

# Population Health Investment Advisory Council

May 2024

Health Equity & Quality Transformation (EQT) Division

# AGENDA


Topic	Time
Welcome	12:30 pm - 12:35 pm
Population Health Investment (PopHI) Presentation: Direct Investment to Enhance Food Security	12:35 pm - 12:55 pm
Discussion	12:55 pm - 1:50 pm
Public comment	1:50 pm - 2:00 pm

# MEETING PROTOCOLS

## Advisory Council Members

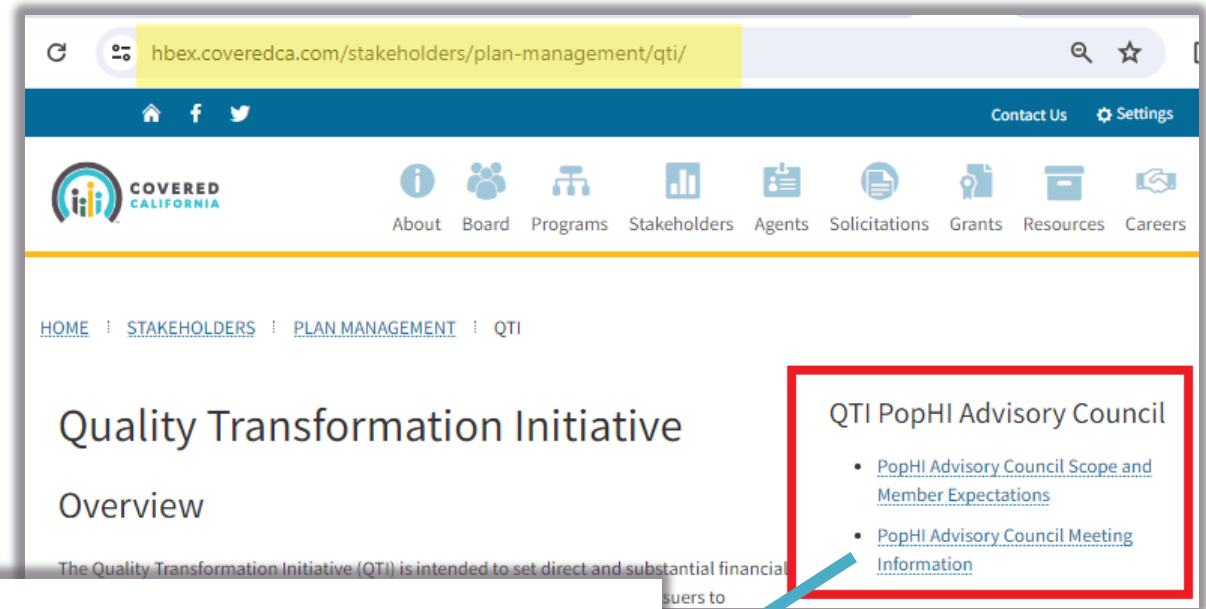
- Please mute/unmute yourself as necessary throughout the meeting.
- If you have any questions, concerns or items you would like to share during the meeting, please email [marisol.meza-badran@covered.ca.gov](mailto:marisol.meza-badran@covered.ca.gov) for assistance.

## Public

- Public comment will be open at the close of the Advisory Council discussion. Please use the Teams function to raise your hand  and limit comments to 2 minutes.
- The Teams chat function will also open at the close of the Advisory Council discussion.
- Written comments regarding this meeting are welcome and can be sent to [EQT@covered.ca.gov](mailto:EQT@covered.ca.gov) by June 3<sup>rd</sup>.
- Materials will be posted at <https://hbex.coveredca.com/stakeholders/plan-management/qti/>.

# ADVISORY COUNCIL MEETING SERIES

- June Meeting
  - June 26, 2024
  - 10:30 am – 12:00 pm PT
- July Meeting
  - July 24, 2024
  - 10:30 am – 12:00 pm PT
- Information about the PopHI Advisory Council and how to join the monthly meetings can be found at <https://hbex.coveredca.com/stakeholders/plan-management/qti/>
- Upcoming meeting details and how to attend will be updated monthly, following the completion of every meeting



# POPULATION HEALTH INVESTMENT ADVISORY COUNCIL

The Council is a **trusted advisory body** consisting of stakeholders and subject matter experts selected by Covered California who support **successful deployment of PopHIs** to improve the quality of healthcare and to reduce health disparities for Covered California enrollees.

- Advise Covered California in the **selection of initial Population Health Investments** (PopHIs, pronounced “Poppy”).
- Guide and **inform program design features** of selected PopHIs, such as: member eligibility, program operations, and key performance indicators and evaluation approaches.
- Establish a forum that **supports successful deployment** of PopHIs through expert and trusted counsel.

The PopHI Advisory Council **does not have decision making authority**, and Covered California is not bound to adopt any of the PopHI Advisory Council’s recommendations, but the input shared is critical to sculpting both design and implementation.

