practice Transformation (EPT) infrastructure to accelerate population health management capabilities in practices serving both Covered California and Medi-Cal enrollees.

Eligibility

30-40 practices participating in EPT, who serve Covered California enrollees will receive enhanced support through tailored enhancements to EPT's technical assistance (TA) structure.

Benefit

Practices selected to participate in enhanced TA structure will receive:

- High-Quality, 1:1 Subject Matter Experts Support
- Virtual Learning and Peer Engagement through small group and 1:1 sessions
- Advanced Data Integration and Testing
- Learning System to distill insights from a diverse practice cohort and disseminate promising models to primary care practices across the state

COVERED CALIFORNIA

pop health LEARNING CENTER

EQUITY AND PRACTICE TRANSFORMATION (EPT): EARLY SUCCESSES

EPT Program

The EPT Program consists of 46 provider organizations spanning 30+ counties throughout California. These providers serve both Covered California and Medi-Cal members, reinforcing our commitment to advancing health equity statewide.

Participant Engagement

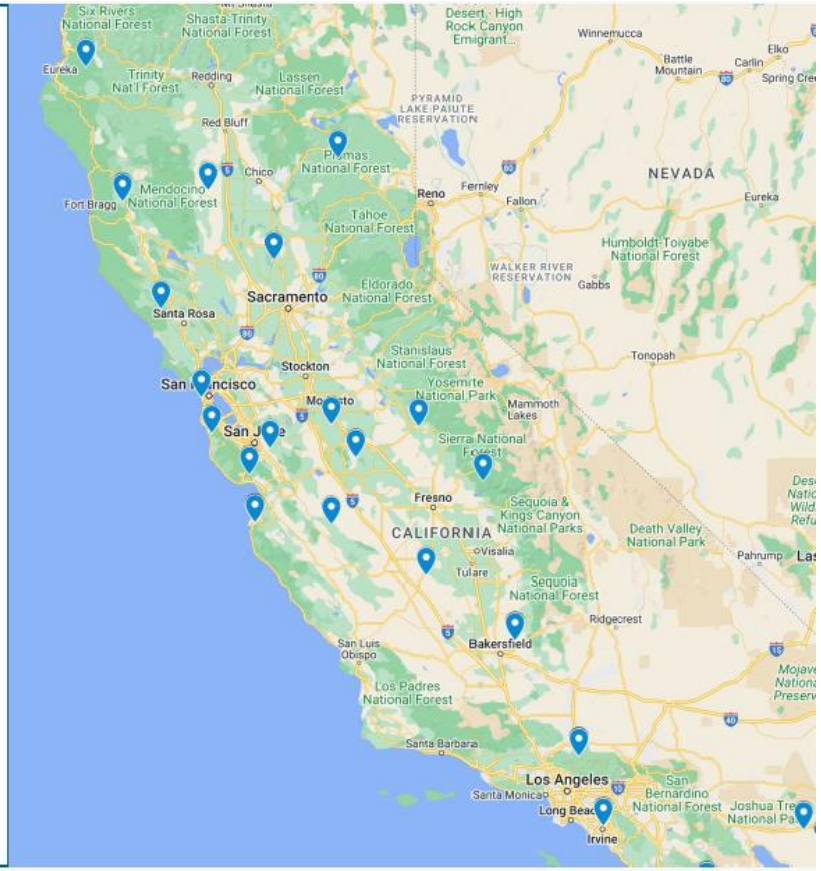
The program launched with a well-attended kickoff session hosted by the PHLC, featuring active engagement from participating provider organizations and several QHP issuers.

Provider Reflections

Feedback emphasized the need for practical support and real-time guidance.

CCA Cohort at a Glance

- 46 EPT Practices
- 619,255 assigned Medical lives
- 26,285 Covered California enrollment
- Practice Setting:
  - 23: Independent Practices
  - 19: Health Centers
  - 4: Tribal Clinics
- Populations of Focus (PoF) selection by practices:
  - 17: Adults with Chronic Conditions
  - 11: Adults with Preventive Care Needs
  - 12: Children and Youth
  - 3: People Living with BH Conditions
  - 1: Pregnant People



PHLC Covered California Population Health Investment Kickoff Call – 2/26/2025

EPT POPHI INVESTMENT FOR 2025

Accelerating practice transformation in the 45 Covered California practices

1:1 and Group SME support

Support to strengthen data systems to report EPT KPIs and close care gaps. Expert-led groups focused on data and workflow optimization and addressing challenges in POFs.

Advanced Data Integration

Design workflows and create implementation plan for data exchange with external partners for a measure-specific use case (8-15 practices).

DxF Bootcamp

Step-by-step guidance to identify priority data sharing use cases, assets, partner engagement best practices, and technology resources for a secure, real-time exchange roadmap.

Care Gap Closure Implementation Guides & Job Aids

Co-designed with EPT practices to maximize performance in EPT HEDIS-like measures.

EQUITY & PRACTICE TRANSFORMATION EVALUATION

Measurement:
Covered California will assess the effectiveness of the Equity and Practice Transformation (EPT) program in improving practice capabilities.

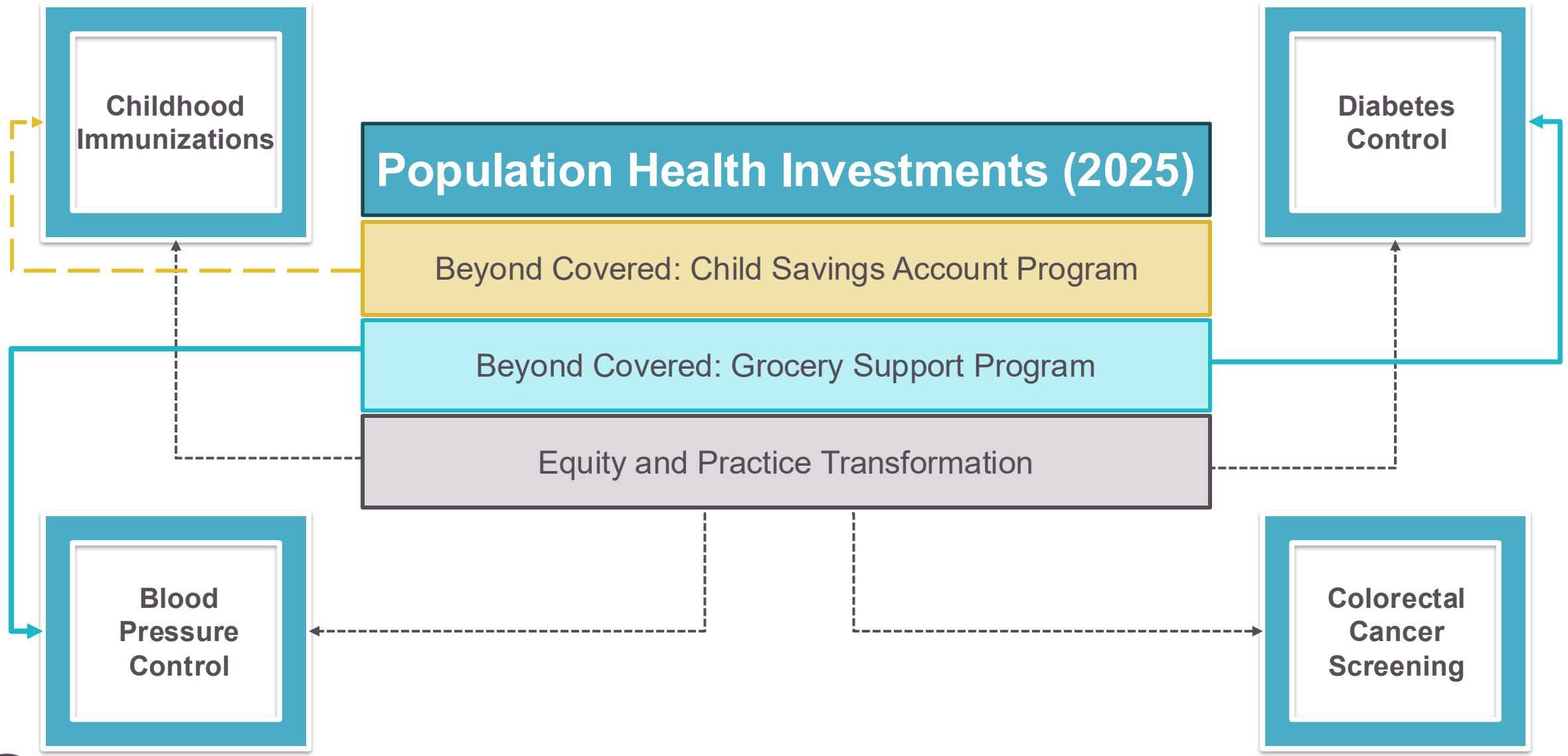
Pre-Program Assessment:
Before implementation, doctors and clinic staff completed a survey evaluating:

- Capabilities as captured by Population Health Management Capabilities Assessment Tool (PhmCAT)

Ongoing Data Collection – Regular Check-Ins (Every 3 Months):
PHLC will share:

- Overall EPT activities and participation
- Motivation to change
- Availability of practice-level data
- Capabilities and process improvements made by practices
  - Examples: submitted deliverables, integration of external data sources, engagement with QHIOs, empanelment quality, continuity, access and time to next available appointment
- HEDIS-like measures
- Qualitative lessons of what was most helpful in enabling high performers and what barriers precluded others from making progress

MOVING THE NEEDLE ON QUALITY



PROPOSED 2026 POPULATION HEALTH INVESTMENTS

S. Monica Soni, MD

Chief Medical Officer
Chief Deputy Executive Director,
Health Equity and Quality Transformation (EQT)

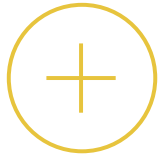
GUIDING PRINCIPLES: USE OF FUNDS

Centered on goal to improve health outcomes for Covered California enrollees

Equity First: funds should preferentially focus on geographic regions or communities with the largest identified gaps in health and quality among California subpopulations

Direct: use of funds should lead to measurable improvements in quality and outcomes for enrollees that are related to QTI Core Measure performance

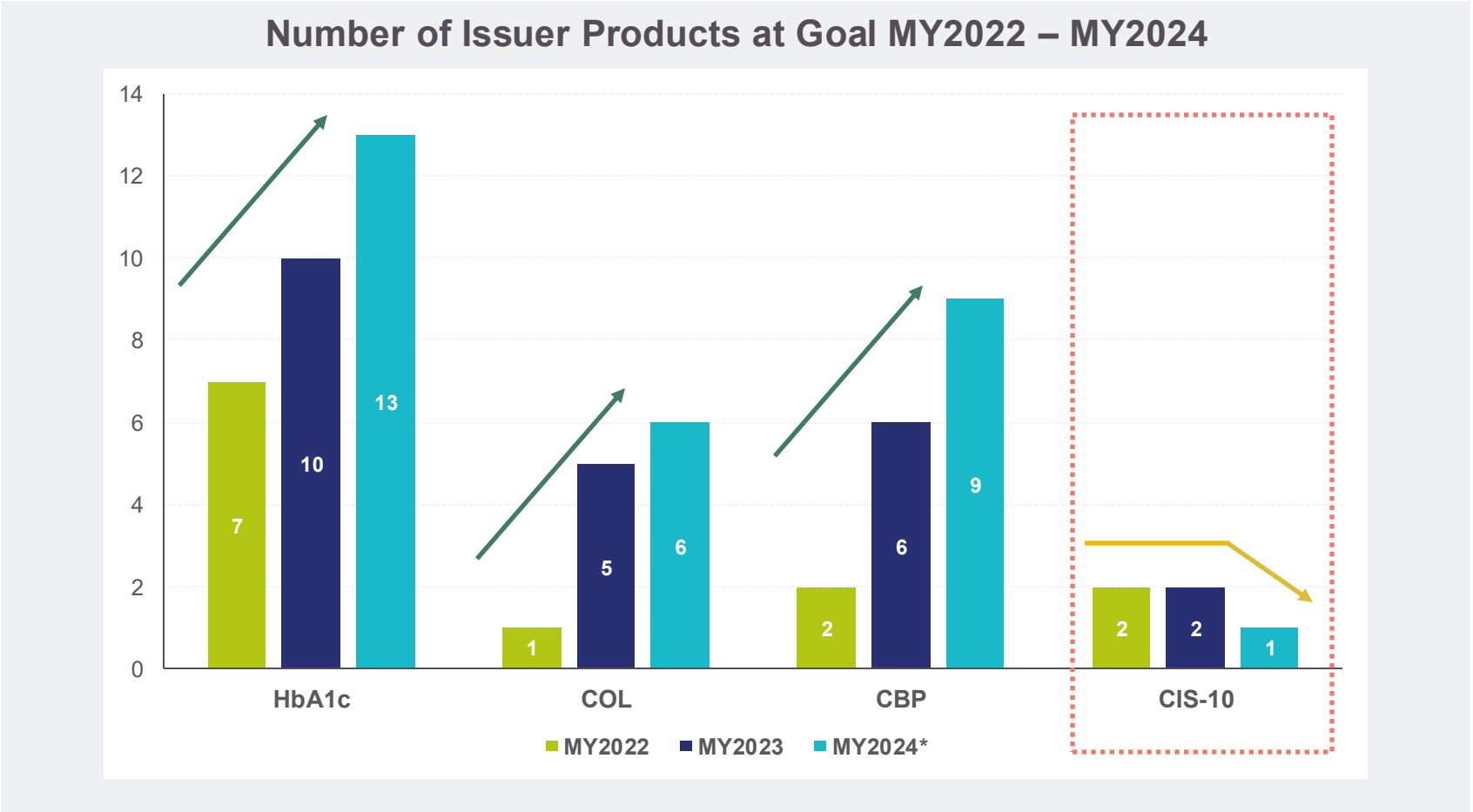
Evidence-based: use of funds should be grounded in approaches that have established evidence of success in driving improvements in quality or outcomes



Additive: funds should be used to advance quality in a currently underfunded arena.

FORWARD PROGRESS ON ALL QTI MEASURES EXCEPT CIS-10

There has been a year-over-year increase in the number of products reaching the QTI goal of the 66th Percentile for HbA1c, COL, and CBP

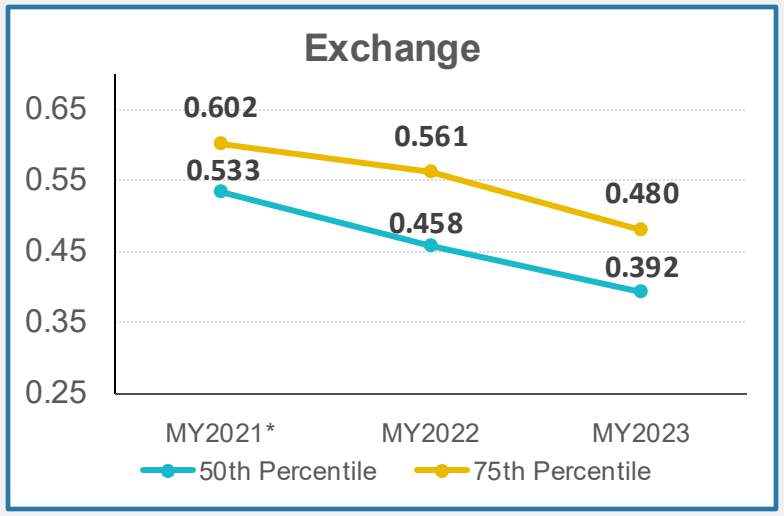


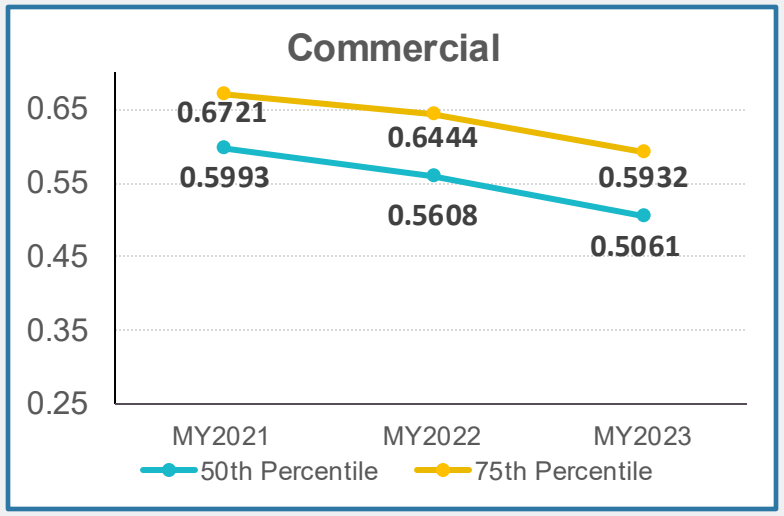
For MY2023 and 2024 13 issuer products were eligible for all QTI measures except CIS-10 where only 10 products were eligible

