Plan Management Advisory Meeting

August 13, 2026

Agenda

Time

01 Welcome and Agenda Review

02 2028 QHP and QDP Model Contract Updates

03 QDP 2028 Attachments 1 and 2

04 Update On 2025 & 2026 Population Health Investments

05 Proposed 2027 Population Health Investments

06 Open Forum

2028 QHP and QDP Model Contract Updates

Plan Management Division

2028 Contract Amendments and Updates

The Plan Management Division (PMD) is amending the Qualified Health Plan (QHP) Issuer Contracts for the Individual and Covered California for Small Business (CCSB) markets for Plan Year 2028, for the duration of 2026-2028.

The Plan Management and Health Equity & Quality Transformation (EQT) Divisions are also developing the Qualified Dental Plan (QDP) Issuer Contract for a new duration of 2028-2030.

Key Update Themes:

- Correction and clarity
- Covered California Agent support
- Marketing expectations and requirements framework
- QDP Issuer contracting principles and proposed strategic focus areas

2028 QHP Amendment

General Updates

General contract updates are proposed to improve accuracy and clarity, including corrections to file names and referenced processes:

Contract Section	2028 Proposed Update
QHP Individual Market, QDP **Article 2 – Eligibility and Enrollment** **2.1.2 Contractor Responsibilities, c), d)**	Covered California proposes file name and process updates to the Reconciliation Process for QHP Issuers' Covered California membership enrollment and financial databases to improve accuracy and clarity of this contract section.
QHP Individual & CCSB Markets, QDP **Article 11 – Recordkeeping** **11.5 Examination and Audit Results, a)**	Covered California proposes to clarify and further define the term "immediately" to state, "within two (2) Business Days of receipt", when a QHP Issuer is required to submit results of final financial, market conduct, or special audits/reviews performed by State and Federal Regulators to Covered California.
QHP Individual & CCSB Markets, QDP **Article 11 – Recordkeeping** **11.5 Examination and Audit Results, d)**	Propose updating current contract language to match current processes for implementing corrective actions in response to audit/review findings.
QHP Individual & CCSB Markets, QDP **Article 14 – Definitions** **Qualified Dental Plan Issuer or QDP Issuer**	*Qualified Dental Plan Issuer or QDP Issuer* definition is proposed to be included to provide clarity when this term is utilized in the contract.

2028 QHP Amendment

Minimum Agent Commission

Contract Section 3.3, b) Compensation Methodology

To recognize the importance of fair compensation for agents, Covered California proposes establishing a minimum commission standard reflecting its commitment to maintain the viability of the agent distribution channel, support consumer access to the vital assistance agents provide, and ensure that Qualified Health Plan (QHP) Issuers proportionally share the responsibility of agent compensation.

Covered California developed this proposal based on a Board-requested study that began in 2019. The study found that Lifetime Value of Account had declined, and later QHP Issuer inflation adjustments did not align compensation with national inflation benchmarks. In the spring and summer of this year, Covered California shared a proposed minimum agent commission with QHP Issuers and collected feedback to inform updated Contract language and requirements.

2028 QHP Amendment

Minimum Agent Commission

Contract Section 3.3, b) Compensation Methodology

Based on completed research and received feedback, Covered California has developed draft 2028 contract language for public review and comment. To support this review, Covered California will also provide guidance in a companion document titled *Covered California Minimum Commission Guidance*.

Contract Section	2028 Proposed Update Summary
QHP Individual Market **Article 3 – Promoting Enrollment** **3.3 Agents in Covered California for the Individual Market b) Compensation Methodology**	Covered California proposes that QHP Issuers be required to pay no less than the minimum commission rate set by Covered California each plan year according to the document titled *Covered California Minimum Commission Guidance*.

2028 QHP Amendment

Marketing Expectations & Requirements

Contract Section 3.2.1 Enrollment and Marketing Coordination and Cooperation

Covered California is proposing to modernize its marketing expectations for QHP Issuers through a more flexible, mission-aligned approach — informed by the carrier listening tour and a broader reassessment of the current framework. The updates would move toward an annual marketing investment plan reviewed for alignment with Covered California's enrollment priorities, marketing objectives, and other relevant program considerations; broaden qualifying activities to better reflect the full range of Issuer efforts that support enrollment, retention, utilization, and member engagement; and align oversight with existing business cycles.

2028 QHP Amendment

Marketing Expectations & Requirements

Contract Section 3.2.1 Enrollment and Marketing Coordination and Cooperation

Based on feedback from QHP Issuers and internal analysis of past years' marketing submissions, Covered California has developed draft 2028 contract language for public review and comment.