# POPULATION HEALTH INVESTMENT ADVISORY COUNCIL

## Membership:

The Advisory Council consists of 10 to 12 members plus Ex Officio, including the following:

- Qualified Health Plan Issuers (2-3)
- California-based Government Officials (2)
- Consumer, Consumer Advocates, Thought Leaders, and Experienced Professionals (4-6)
- California-based Providers (2-3)
- Ex Officio (2)
  - California Department of Health Care Services
  - California Public Employees' Retirement System

## Participants:

- **Tomás Aragón, MD, DrPH** - Director and State Public Health Officer, California Department of Public Health
- **Palav Babaria, MD, MPH** - Deputy Director & Chief Quality and Medical Officer, QPHM, Department of Health Care Services
- **Corrin Buchanan, MPP** - Deputy Secretary for Policy and Strategic Planning, CalHHS
- **Tracy M. Imley, MD** - Regional Assistant Medical Director, Quality and Clinical Analysis, Southern California Permanente Medical Group
- **Amanda Johnson** - Deputy Director, State and Population Health Group, CMS Innovation Center
- **Edward Juhn, MD, MBA, MPH** - Chief Quality Officer, Inland Empire Health Plan
- **Julia Logan, MD** - Chief Clinical Director, Clinical Policy & Programs Division, CalPERS
- **Peter Long, PhD** - Executive Vice President, Strategy and Health Solutions, Blue Shield of California
- **Bianca Mahmood** - Covered California Consumer
- **Sarita Mohanty, MD** - President and Chief Executive Officer, The SCAN Foundation
- **Cary Sanders, MPP** - Senior Policy Director, California Pan-Ethnic Health Network
- **Kristof Stremikis, MPP, MPH** - Director, Market Analysis and Insight, California Health Care Foundation
- **Sadena Thevarajah, JD** - Managing Director, Health Begins
- **Raymond Tsai, MD, MS** - Vice President, Advanced Primary Care, Purchaser Business Group on Health