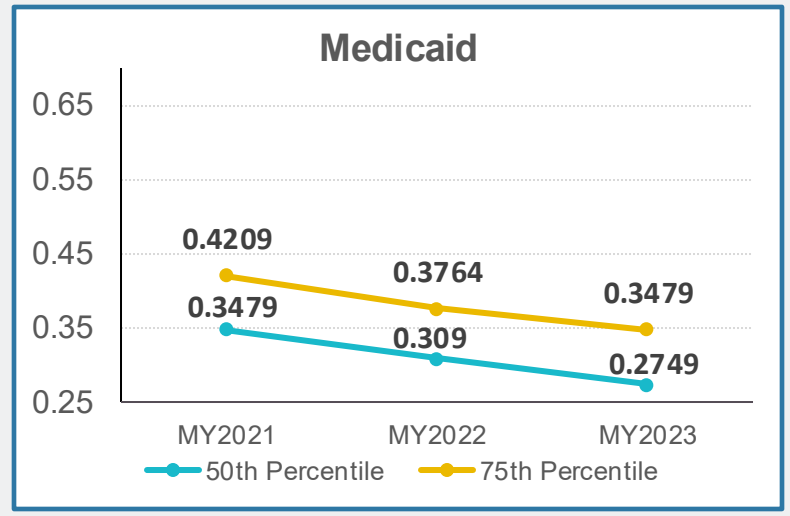
*Based on preliminary MY2024 scores

ONGOING CHALLENGES WITH CHILDHOOD VACCINATION

National CIS-10 Trends







Factors that contribute to low performance on CIS-10 measure:

- Caregiver vaccine fatigue after COVID-19
- Healthcare systems are struggling with access in primary care and declines in usual source of care persist
- CDC allowable catch-up schedule is not fully captured in CIS-10 measure specifications
- Parental refusal of selected vaccines

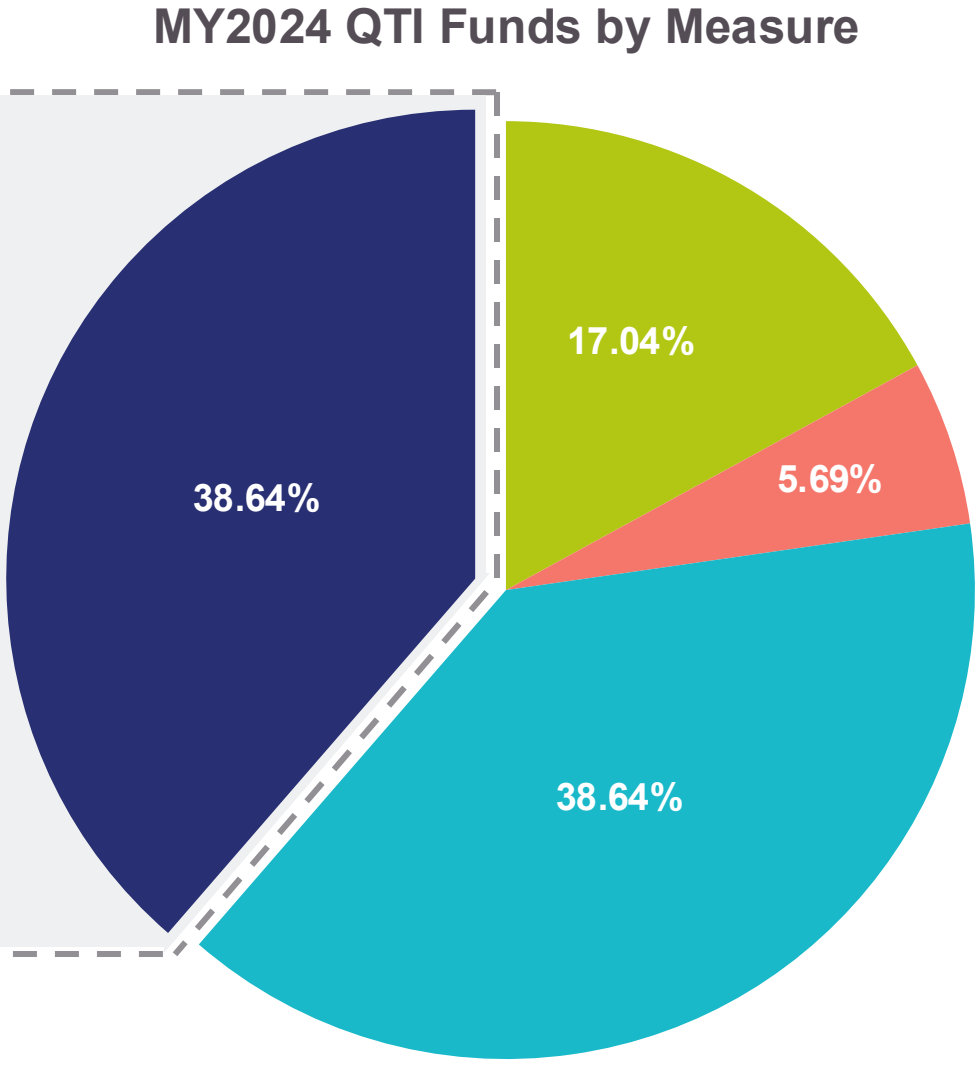
COVERED CALIFORNIA

*MY2021 Only reported, not scored

ESTIMATED 2026 QTI PAYMENT

~$11.8 Million

QHP Issuers to Retain 50% of MY2024 CIS-10 Funds (after QTI Allowance) for use in new or existing Issuer-led Quality Improvement Activities that meet Covered California criteria



~$18.9 Million

To be allocated to Covered California selected PopHIs

PROPOSED 2026 POPULATION HEALTH INVESTMENTS

2025 PopHI Budget: **$15.9M** → 2026 Estimated PopHI Budget: **$18.9M**

1

Beyond Covered by Covered California: Child Savings Account Program – *Returning with Proposed Modifications*

- Rolling over funds to make the program multi-year to allow full encumbrance and allow families longer participation.
- Refine outreach strategies using insights on timing and messaging from 2025 PopHI implementation.

2

Beyond Covered by Covered California: Grocery Support Program – *Returning with Proposed Modifications*

- Considering expanded funding to meet demonstrated need and unmet demand in 2025.
- Use survey data to assess transportation and food access challenges, informing future refinements.
- Exploring removing the chronic illness filter to include increase eligibility, especially among non-English households.

3

Covered California Equity and Practice Transformation – *Returning with Proposed Modifications*

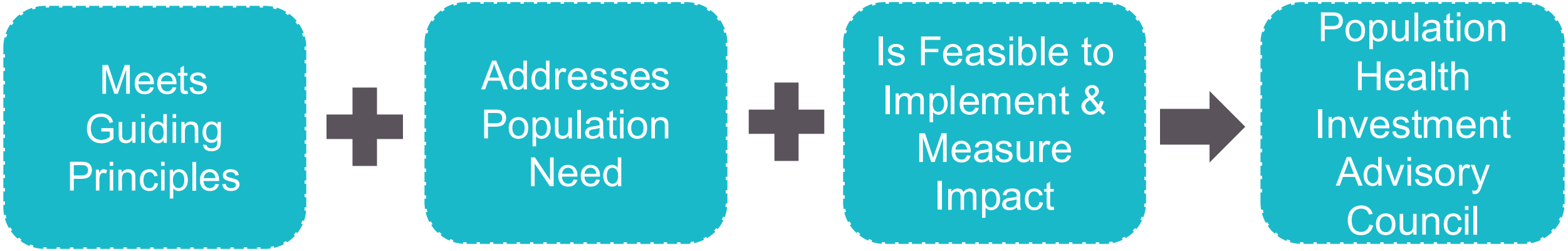
- Use CHCF-supported evaluation (E-LAB) to assess long-term capacity-building, impact and outcomes.
- Explore integration with HPPP PopHI to connect practice transformation with upstream workforce development strategies.