Contract Section	2028 Proposed Update Summary
QHP Individual Market **Article 3 – Promoting Enrollment** **3.2.1 Enrollment and Marketing Coordination and Cooperation**	Covered California proposes eliminating the fixed 0.4 percent of projected premium spend expectation and replacing it with an annual marketing investment plan that each QHP Issuer submits and reviews with Covered California, recognizing a wider range of qualifying marketing activities. This approach maintains the commitment that carriers make meaningful investments in enrollment-driving activities while accounting for each carrier's circumstances and current market conditions. As market conditions evolve, the plan can be adjusted through additional check-ins as needed throughout the year, in support of shared enrollment and retention goals.

2028 - 2030 QDP Issuer Contract Updates

Minimum Performance Standards for Continued Certification (New Sections 7.4.2–7.4.3)

Removal from Covered California if a QDP doesn't meet or exceed any of the following Minimum Performance Standards:

- **Healthcare Evidence Initiative (HEI) data submission**: At least 350 dental claims/encounters per 1,000 members
- **Dental Loss Ratio**: At least 50% for each QDP offered
- **Pediatric Oral Evaluation**: At least 20% utilization
- **Adult Use of Preventive Services**: At least 15% utilization

Remediation Period and Corrective Action Plan - If a QDP fails to meet any minimum performance standard, Covered California will notify the QDP Issuer and allow them one year to remediate the issue (the Remediation Period). During the Remediation Period the QDP Issuer will work with Covered CA on a Corrective Action Plan to resolve the issue. If the QDP is unable to meet the minimum performance standard following the Remediation Period, the QDP will not be certified in the next certification period.