# QUALITY TRANSFORMATION INITIATIVE

Make  
Quality  
Count

0.8% to 4%  
premium  
at risk for

Measures  
that  
Matter

a small set  
of clinically  
important  
measures

Equity  
is  
Quality

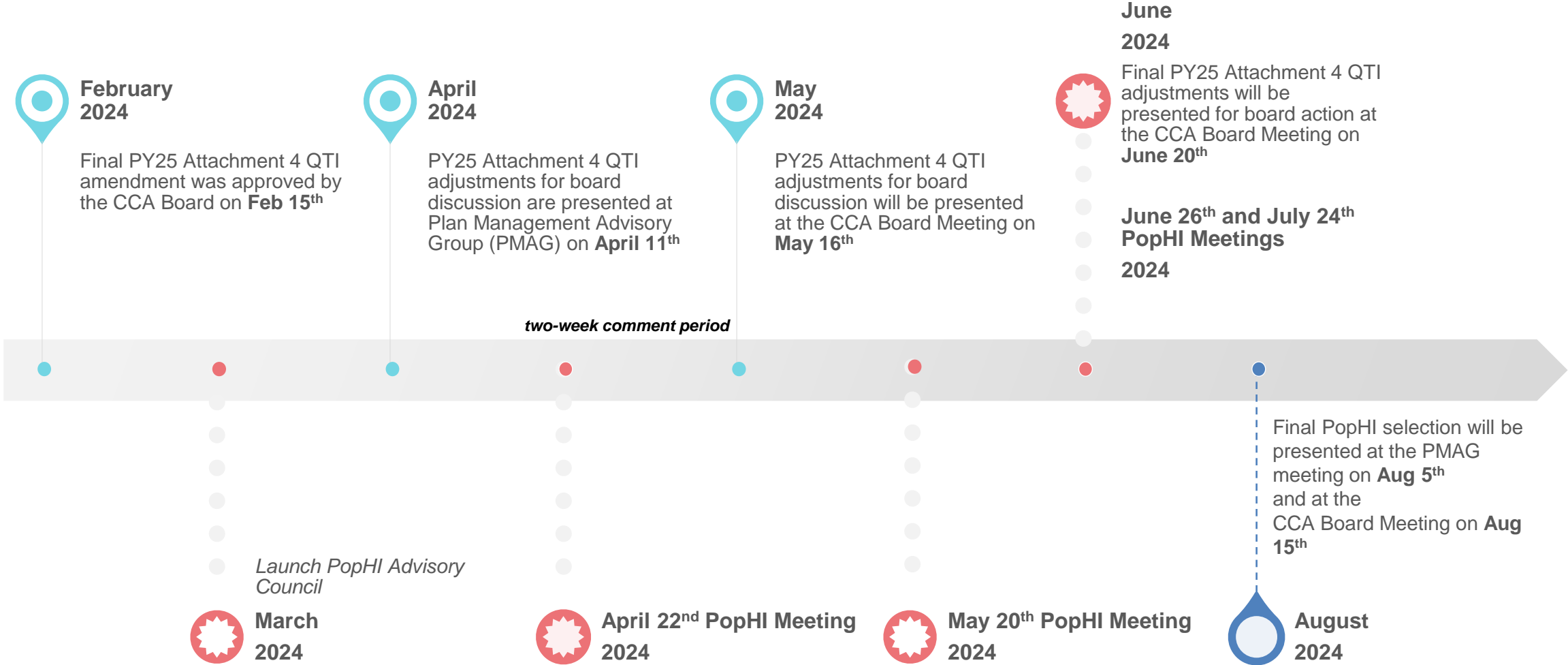
stratified by  
race/ethnicity

Amplify  
through  
Alignment

selected in  
concert with  
other public  
purchasers\*

\*Public purchasers includes CalPERS and DHCS/Medi-Cal

# TIMELINE





# 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

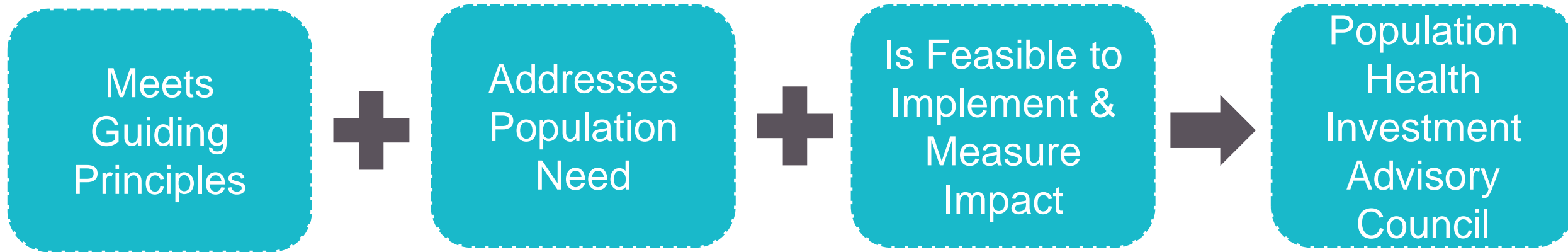


**Evidence-based:** use of funds should be grounded in approaches that have established evidence of success in driving improvements in quality or outcomes



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

# POPULATION HEALTH INVESTMENTS: SELECTION CRITERIA



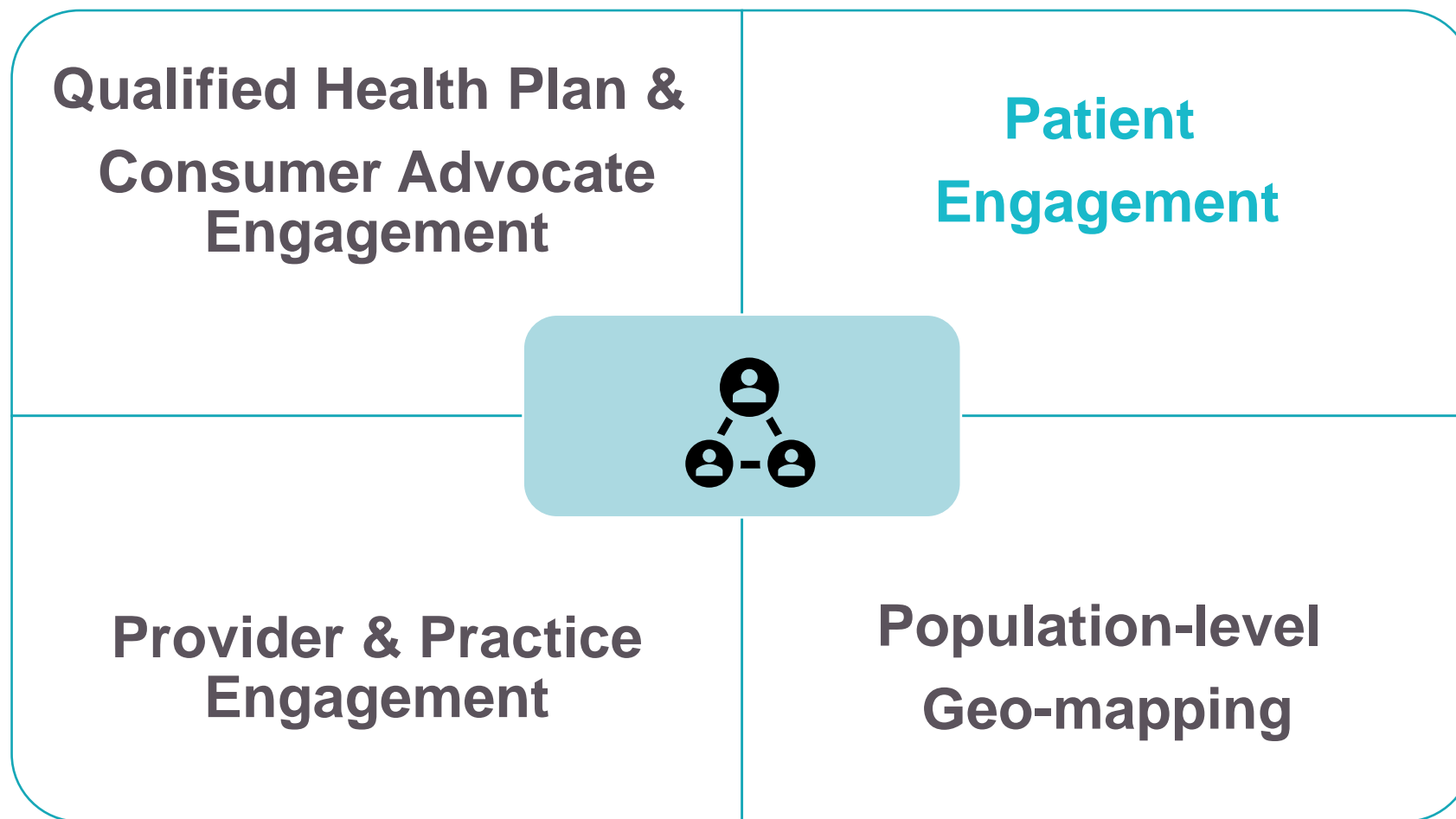
A prioritized list of Population Health Investments will be presented at Plan Management Advisory Workgroup and Covered California Board in 2024