4

Health Professions Pathways Program - *New*

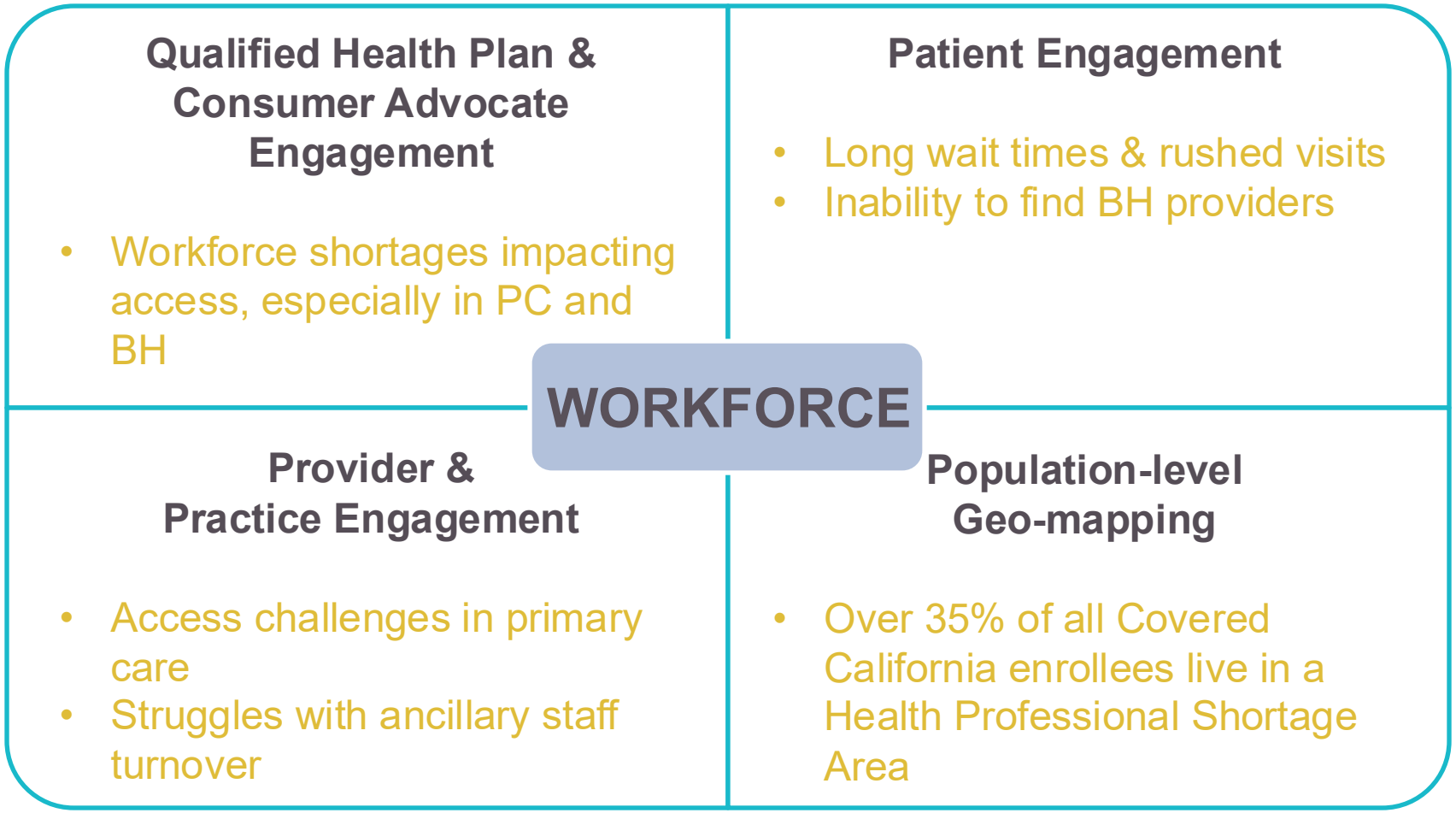
- Targets California workforce by focusing on select health professional shortage areas which most impact Covered California members.
- Leverage HCAI's HPPP infrastructure to invest in a health workforce that reflects Covered California's diversity while addressing shortages and inequities.

POPULATION HEALTH INVESTMENTS: SELECTION CRITERIA



POPULATION NEEDS ASSESSMENT

Consensus that workforce challenges hinder achievement of quality outcomes



CONSUMER ADVOCATE ENGAGEMENT

Goal: To receive feedback from Consumer Advocates on what barriers they perceive to most strongly impact achievement of quality care for members and how to advance health and wellness

Method: 1:1 meeting series, plan management advisory group, written comment opportunities

Themes and Learning

- Recommend working across siloes to bridge programs available in DHCS/Medi-Cal and other state departments given fluidity of enrollment and mixed family status
- Need to continue to **hold QHP issuers accountable for full spectrum of responsibilities**, **which includes access**, quality, and equity
- Address underlying financial barriers, not limited to just cost of coverage, but also related financial burden of access and other immediate health related social needs
- Ensure place-based and regional investments are not a proxy for addressing racial and ethnic inequities
- Increase transparency of quality and equity reporting at issuer level and across purchaser programs

QHP ISSUER ENGAGEMENT

Goal: To inventory current interventions deployed and remaining challenges plans face while striving for the 66th percentile for QTI measures

Method: 1:1 meeting series, carrier calls, plan management advisory group, written comments

Themes and Learning

- Significant new investments made in quality (new departments, staff, vendors), although some work did not ramp up until 2023 therefore impact not yet seen
- New senior and executive leadership commitment given financial impact
- Several new vendors launched, some with good success, but others without desired impact
- Increased incentive dollars utilized at member level targeting eligible members
- **Impacted or limited provider availability and workforce shortages**
- Increased in-home services (in-home lab testing and colorectal cancer screening mailers)
- Provider contracts with additional dollars or increased weighting of measures
- New infrastructure for direct to member outreach as well as enhanced data exchange
- Concern that plans are being held accountable for “non-compliant” members or families and that plans should be held harmless

PROVIDER ENGAGEMENT

Goal: To gain insights into the challenges and barriers practices face in delivering quality care for Covered California members for consideration in Population Health Investment selection

Method: 1:1 listening sessions with practices with large volumes of attributed Covered California members

Themes and Learning

- Payor-agnostic practice patterns and workflow
- **Challenges with access for patients in primary care, pediatrics, and ancillary services for preventive screenings**
- **Struggles with workforce turnover: provider, nursing staff, and ancillary staff such as technicians and front and back office**
- Sub-optimal data exchange, lack of interoperability & inconsistent electronic medical record use, especially in small, independent practices
- Desire to engage with community-based organization to address health-related social needs, but varying levels of capacity and maturity

PATIENT ENGAGEMENT

Goal: To gain insights into the challenges and barriers members face in managing their health conditions that will inform selection of Population Health Investments

Method: Outbound calls made to members with a diagnosis of diabetes and/or hypertension to gather qualitative feedback on successes and challenges with chronic disease management

Themes and Learning

- Attempts to adopt healthier habits, although barriers like affordability or time often hinder their efforts
- Rising out of pocket and premium costs pose significant financial challenges for some members
- Difficulties finding culturally sensitive care or desired providers
- **Challenges with access including rushed consultations and long wait time for appointments**
- Personal barriers experienced that prevent some members from obtaining food, such as changes in the economy and current job situations
- Attempts to try to save money or ration food on a weekly basis
- Barriers related to transportation, such as not having enough money for gas or needing to take a bus distances to go grocery shopping
- Additional financial concerns and advocacy for funds to help support utility bills and/or rent
- Members concluded that additional monetary support in the range of $100-$200 / month would be most beneficial