QDP 2028 Attachment 1 Updates

EQT Team

August 13, 2026

2028-2030 QDP Contracting Principles and Proposed Strategic Focus Areas

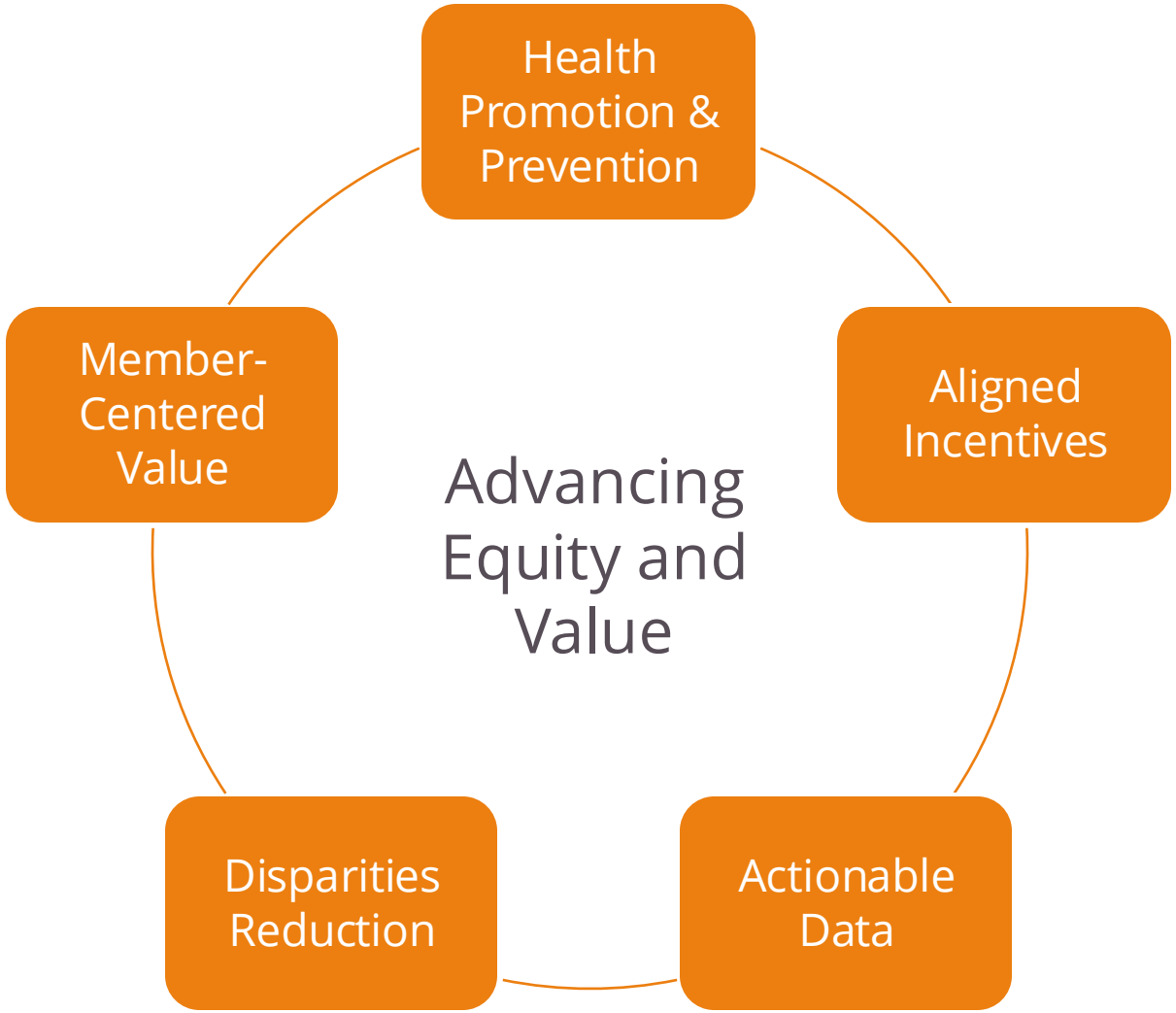
Equity is quality

Center the member

Make it easy to do right

Amplify through alignment

Focused scope for high impact



2027 Current Contract Requirements

Article 1: Equity and Disparities Reduction

- **1.01 Demographic Data:** Covered California will stratify dental quality measures and expand demographic categories over time; Contractors will work with Covered California to expand disparity identification and improvement requirements.
- **1.02 Monitor Disparities:** Covered California will stratify priority dental quality measures and Contractor must engage with Covered California on HEI data submission processes.
- **1.03 Disparities Identification and Reduction**: Contractors must submit an annual Health Equity Capacity Building progress report describing efforts establish or expand disparities reduction infrastructure; Contractor must participate in disparities reduction learning and engagement sessions.
- **1.04 Cultural and linguistic competence:** Contractor must submit an annual report to demonstrate compliance on with specified requirements to provide culturally and linguistically appropriate Written Language Services and Spoken Language Services to communicate with patients who speak a language other than English.

Workgroup Comment Key Themes

Attachment 1 Article 1 – Equity and Disparities Reduction

One issuer submitted comments:

- Describing its capacity to collect, ingest and store member level data, and report self-reported demographic information
- Offering suggestions for enhancing collection of member demographic data through the member portal and workflows that prompt customer service representatives to collect missing race and ethnicity information during member interactions
- Suggesting leveraging existing available data available to enhance data completeness
- Noting disparities reduction efforts in the oral health setting are nascent due to significant data challenges

2028-2030 Proposed Contract Requirements

Article 1: Equity and Disparities Reduction

- **1.01 Demographic Data:** Covered California will stratify dental quality measures and expand demographic categories over time; Contractors will work with Covered California to expand disparity identification and improvement requirements
- **1.02 Monitor Disparities:** Covered California will stratify priority dental quality measures and Contractor must engage with Covered California on HEI data submission processes
- **1.03 Disparities Identification and Reduction**: Shifting focus of progress reports from readiness to engaging in disparities identification, planning and implementation of efforts to reduce disparities and address any HEI data deficiencies, and by 2030, reporting results of these interventions.
- **1.04 Cultural and linguistic competence:** Adding language to bolster Contractor's Cultural and Linguistic competence, includes additional demonstration of how organization or provider network meaningfully communicates with Covered California enrollees via written and spoken language services, and inclusion of new requirement to evaluate these efforts

2027 Current Contract Requirements

Article 2: Population Health

2.01 Dental Population Health Assessment

Contractor must submit a plan addressing the following components for children, adolescents, and members with disabilities enrolled in Contractor's QDP(s):

- Outline of goals, opportunities, programs, and services designed to maintain health and manage oral health risks.
- Strategy for collecting, merging, and analyzing data for these groups using sources like dental claims, health evaluations, risk assessment surveys, health initiatives, and other advanced data tools.
- Application of these data to pinpoint needs and categorize them for focused interventions.

Workgroup Comment Key Themes

Attachment 1 Article 2 – Population Health

- No comments received

2028-2030 Proposed Contract Requirements

Article 2: Population Health – No Changes

2.01 Dental Population Health Assessment

Contractor must submit a plan addressing the following components for children, adolescents, and members with disabilities enrolled in Contractor's QDP(s):

- Outline of goals, opportunities, programs, and services designed to maintain health and manage oral health risks.
- Strategy for collecting, merging, and analyzing data for these groups using sources like dental claims, health evaluations, risk assessment surveys, health initiatives, and other advanced data tools.
- Application of these data to pinpoint needs and categorize them for focused interventions.