# POPHI: YEAR 1 AND 2 FOUNDATIONAL ELEMENTS

High-Impact	Covered CA Oversight	Feasible and Measurable	Alignment
<ul style="list-style-type: none"> <li>• 4-5 investments</li> <li>• Selected by Covered California</li> <li>• Informed by the Advisory Council</li> <li>• Focused on areas identified through Population Needs Assessment</li> <li>• Not duplicative of the work of QHP Issuers or delivery system</li> </ul>	<ul style="list-style-type: none"> <li>• PopHI will be selected by Covered California</li> <li>• Program design including eligibility, enrollment, regions, etc. will be done by Covered California and include input from Advisory Council and stakeholders</li> <li>• Aim to spend funds in same year collected</li> </ul>	<ul style="list-style-type: none"> <li>• Reports will be shared with Issuers</li> <li>• Formal quantitative and qualitative evaluation of impact with partners</li> <li>• Example outcomes: health seeking behaviors, self-efficacy, financial toxicity, delays due to cost, global health and well-being</li> </ul>	<ul style="list-style-type: none"> <li>• Continued partnership with DHCS and CalPERS</li> <li>• Synergies with DHCS/Medi-Cal work, especially for Community Reinvestment and Equity and Practice Transformation</li> </ul>

# POPULATION NEEDS ASSESSMENT

Covered California is currently leading a multipronged assessment to understand existing supports and barriers to enrollees achieving good health and wellness to inform selection of Population Health Investments.

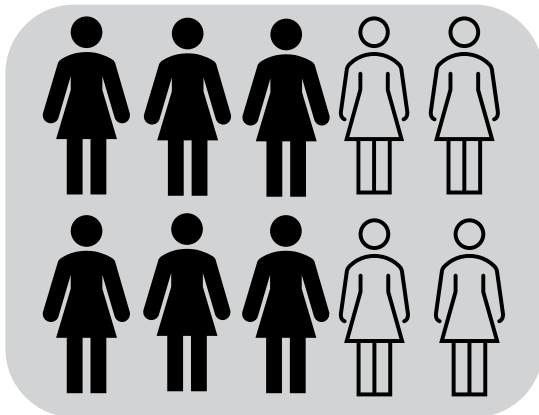


# SNAPSHOT OF OUR ENROLLEES

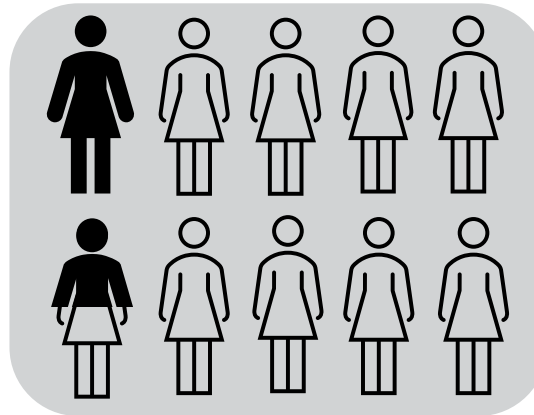
- **60%** of Covered California enrollees (880,770 total individuals) at **FPL 250% or less**
- **47%** of new members report feeling like they **do not have enough money to make ends meet** in the last 12 months

## Of enrollees at FPL <200%

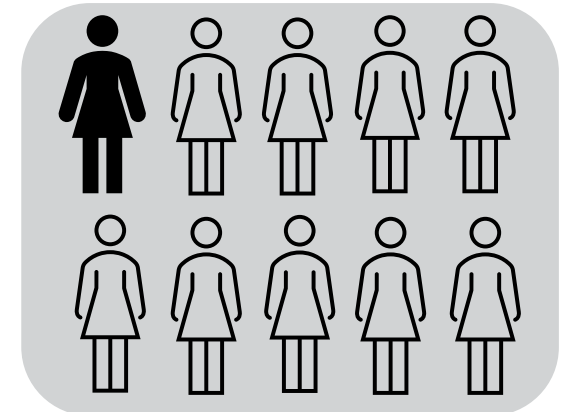
**58%** of new members who reported **food insecurity** had an FPL < 200%