CALIFORNIA'S GROWING PRIMARY CARE CRISIS AND WORKFORCE DISPARITIES

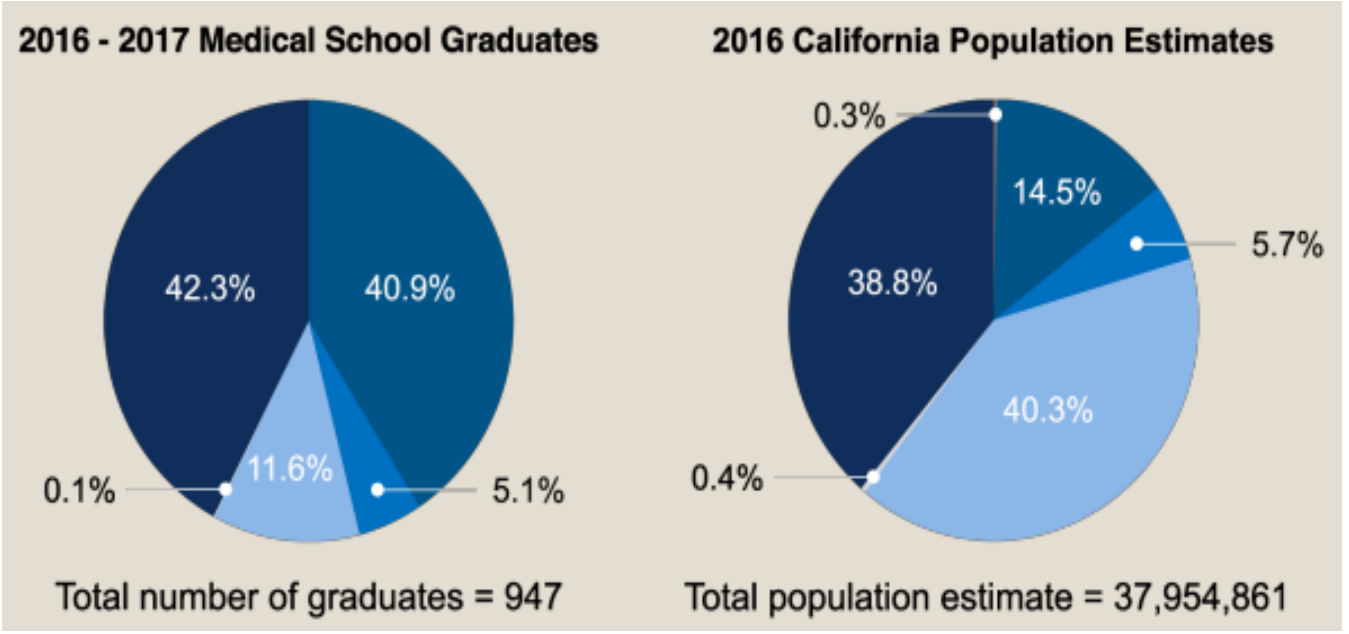
Critical Shortage of PCPs

- ~7 million Californians live in HPSAs
- Aging population and growing demand will worsen shortages; **projected gap of 4,100 PCPs by 2030**

Persistent Racial and Linguistic Gaps

- Latino physicians are severely underrepresented – would take **five (5) centuries** to reach parity if trends continue.

Figure 1. Share of California medical school graduates vs. California's population by race and ethnicity for 2016-2017.



Note: *The total state population estimate excludes non-Hispanic/Latino and Hispanic/Latino populations who reported "some other race alone" or "two or more races".*

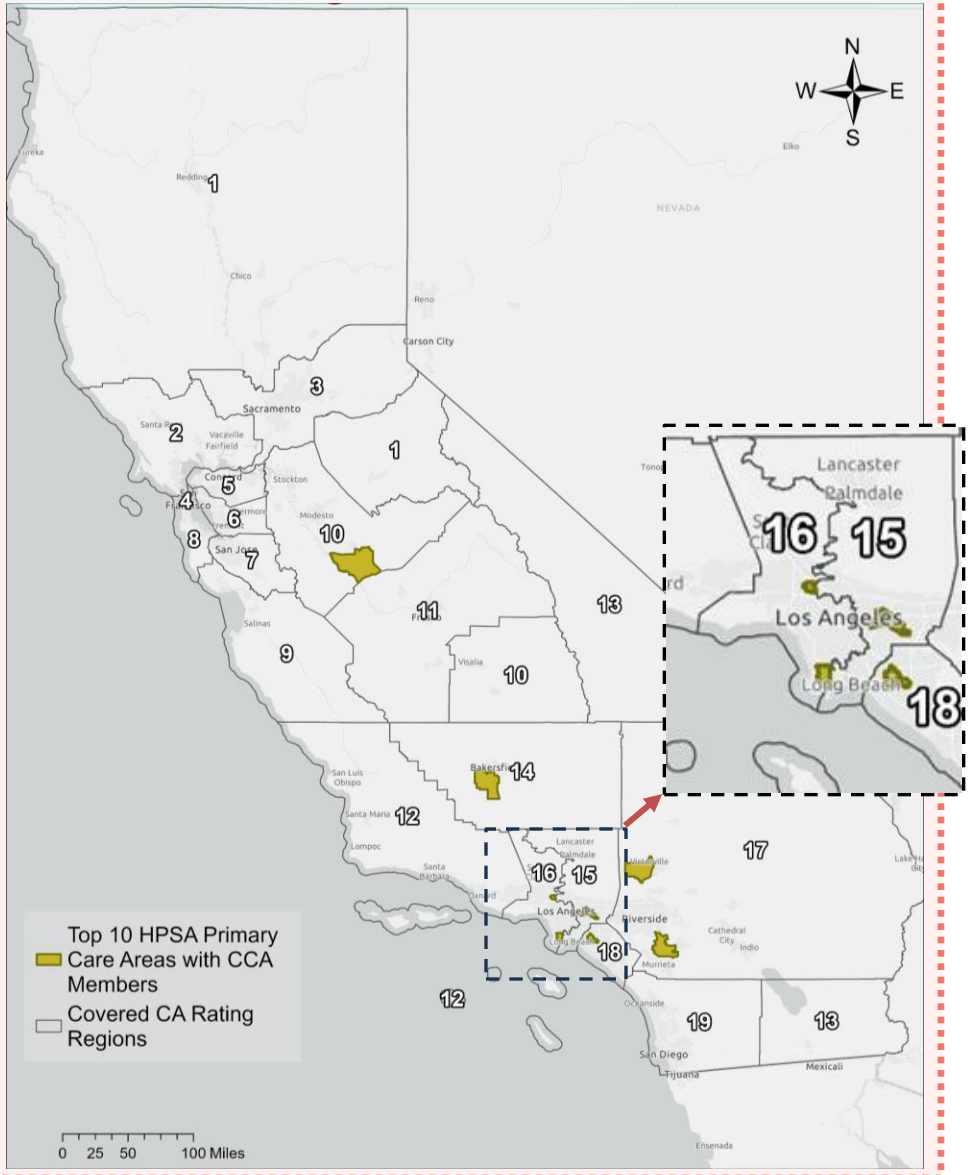
Sources: AAMC Data & Facts Table B-6.1 for total graduates by U.S. Medical School and Race/Ethnicity (alone) (GME year 2016-2017). Data excludes percentage estimates for other race/ethnicity; multiple race/ethnicity; unknown race/ethnicity; and non-U.S. citizens or non-permanent residents. U.S. Census Bureau, 2016 American Community Survey (ACS) 1-Year Estimates for Total Population by Race (Table B02001) and Hispanic or Latino Origin by Race (Table B03002).

COVERED CALIFORNIA

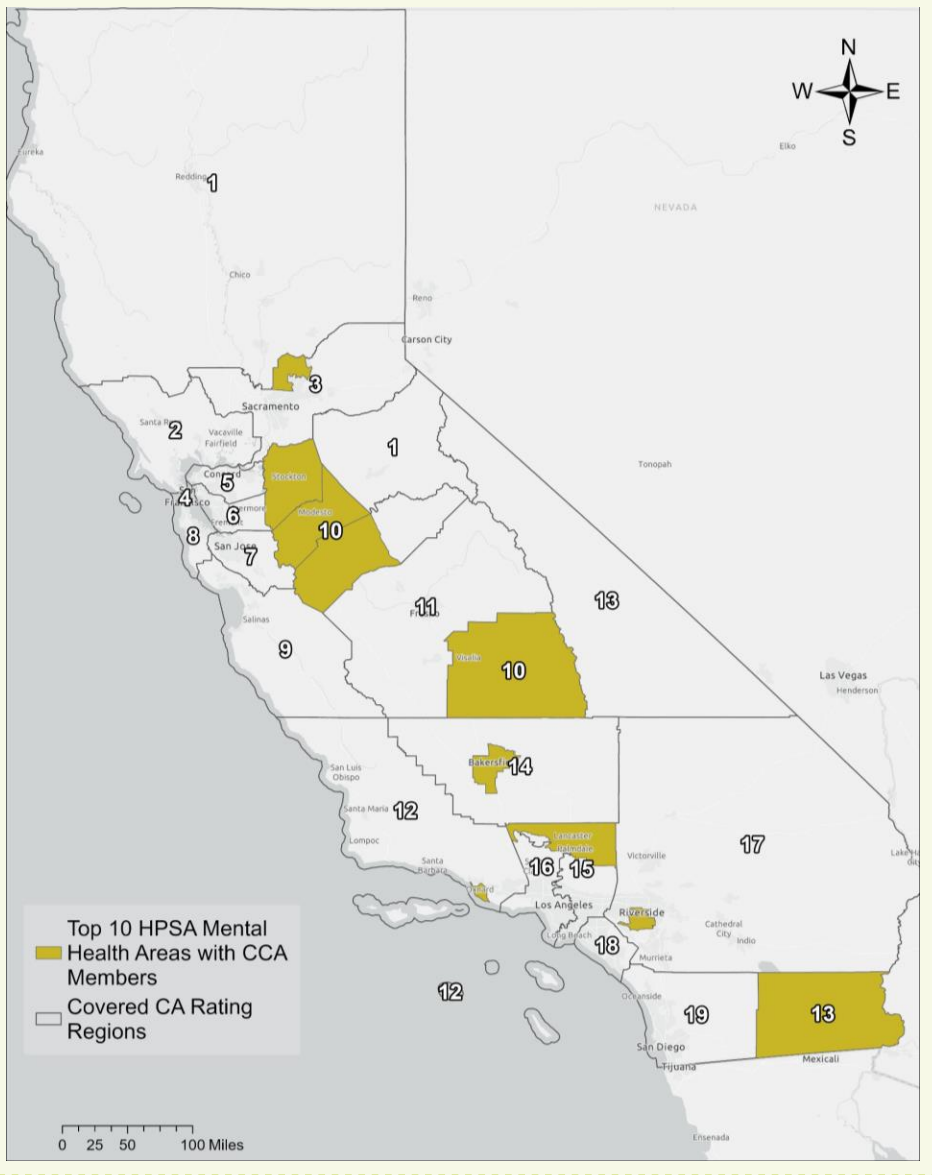
Source: California's Physician Shortage: Brief. In UCLA Latino Policy & Politics Institute. https://latino.ucla.edu/wpcontent/uploads/2021/08/LPPI-CPS-Summary.pd