2027 Current Contract Requirements

Article 3: Health Promotion and Prevention

3.01 – Dental Plan Benefits and Services Communication

- Contractor must conduct outreach to all Covered California Enrollees and monitor the proportion of Enrollees who obtain preventive diagnostic services and treatment for oral health conditions within the first year of enrollment and at least annually thereafter the Enrollee's enrollment
- Contract must provide enrollee education on their benefits and rights, and monitor utilization of preventive, diagnostic and treatment services

3.02 - Tobacco Cessation

- Contractor must ensure that all contracted dentists screen members for tobacco use, refer users for treatment, and report strategies for prevention and early detection of tobacco-related oral diseases

3.03 - Pregnancy

- Contractor must offer, ensure, and support all contracted dentists in screening adult Covered California Enrollees for pregnancy annually and have a mechanism to facilitate status updates, and provide enhanced oral health outreach and education

3.04 - Patient-Centered Information and Communication

- Contractor must ensure enrollees have access to clear and current data on provider cost and quality, enrollee cost transparency with updated total and out-of-pocket information, and enrollee benefit information; and report to Covered California, its plan, measures, and process to provide Covered California enrollees with quality information for network providers

Workgroup Comment Key Themes

Attachment 1 Article 3 – Health Promotion and Prevention

- No comments received

2028-2030 Proposed Contract Requirements

3.01 – Dental Plan Benefits and Services Communication - No Changes

- Contractor must conduct outreach to and track the percentage of Covered California Enrollees that receive preventive, diagnostic, and treatment services for oral health issues within the first year of registration and once annually
- Contractor must provide education to Covered California Enrollees on accessing services, member benefits, the availability of diagnostic and preventive services, finding and matching providers, health risk assessments, their rights as patients, and the process for filing a grievance
- Contractor must stratify enrollee risks, notify high-risk individuals, provide customized education and outreach, report on high-risk management and dental benefit usage, and educate on no-cost preventive services and oral health self-management tools via its portal

2028-2030 Proposed Contract Requirements

3.02 – Tobacco Cessation - No substantive changes

- Contractor must ensure contracted dentists screen all Covered California enrollees for tobacco use and refer those who report use to their health plan and Primary Care Physician (PCP) for treatment options.

- Contractor must report how it supports contracted dentists in identifying tobacco use among Covered California enrollees and describe strategies to improve tobacco use prevention, **and early detection of oral diseases associated with tobacco use**, including current or anticipated outcomes of interventions.

2028-2030 Proposed Revised Contract Requirement

3.03 – Pregnancy

- Contractor must ensure dentists screen for and identify pregnancy among Covered California Enrollees annually, facilitate status updates, and offer enhanced outreach for preventive and treatment services for oral health during pregnancy.
- Contractor must report how it supports dentists in identifying pregnant Covered California Enrollees, its outreach and education for preventive care, and collaboration with dental providers to advise patients on discussing oral health with their obstetrician.

- **Adding**
  - **Revised Contract Language** – Covered California will monitor rates of the portion of Covered California members who receive any dental service during pregnancy (overall and stratified by race/ethnicity) and will engage with Issuers to address outlier performance.

2028-2030 Proposed Contract Requirements

3.04 – Patient-Centered Information and Communication

Contractor shall demonstrate to Covered California how it provides Covered California Enrollees with current cost and quality information for network providers through submission of sample materials and conducting a live demonstration of how enrollees access such information through member portals or other modalities.

- Contractor shall report how it makes or intends to make provider specific cost and quality information available, and the processes by which it updates the information.
    - Information delivered through Contractor's provider performance programs shall be meaningful to Covered California Enrollees and reflect a diverse array of provider clinical attributes and activities, including: provider background; quality performance; patient experience; volume; efficiency; and price of services.
    - The information shall be integrated and accessible through one forum providing Covered California Enrollees with a comprehensive view.

2027 Current Contract Requirements

Article 4 Delivery System and Payment Strategies to Drive Quality

4.01 Promoting the Development and Use of Dental Home Model

- Contractor must promote the dental home model through network dentists to improve access, care coordination, and quality.

4.02 Networks Based on Value

- Contractor must manage provider networks based on quality, cost, and value.

4.03 Teledentistry

- Contractor must report annually on teledentistry use, delivery models, and enrollee communications.