**16%** were concerned that in the next 60 days, they **may not have stable housing**

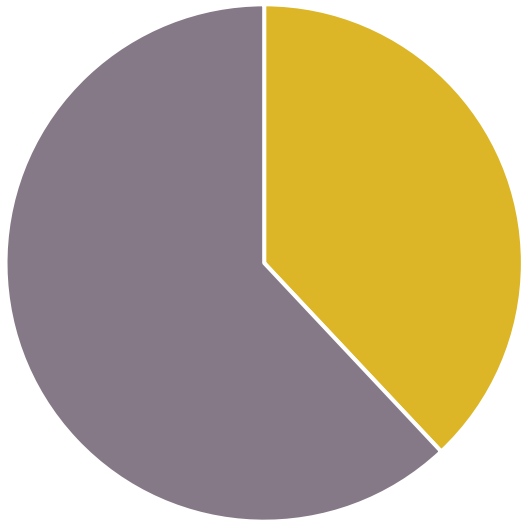


**9%** have **experienced homelessness** (2% in the past year and 1% currently)

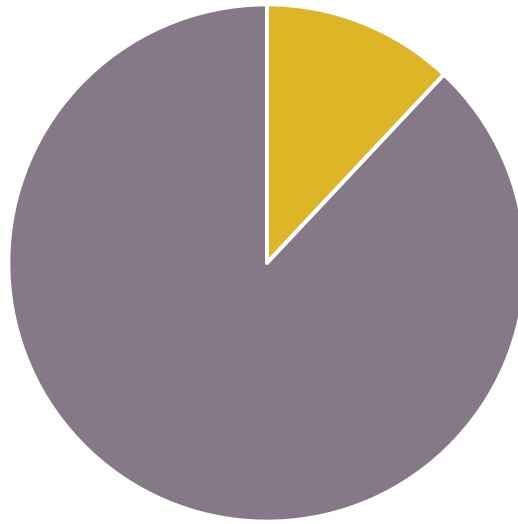


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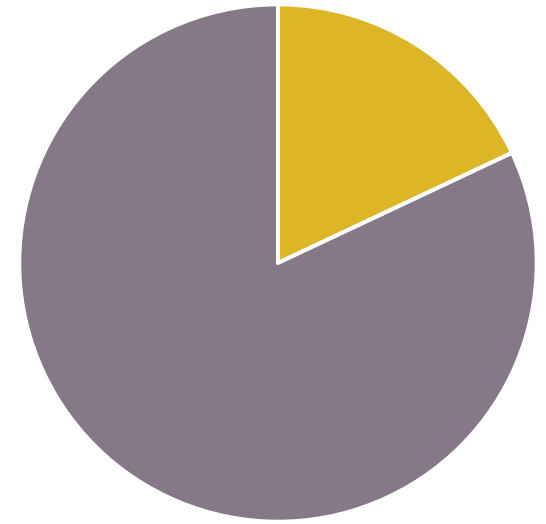
**Covered California enrollees have a high prevalence of medical, mental health, and social health needs.**



38% of all enrollees have a chronic condition



12% of all enrollees have a mental health diagnosis



18% of all enrollees live in Healthy Places Index lowest Quartile

# EQT-LED 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

## Methods

Outbound calls made to >250 members (~15% reach rate) 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** hinder efforts
- ❑ Rising out of pocket and premium costs pose **significant financial challenges** for some
- ❑ Difficulties finding culturally sensitive care or desired providers
- ❑ **Challenges with access** including rushed consultations and long wait times for visits

## Next Steps

Engagement sessions will continue in 2024 to inform Population Health Investment selection

# FINANCIAL DISTRESS PREVALENT

“ I have to pay for car, for rent, gas, food, spend 40 hours working a week. I don't have the money or time for Covered California. I am not able to pay in this moment. -GG