IMPACT OF WORKFORCE SHORTAGES ON CCA ENROLLEES

Primary Care HPSAs with Highest Count of Covered California Members



Mental Health HPSAs with Highest Count of Covered California Members



COVERED CALIFORNIA

Analysis includes Covered California members identified as enrolled & pending from 2024 pulled from CalHEERS on 6/5/25

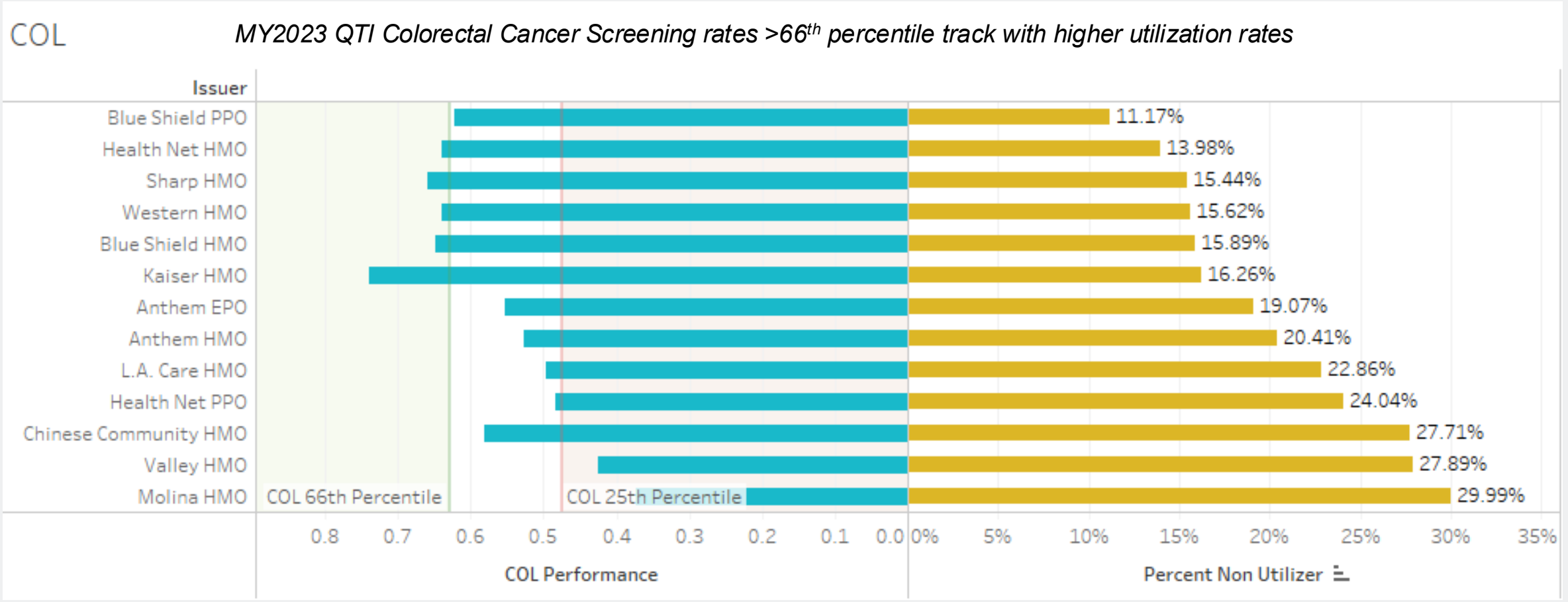
COVERED CALIFORNIA MEMBERS LIVING WITHIN A HPSA

Over 35% of all Covered California enrollees live **in a Health Professional Shortage Area.**

HPSA Designation	Count of Unique Members	Percent of Total Members
Primary Care	263,298	16.60%
Mental Health Care	486,414	30.68%
HPSA Member (Any HPSA)	**558,874**	**35.25%**
HPSA Member (Both HPSAs)	190,838	12.04%

Analysis includes Covered California members identified as enrolled & pending from 2024 pulled from CalHEERS on 6/5/25

ACCESS TO PRIMARY CARE IS KEY DRIVER OF QTI MEASURE PERFORMANCE



IMPACTED HEALTHCARE WORKFORCE LEADS TO WORSE OUTCOMES

Insufficient workforce leads to lower quality		Discontinuous care leads to lower quality, higher cost		Concordant care has a mortality benefit	
Lower density of PCPs associated with worse cardiovascular outcomes [1]	Workforce shortages raise medical errors and harm outcomes [2]	Increasing primary care visits without continuity increases TCOC [3]	Virtual visits with a PCP other than one's own leads to an increase in ER visit rates [4]	Black infants have a lower mortality rate when cared for by Black physicians [5]	Patient-physician racial concordance reduces in-hospital mortality [6]

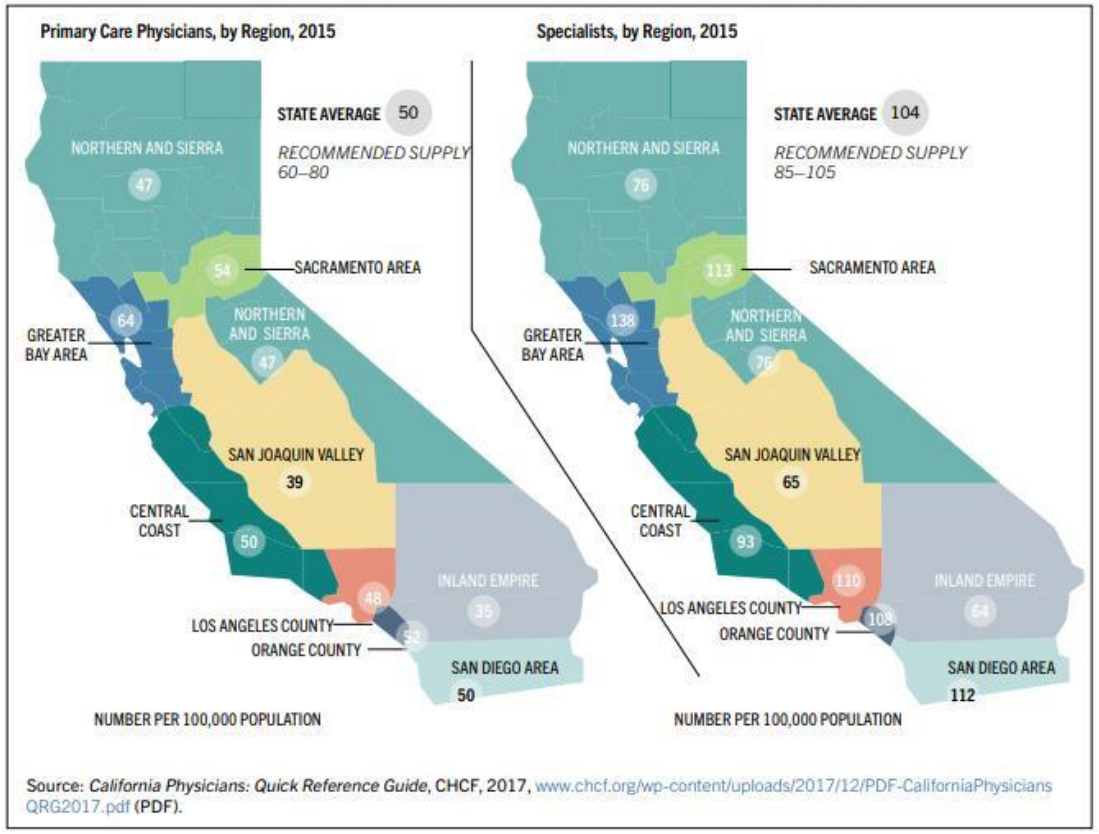
Increasing healthcare workforce is critical to achieving and maintaining gains achieved in QTI