4.04 Participation in Collaborative Quality Initiatives

- Contractor must report annually on participation in dental quality collaboratives or initiatives.

Workgroup Comment Key Themes

Article 4 Delivery System and Payment Strategies To Drive Quality

One Issuer submitted comments requesting:

- clearer guidance on data feasibility, noting that ethnicity is available for only part of the membership, race is not consistently available, and member-level income is not provided to the dental issuer.

- clearer technical specifications for the new performance standards, including data elements, missing-data treatment, denominator and suppression rules, baseline year, targets, and implementation guidance.

- a phased approach that starts with overall utilization and ethnicity stratification where data are available and adds race and SES later after completeness thresholds and a standardized methodology are established.

- clearer technical standards for measuring “any services,” including eligible CDT codes, the measurement period, exclusions, HEI submission and validation requirements, and acceptable DHMO encounter or proxy data to support comparability across PPO and DHMO products.

2028-2030 Proposed Contract Requirements

4.01 Promoting the Development and Use of Dental Home Model

- Contractor promotes the dental home model through network dentists to improve access, care coordination, and quality.

4.01.1 Encouraging the Use of Primary Dental Care

- DHMO Primary Dentist: Contractor must inform DHMO enrollees about primary dentist benefits, allow selection, assign one if none chosen within 60 days (considering preferences and access), notify enrollees of assignments, and ensure dentists accept new patients.

- **Adding** requirement for member engagement in care across all products.
  - The Member Engagement requirement is a new quality strategy to strengthen the extent to which Covered California enrollees use and benefit from their dental coverage by increasing utilization.
  - Accompanying performance standard is proposed for inclusion in Attachment 2

2028-2030 Proposed Contract Requirements

4.02 Networks Based on Value

- Contractor must manage provider networks using quality, cost, value-based payment reporting, and data driven quality improvement strategies to improve affordability, equity, and oral health outcomes

- **Adding** new requirement: Contractor must develop, submit, and annually update at least one data-driven Quality Improvement Plan (QIP) with measurable goals, targeted interventions, and reporting on progress for priority populations.

2028-2030 Proposed Contract Requirements

4.03 Teledentistry

- Contractor must report annually on teledentistry use, including enrollee utilization, service types, delivery models, and intended outcomes.
- Contractor must report how it informs enrollees about teledentistry services, costs, and interpreter access on key website pages.
- Contractor must continue to meet network adequacy standards for in-person services.

- **Adding** new reporting item:
  - How is Contractor leveraging teledentistry to expand access and enhance member engagement in care?

2028-2030 Proposed Contract Requirements

4.04 Participation in Collaborative Quality Initiatives No Changes

- Contractor must report annually on its participation in dental quality collaboratives or initiatives, including any financial support provided.
- Contractor must collaborate with Covered California to identify and evaluate effective programs for improving care, with potential future participation in required quality improvement and data sharing initiatives.

2027 Current Contract Requirements

Article 5: Measurement and Data Sharing

5.01 – Measurement and Analytics

- Contractor must submit dental claims and encounter data for specified measures to the Healthcare Evidence Initiative (HEI), collaborate on establishing benchmarks for dental performance measures, and participate in data quality reviews and refinements
- Contractor must work in partnership with Covered California to refine data measurement specifications, assure data quality, and comply with California law for sharing information on healthcare cost, quality, and disparities; may include providing HEI Data for audits, investigations, and health equity monitoring
- Contractor must adhere to Covered California's specifications for submitting data through an HEI Vendor, with obligations to transition smoothly between vendors as notified by Covered California
- Covered California may use submitted data for quality improvement purposes and for public reporting, under compliance with HIPAA and state laws to ensure the protection of Personal Health Information (PHI) and other sensitive data from public disclosure

Workgroup Comment Key Themes

Attachment 1 Article 5 – Measurement and Data Sharing

One issuer submitted comments:

- confirming current 5.01.1 reporting collects the information needed to produce required measures and suggested a possible enhancement: contractually requiring DHMO networks to report specific data encounters to improve visibility into utilization.
- recommending shifting the quality analysis approach to the member level to more accurately capture care for members with both embedded and standalone dental coverage.
- Affirming current 5.02 HEI data submission requirements provide a good picture of completeness and offered suggestions to further bolster encounter-data completeness — while noting that meaningful gains in DHMO encounter data would require industry-wide provider-contract changes and cautioning about the risk of provider attrition from DHMO networks.
- Noting that current 5.02.2 data exchange contract language appears broad enough to align with a potential HCAI/DxF expansion to dental data, but that a definitive assessment depends on the specifics of any future DxF expansion.