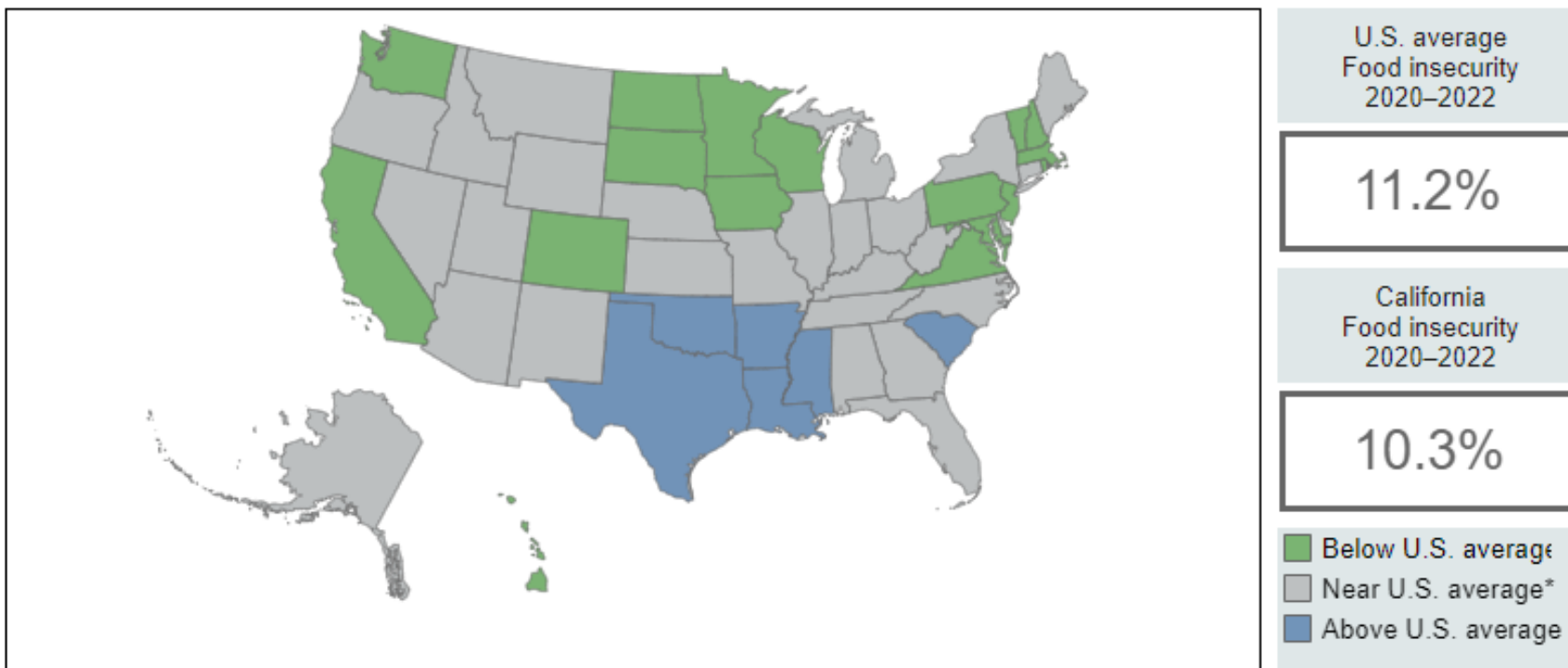
“ Healthcare is a necessity but you have to create that priority - are you going to put food in your mouth or are you going to pay for something you use every 3 months? You're gonna eat first. - CF

“ I would like them to take into account all of the expenses we have with our income so that they would understand the situation... factor that into whether we would qualify for coverage or not. -JC



## How do States compare to the U.S. average?

Food insecurity • 2020–2022



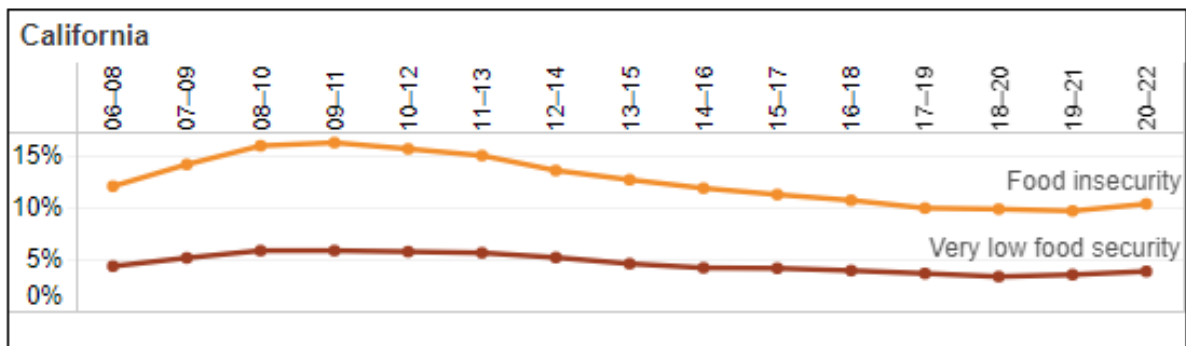
Select a level of severity.

- ☒ Food insecurity  
☐ Very low food security

Select a year.

2020–2022

Click on a State in the map to see  
State-level estimates & trends in food  
insecurity from 2006–08 to present.