See appendix for references

A LONGSTANDING PROBLEM WILL WORSEN IF WE DON'T CHANGE OUR APPROACH

2015: California statewide and regional primary care physician shortages

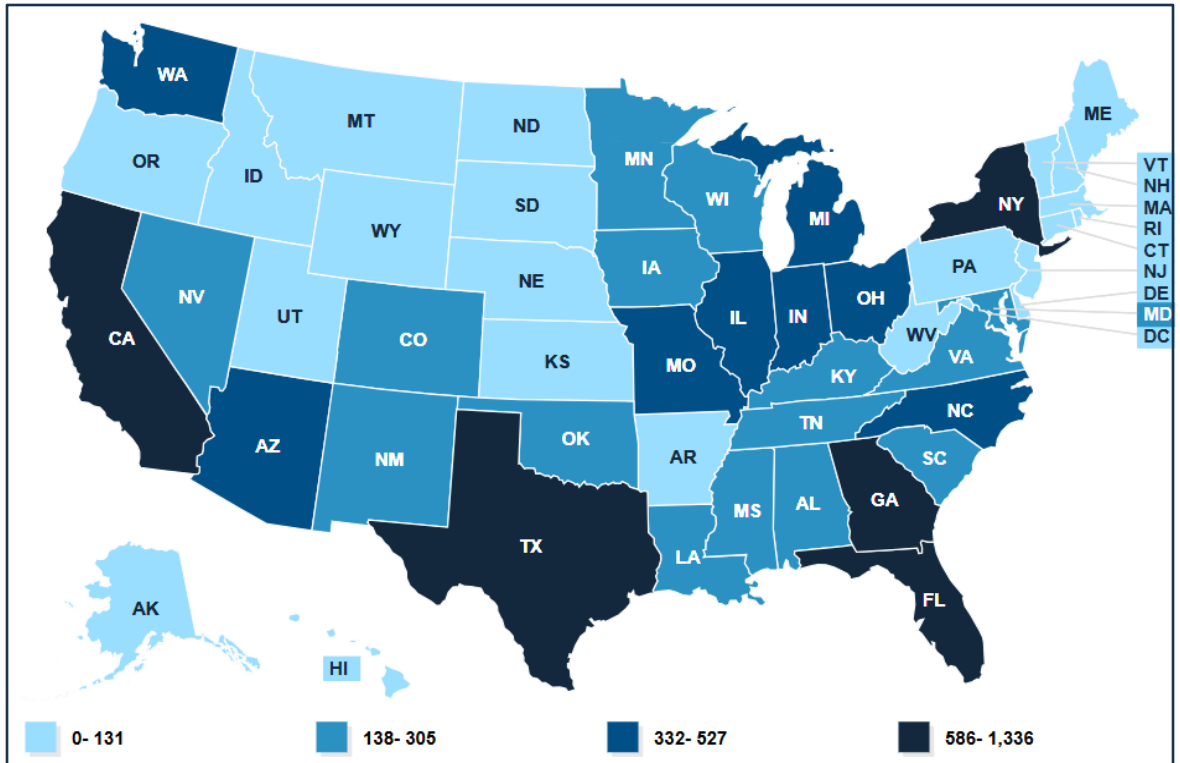
Figure 2. Supply of Primary Care Physicians and Specialists in California, by Region, 2015



Source: *California Physicians: Quick Reference Guide*, CHCF, 2017, www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaPhysiciansQRG2017.pdf (PDF).

2025: California is one of several states with highest number of PCPs needed

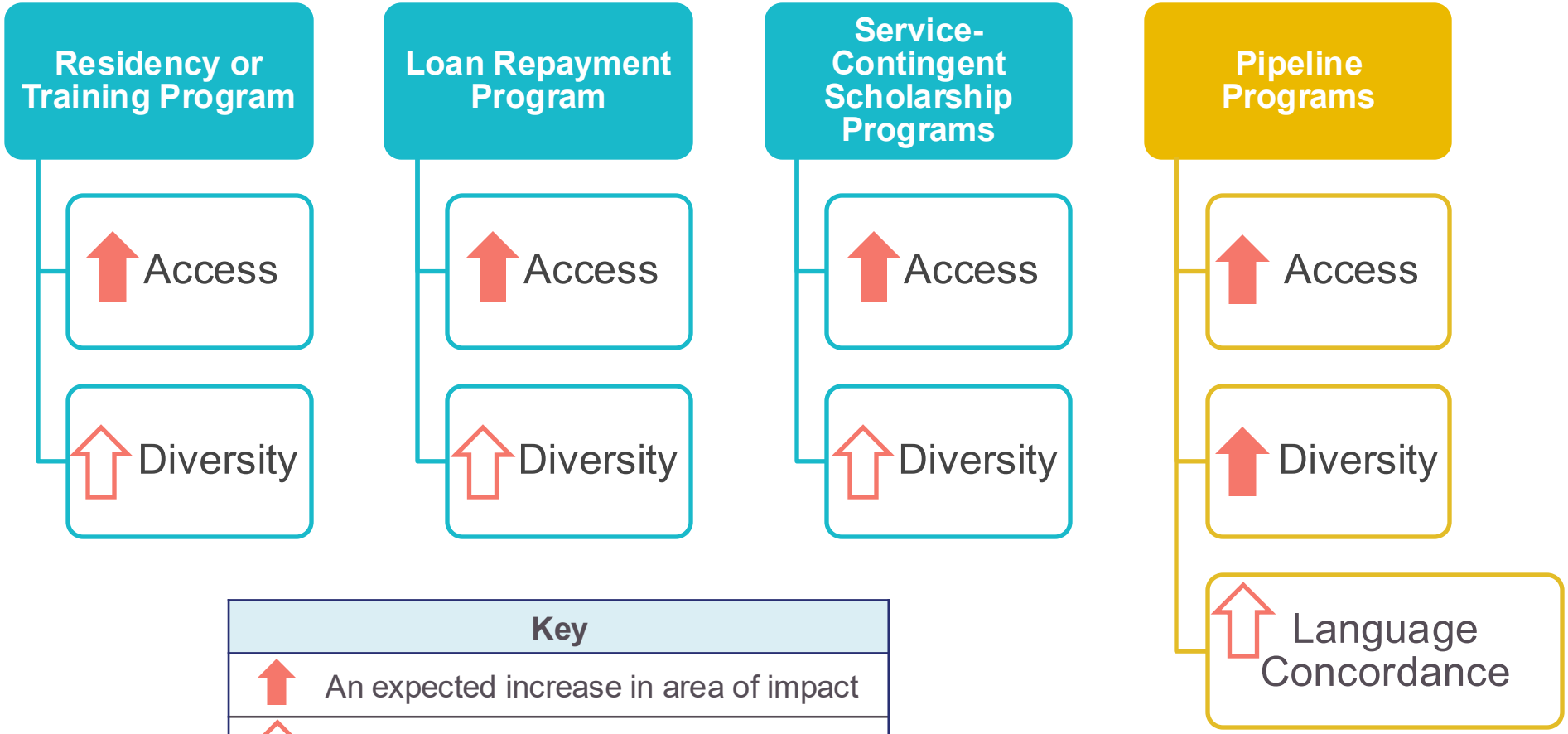
Number of Practitioners Needed to Remove Primary Care HPSA Designations, by State (12/31/24)



Sorce: *KFF State Health Facts Data / Providers & Service Use / Health Professional Shortage Areas*
https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/

CLEAR EVIDENCE SUPPORTING HEALTH WORKFORCE

Evidence shows that pipeline programs, known also as career pathway programs, can have a positive impact on access, diversity, and language concordance by targeting support towards students from under-represented backgrounds.