2028-2030 Proposed Contract Requirements

5.01 – Measurement and Analytics – No Changes

- Contractor must submit dental claims and encounter data for specified measures to the Healthcare Evidence Initiative (HEI), collaborate on establishing benchmarks for dental performance measures, and participate in data quality reviews and refinements
- Contractor must work in partnership with Covered California to refine data measurement specifications, assure data quality, and comply with California law for sharing information on healthcare cost, quality, and disparities; may include providing HEI Data for audits, investigations, and health equity monitoring

QDP 2028 Attachment 2 Updates

EQT Team

August 13, 2026

Current Contract: 2024-2027 QDP Attachment 2

Current Contract

- Total at-risk amount 2024-2027 is 1% of gross QDP premium across six Attachment 2 performance standards
- Covered California defines the percent of premium at risk as the share of a Contractor's total Gross Premium for the applicable Plan Year that is designated as at-risk for Attachment 2 performance.

Key Learning:

- EQT analysis of QDP performance on dental quality measures indicates improvements are needed, particularly for DHMOs
- Current 10% annual improvement expectation has the unintended consequence of being hardest to achieve for higher-performing QDPs

2024-2027 QDP Attachment 2 – Performance Standards and Penalties

Performance Standards with Penalties 1% gross premium at-risk		Percent At-Risk Amount 2024	Percent At-Risk Amount 2025	Percent At-Risk Amount 2026	Percent At-Risk Amount 2027
Data Submission 50%	1. Healthcare Evidence Initiative (HEI) Data Submission	45%	45%	45%	45%
	2. Provider Directory Submission	5%	5%	5%	5%
Oral Health 50%	3. Pediatric Oral Evaluation, Dental Services	5%	5%	5%	5%
	4. Pediatric Topical Fluoride for Children, Dental Services	5%	5%	5%	5%
	5. Pediatric Sealant Receipt on Permanent First Molars	5%	5%	5%	5%
	6. Adult Preventive Services Utilization	35%	35%	35%	35%

QDP Attachment 2: Proposed Percent At-Risk

Proposed Direction:

- Increase financial accountability for QDP performance with increased percent of gross premium at-risk for 2028-2030 Attachment 2 performance standards
- Covered California recommends raising the at-risk amount to more effectively influence plan behavior, along with offering technical assistance and implementing additional incentives for high performers

Proposed 2028-2030 QDP Attachment 2 percent at risk: 2.0%

QDP Attachment 2: Data Submission Performance Standards

Performance Standard 1: Healthcare Evidence Initiative (HEI) Data Submission

Measure of data completeness, format compliance, and justified deviations from historical patterns

Performance Standard 2: Provider Directory Submission

Measure of provider data submission

No changes proposed for 2028-2030

QDP Attachment 2: Oral Health Performance Standards

Performance Standard 3: Pediatric Oral Health Evaluation, Dental Services

Measure of enrolled children who receive a qualifying oral evaluation during the year

Performance Standard 4: Pediatric Topical Fluoride for Children, Dental Services

Measure of enrolled children who receive recommended topical fluoride applications as a dental service

Performance Standard 5: Pediatric Sealant Receipt on Permanent First Molars

Measure of enrolled children who receive dental sealants on their permanent first molars in the measurement year

Performance Standard 6: Adult Preventive Services Utilization

Measure of adult dental members who receive at least one preventive dental service during the plan year

Proposed for 2028-2030: Member Engagement (Pediatric and Adult)

Measure of adult dental members who receive at least one preventive dental service during the plan year

2028-2030 Proposed New Performance Standard: Pediatric and Adult Member Engagement

Requirement: Member Engagement

- **Aim:** Increase the proportion of Covered California members with any services in the measurement year (overall and by race/ethnicity subpopulation).
- **Description:** The percentage of pediatric and adult QDP members who utilized any services within the measurement period.
- **Pediatric Member Engagement:** Pediatric (aged 0-18) rates of receipt of any dental service within the measurement year
- **Adult Member Engagement:** Adult (aged 19 and older) rates of receipt of any dental service within the measurement year
- **Data Collection:** Covered California will use Healthcare Evidence Initiative (HEI) data submitted by contracted QDP Issuers to calculate measure rates.
- **Accountability:** Performance standard subject to penalty

Improvement Thresholds for Performance Standards 3-8 for 2028-2030

To address unintended consequences of current 10% annual improvement expectation, propose replacement with Performance Gap Reduction methodology:

- calculate performance gap between baseline rate and 70%
- require plans to reduce Performance Gap by at least 10% annually
- no penalty assessed for performance at or above 70% as established in 2027 contract amendment

Workgroup Comment Key Themes

Attachment 2

- Multiple Issuers questioned whether increasing the At-Risk amount from 1% to 2% would improve performance, emphasizing member engagement and addressing data limitations as more direct levers
- One Issuer requested maintaining the HEI data-submission weighting at 45%, while another issuer raised concerns that the updates don't fully balance data submission with advancing oral health outcomes, and recommended balancing outcome measures with plan-driven activities such as outreach, access facilitation, provider engagement, and data submission
- Multiple Issuers requested phased implementation with clear technical specifications, standardized reporting, readiness assessments, monitoring, and remediation before penalties apply
- One Issuer identified DHMO encounter-data gaps and Stand-Alone Dental Plan limitations in access to medical data as measurement challenges
- One Issuer raised concerns that new member engagement standards could duplicate existing measures and increase administrative complexity or provider attrition

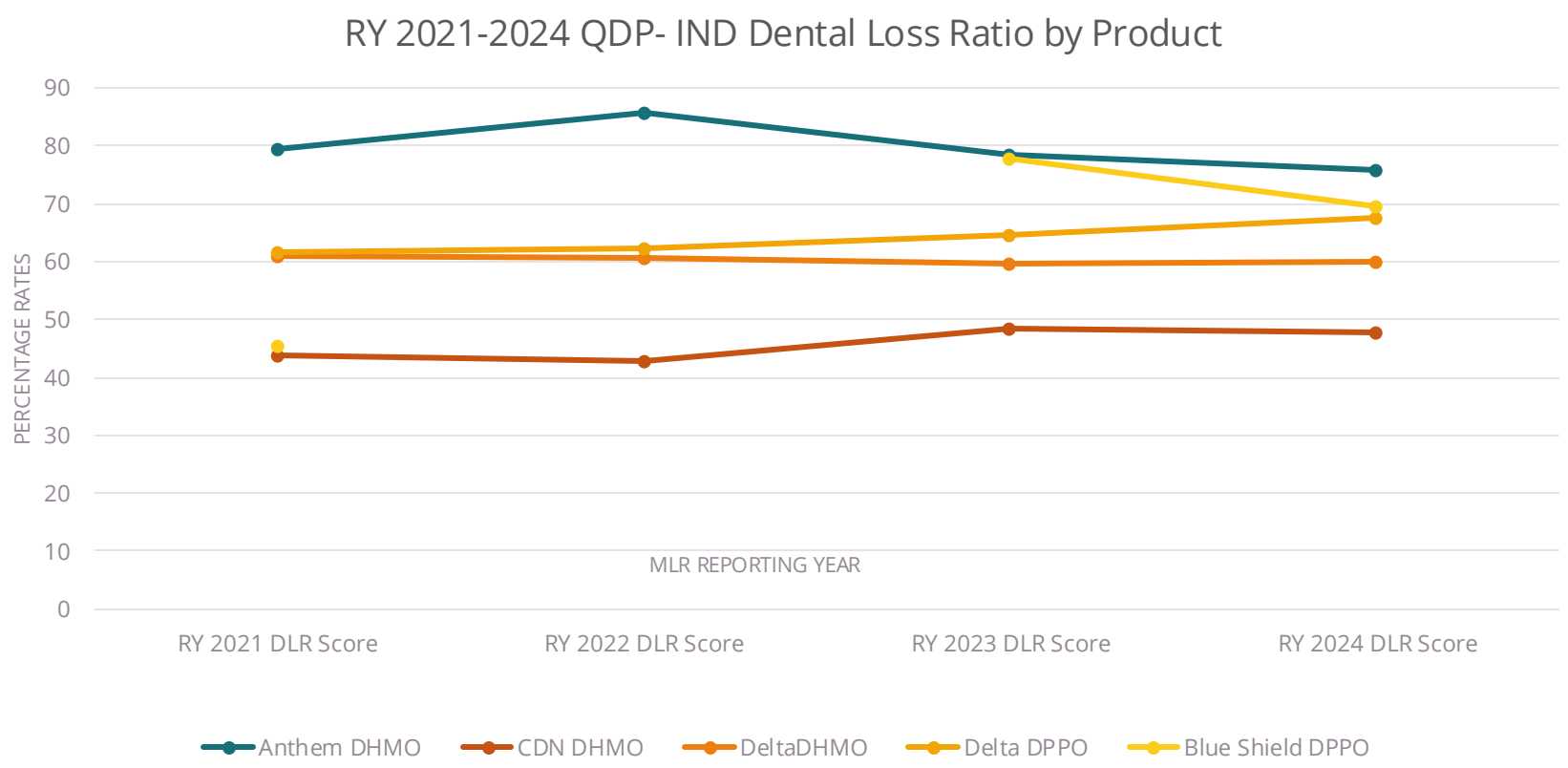
2028-2030 Proposed QDP Attachment 2 Proposed Performance Standards and Penalties