# WHAT WE KNOW

1. Food insecurity leads to **poor physical and mental health** outcomes AND **increased health care utilization and cost**
2. Provision of food improves health outcomes and lowers health care utilization, although these **findings are not uniform**
3. A number of **interventions have shown benefit**: medically tailored meals, medically tailored groceries, and produce prescriptions have been replicated and scaled. Benefits include reduced food insecurity, improved dietary intake, improved disease management and improved mental health
4. Programs of **\$60-80** per month are **6+ months** are more likely to have impact
5. **Household size matters** and meals should be scaled to household size
6. Restrictions in use (such as only a farmer's market) or location **decrease adherence**

# WHAT WE AREN'T SURE ABOUT

1. **Ideal structure** of food intervention to maximally impact health status
2. What **sub-population** is best positioned to benefit (e.g., disease specific, income specific)
3. **Ideal intensity of intervention** (how much food is provided, kind of food, how long)
4. Impact of **maximizing flexibility** of funds

# PROPOSED POPHI: DIRECT INVESTMENT TO ENHANCE FOOD SECURITY

## Proposed PopHI Structure

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- Eligible Population: FPL < 200-250% + Chronic Condition + Positive Screen for Food Insecurity
- 



- Reusable card with funds loaded
  - Merchant codes restricted to food retailers (inclusive of food retailers which sell other goods)
- 



- Third party partner supports funds disbursement and survey data collection
  - Participating enrollees are surveyed at regular intervals as part of funds dissemination on outcomes
- 



- Utilization of cards as well as merchants accessed is tracked and reported on a monthly basis

# NEXT PLANNED PATIENT ENGAGEMENT

## Multimodal

- Broad email campaign with discrete survey question and answer options
- Targeted member telephone interviews

## Co-design Approach

- Questions focus on how best to use funds to meet the needs of their family or families in their community
- Open ended interview to understand barriers and specific needs

## Population Focus

- Members with chronic conditions
- Members with low-income
- Members who live in areas with community-level risk for food insecurity

## Data Collection

- Surveys and interviews to occur June - September
- Design in collaboration with research team with expertise in survey tools and data collection
- Goal is to collect direct, structured feedback from 150-200 members via phone and email

# FORWARD

FORWARD partners with governments and organizations to deliver resources and funding to their communities using **human-centered technology and customized solutions.**



# FORWARD

We're Trusted Partners, Accelerating  
Access and Opportunity for Communities



WASHINGTON COVID-19  
IMMIGRANT RELIEF FUND



Washington State  
Department of Social  
& Health Services

*Transforming lives*



NEW YORK  
STATE OF  
OPPORTUNITY.

Empire State  
Development



WHATCOM  
COMMUNITY  
FOUNDATION



Washington State  
Department of  
Commerce



CITY OF  
LONG  
BEACH

ANTIOCH  
CALIFORNIA





FORWARD is helping **government and nonprofit teams serve nearly 300,000 people**, administering over **\$1 billion dollars** in program funding nationwide



50+ unique program solutions



1,500+ cities and counties served



132 Non-profit partnerships



**285,000 people served**





# Household Program Experience



## **WA State Department of Social and Health Services Immigrant Relief Fund**

- \$306M in grants to undocumented workers across the State
- Successfully processed over 10,000 applications
- Partnered with dozens of CBOs for direct outreach
- Equitable payment distribution model, including pre-paid cards for unbanked



## **City of Takoma Park, MD Direct Cash Assistance**

- Distributed over \$10 million to 894 small businesses, 68% of awardees BIPOC-owned & 62% women-owned
- Partnered with local organizations to ensure underserved communities were enrolled in the program



## **WA State Department of Commerce Homeless Service Provider Stipend**

- Distributing over \$50M in direct cash payments
- Over 7,500 applications received and processed
- Verification of hours worked and that employer is an approved entity



## **Volusia County Septic Upgrade Incentive Program**

- \$1.1M for households to upgrade their septic systems
- Coordinating with contractors that are installing the upgrades
- Eligible households apply for the program and receive a rebate for work performed



## **City & County of St. Louis Emergency Rental Assistance Program**

- \$42M administered to more than 5,000 households in the City and County
- Partnered with 7 CBOs for additional staff capacity
- Single application using FORWARD infrastructure regardless of applicant's residence in the City vs County



# Specified Funding Uses



## FORWARD ADMINISTRATION EXPERIENCE

FORWARD has administered several programs where the award was distributed to recipients by using prepaid credit cards (Master Card). The recipients could use the card to purchase products and services wherever the card is accepted.

FORWARD has established partnerships with payment providers that specialize in providing gift cards and or prepaid credit cards. The recipients of these cards can purchase items wherever the card is allowed.

The payment solution (cards) can restrict specific merchant types (E.g. Liquor stores) by identifying Merchant Category Codes (MCCs). The payment solution cannot restrict the types of products purchased at allowed Merchants by (stock Keeping Unit or SKUs).