Rittenhouse et. al. (2021). Health Workforce Strategies for California: A Review of the Evidence. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2021/04/HealthWorkforceStrategiesReviewEvidenceInfographic.pdf

HEALTH PROFESSIONS PATHWAY PROGRAM

The Health Professions Pathway Program (HPPP) supports and encourages underrepresented and disadvantaged individuals to pursue health careers to develop a more culturally and linguistically competent healthcare workforce.

HCAI California Department of Health Care Access and Information

HPPP expands and diversifies California's health workforce for underserved areas and populations by supporting the following activities:

- Pipeline programs that provide comprehensive academic enrichment, career development, mentorship, and advising support to students to pursue health careers
- Paid summer internships for undergraduate students
- One-year post undergraduate fellowships
- One-year post baccalaureate scholarships
- Conference and/or workshop series aimed at informing individuals of opportunities in health professional careers
- Support and technical assistance to health professional schools and colleges, as well as to student and community organizations active in minority health professional development
- Research and data analysis in the field of minority and disadvantaged health professional development

PROPOSED POPHI:
HEALTH PROFESSIONS PATHWAYS PROGRAM (HPPP)

Proposed PopHI Structure

- Leverage HCAI's HPPP infrastructure to invest in a health workforce that reflects Covered California's diversity while addressing shortages and inequities

- Provide grantee organizations with funds to support programs that encourage individuals to pursue health careers through advising/career development programs, summer internships, post undergraduate fellowships, and post baccalaureate scholarships

- Tailor the grant program to focus on workforce shortage areas where Covered California members reside and health professions that manage the chronic conditions and preventive care measured by QTI

- Short-term output includes diverse students participating in pathways programs
- Long-term output includes diverse professionals entering the health workforce to better serve Covered California members

FEEDBACK THEMES TO DATE

4

Health Professions Pathways Program

Advisory Council

- Acknowledged importance of investing in workforce diversity and culturally/linguistically concordant care to improve access and trust
- General support for the idea that upstream workforce investments are aligned with Covered California's mission to address systemic barriers to health equity
- Encouraged further demonstration on direct link to Covered California's members and the QTI measures
- Some members raised concerns about the long-term nature of workforce investments, asking whether this approach yields meaningful short-term impact for enrollees
- Suggestions to enhance program focus and design: expanding scope to consider ancillary professions like medical assistants, CHWs, and translators, especially for populations facing language access barriers and recommendation to evaluate program

QHP Issuers

- Two issuers were concerned that this PopHI would not impact QTI metrics
- Two issuers requested a formal evaluation to assess long-term workforce diversity outcomes
- One issuer recommended preferentially expanding PopHI to include member-centered supports such as transportation assistance and community-based outreach to close preventive care gaps
- One issuer requested funds are returned to QHP issuer preferentially for their own programming

MODIFICATIONS BASED ON FEEDBACK

4

Health Professions Pathways Program

To strengthen alignment with field needs and feedback from QHP Issuers and Advisory Council, Covered California is exploring the following program design changes**:**

- Refining Scoring Methodology – Increase scoring for programs focused on **primary care and behavioral health workforce**; exploring allied health workforce needs
- Adjusting Program Focus – Exploring shifts in investment toward more **downstream opportunities** (e.g., post baccalaureate programs)
- Reviewing Grant Agreement Terms – Considering **opportunities for grantees** to interact directly with public purchasers, learn about quality metrics such as those in QTI, and engage with in-network primary care practices
- Launching a Formal Program Evaluation – Covered California plans to fund an external evaluation to **assess long-term impact and effectiveness**

HEALTH PROFESSIONAL INVESTMENTS

Meets Guiding Principles

+

Addresses Population Need

+

Is Feasible to Implement & Measure Impact

- ✓ *Equity First*
- *+/- Direct*
- ✓ *Evidence-Based*
- ✓ *Additive*

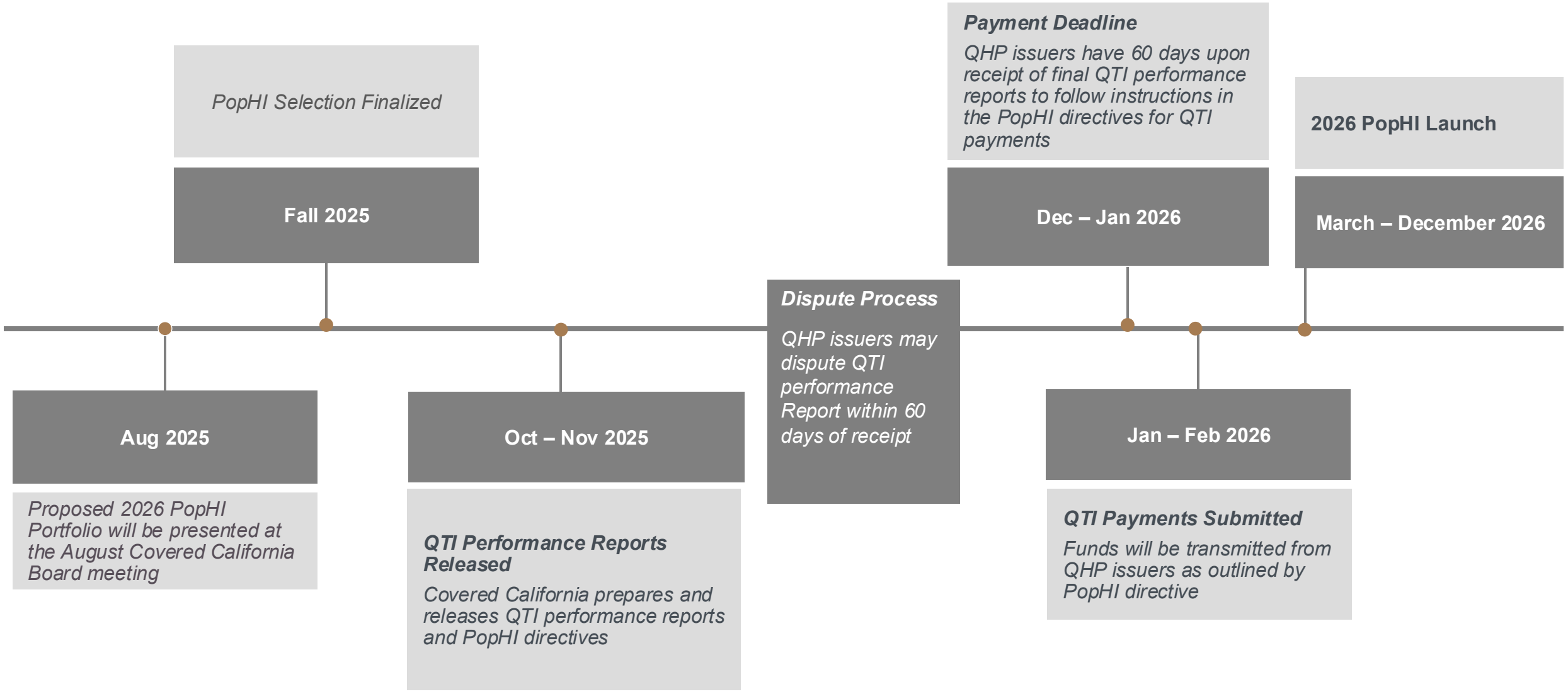
- ✓ *Supports needed workforce investments communicated by all stakeholders*

- ✓ *Utilizes existing infrastructure*
- *+/- Measurement of long-term impact*

MOVING THE NEEDLE ON QUALITY

APPENDIX

TIMELINE


Aug 2025
Proposed 2026 PopHI Portfolio will be presented at the August Covered California Board meeting
Fall 2025
PopHI Selection Finalized
Oct – Nov 2025
QTI Performance Reports Released
Covered California prepares and releases QTI performance reports and PopHI directives
Dispute Process
QHP issuers may dispute QTI performance Report within 60 days of receipt
Dec – Jan 2026
Payment Deadline
QHP issuers have 60 days upon receipt of final QTI performance reports to follow instructions in the PopHI directives for QTI payments
Jan – Feb 2026
QTI Payments Submitted
Funds will be transmitted from QHP issuers as outlined by PopHI directive
March – December 2026
2026 PopHI Launch

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