# Providing End to End Program Management For Direct Assistance Programs



**Program Design  
& Implementation**



**Program  
Awareness  
& Outreach**



**Application  
Assistance**



**Project  
Management,  
Evaluation,  
& Reporting**



**Online  
Application  
Platform**



**Programmatic  
Reporting**



**Application  
Processing  
& Eligibility  
Verification**



**Financial  
Management,  
Compliance  
& Controls**



**Decisioning  
& Funds  
Disbursement**



**Equity Across All  
Program Phases**



# Office of Refugee and Immigrant Assistance

Washington State

Case Worker: Marlene Taylor  
Organization: Together We Thrive Foundation



[Back to Dashboard](#)

## Isabella Thompson

Female, 48 years old

Email

SMS

Call

Case ID  
2983-7401

Applied on  
Jan 30, 2024

Eligibility

Eligible

Case worker



Marlene Taylor

Phone

(206) 092-1391

Email

isabella.thompson@gmail.com

Address

622 Dexter Ave N  
Seattle, WA 98109

Dependents

Ravi Thompson (spouse, 45)

Laura Thompson (child, 12)

## Communications

Call

Today, 9:41 AM

### Transcript

Hello Isabella, I'm your case manager. Before we start, I want to assure you that our conversation is confidential and my primary aim is to help you navigate through...

Email

Yesterday, 3:21 PM

### Follow-Up And Next Steps

Dear Isabella, I hope this email finds you well. I wanted to extend my heartfelt congratulations on successfully signing up for SNAP! It's wonderful news, and I'm...

SMS

Monday, 8:56 PM

Hi Marlene, just wanted to share the good news! I was able to successfully sign up for SNAP as you directed. Thank you so much for your assistance and support...

Email

Feb 2, 11:20 AM

### Recap Of Our Last Meeting And SNAP Program

Dear Isabella, I hope this email finds you well. Following our recent meeting, I wanted to take a moment to revisit our discussion and ensure we're aligned on the next...

Call

Jan 30, 2:14 PM

### Transcript

Ethan: Hi Isabella, it's Ethan from the Office of Refugee and Immigrant Assistance. How are you today?  
Lucas: Oh, hi! I'm doing okay, thank you. How about...

Call

Jan 11, 10:37 AM

### Transcript

Isabella: Hello?  
Marlene: Hi Isabella, this is Marlene Taylor from the Office of Refugee and Immigrant Assistance. How are...

Email

Jan 8, 9:45 PM

New Registration Notification: Isabella

Outgoing Call

Feb 9, 2024, 9:41 AM



02:07

-14:32

Transcript

Summary of needs

Follow up

Marlene

AI generated

Hello Isabella, I'm your case manager. Before we start, I want to assure you that our conversation is confidential and my primary aim is to help you navigate through your current situation. Can you tell me a little bit about what's been going on recently?

Isabella

Hi, things have been tough. I lost my job a few months ago and I'm struggling to keep up with bills and rent.

Marlene

I'm sorry to hear that, Isabella. I understand this must be a stressful time for you. Let's dive into details so we can create an action plan. Can you provide information about your last job and what your income was?

Isabella

I was an Account Manager, and I was making \$60,000 a year.

Marlene

Thank you for that information, Isabella. And what is your current income situation? Any unemployment benefits, savings, or other sources of income?

Isabella

I'm currently receiving \$400 per week in unemployment and \$600 a month in child support. I had about \$6,000 in savings, but it's dwindling quickly.

Marlene

I see. Let's now talk about your monthly expenses and any debts you may have.

# EXAMPLE METRICS & MEASURES OF SUCCESS

- **Process & Implementation Measures**
- **Health Care Utilization and Cost**
- **Outcome Measures**
  - Health Specific:
    - Self-reported health
    - Self-reported emotional and mental health
    - Healthy Days at home
    - Depression as measured by PHQ9 (or PHQ2)
    - Disease Self-Management
    - Impact of medication use
    - Fruit and vegetable consumption
  - Wellbeing:
    - Individual and household stress
    - Self-efficacy
    - Impact on household finances and financial trade-offs
    - Impact on employment

# DIRECT INVESTMENT TO ENHANCE FOOD SECURITY

Meets  
Guiding  
Principles

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



Addresses  
Population Need

- ✓ *Financial insecurity and instability evident through quantitative and qualitative assessment*




Is Feasible to  
Implement &  
Measure Impact

- ✓ *Accepted metrics to track*  
+/- *Requires third party partner to implement*  
+/- *Targeted outreach challenging*

# DISCUSSION QUESTIONS

1. Given Advisory Council's feedback on meeting short-term needs, how would Council advise Covered California on adding more flexibility for the funds? As an example, expanding merchant codes for transportation (e.g., rideshare, taxis, metro, gas) or other needs?
2. How should Covered California consider funds for a household with multiple enrolled (or not enrolled) members?
3. Which chronic conditions should be included (a narrower view focused on QTI measures of HTN/DM or a broader view inclusive of others from literature)?
4. How should Covered California approach the inherent “churn” of the population with desire to measure impact of a 6+ month intervention?

# PUBLIC COMMENT

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# FUTURE MEETINGS

## Dates

- June 26<sup>th</sup> 10:30 am – 12:00 pm PT
- July 24<sup>th</sup> 10:30 am – 12:00 pm PT
- August 19<sup>th</sup> 1:30 pm – 3:00 pm PT