Performance Standards with Penalties		Percent At-Risk 2024-2027	Percent At-Risk Amount 2028	Percent At-Risk Amount 2029	Percent At-Risk Amount 2030
Data Submission	1. Healthcare Evidence Initiative (HEI) Data Submission	45%	30%	30%	30%
	2. Provider Directory Submission	5%	5%	5%	5%
Oral Health	3. Pediatric Oral Evaluation, Dental Services	5%	5%	5%	5%
	4. Pediatric Topical Fluoride for Children, Dental Services	5%	5%	5%	5%
	5. Pediatric Sealant Receipt on Permanent First Molars	5%	5%	5%	5%
	6. Adult Preventive Services Utilization	35%	25%	25%	25%
	7. New: Pediatric Member Engagement Pediatric (aged 0-18) rates of receipt of any dental service within the measurement year	N/A	5%	5%	5%
	8. New: Adult Member Engagement Adult (19 and older) rates of receipt of any dental service within the measurement year	N/A	20%	20%	20%

Current Contract Requirements: Attachment 3
Dental Loss Ratio Performance Standard and Expectation

- DLR definition: per AB 1962, regulatory metric measuring the share of premium revenue spent on dental services and quality improvement versus administrative costs or profit.
- Issuers must submit to applicable regulator the DLR report each plan year.
- Current contract requirements set a performance expectation of 50% DLR for each Covered California QDP.
- DLR is evaluated annually by product for Covered California business only.
- Requires monitoring, reporting, and corrective action, and subject to Section 7.4 Patterns of Noncompliance, but does not impose monetary penalties or rebates specifically for low DLR or outlier performance.

Covered CA QDP Individual Marketplace DLR by Product



62%
2021-2024 average DLR all QDP products

***Key takeaway**: there is no clear pattern in DLR by product*

Covered CA QDP Individual Marketplace DLR Insights by Product

- 62% average DLR all QDP products in 2021-2024
- Five of the six issuers met Covered California's 50% DLR expectation, while CDN DHMO remained below the 50% CCA threshold across DLR Reporting Years 2021–2024.
- Anthem's DHMO product reported the highest DLR among all products for the MLR 2021-2024 reporting period.
- Blue Shield's DHMO product reported a comparatively lower DLR, whereas Blue Shield's DPPO reported higher DLRs during the 2023-2024 DLR reporting period.
- Delta Dental demonstrated consistent and stable DLR across both the DHMO and DPPO product offerings.

Workgroup Comment Key Themes

Issuer Recommendations:

- **Product differences:** Covered CA should account for differences across issuers and products and avoid a uniform DLR requirement to avoid premium increases and reduced support for networks, service, and operations.
- **Framework and threshold:** Covered CA should use an NCOIL-informed, multi-year framework to identify and address outliers; Covered CA should not adopt a 62% threshold without actuarial support, transparency, and validation.
- **Reporting:** Covered CA should require a feasible DLR reporting process that improves oversight or outcomes.
- **Implementation safeguards:** Covered CA should phase implementation and use calibration, actuarial review, market monitoring, transparency, and stakeholder feedback before enforcement.
- **Performance improvement:** Covered CA should support performance improvement through prevention, member engagement, equity requirements, and collaborative, evidence-based implementation rather than more rigid or punitive approaches.

2028-2030 Proposed Contract Requirements: DLR Performance Standard and Expectation

- Attachment 3 will set the DLR requirement at **62%** for each Covered California QDP product, reflecting the average DLR across Individual Marketplace QDPs.
- Contractors will continue submitting annual DLR reports by product for Covered California business.
- Covered California will monitor performance against the 62% requirement during the 2028–2030 contract term without applying a financial penalty.
- Covered California anticipates moving the DLR expectation to Attachment 2 and applying a financial penalty in the next contract cycle.

2028 Contract Drafts & Public Comment

California's Health Benefit Exchange Website (HBEX)

California's Health Benefit Exchange - Plan Management

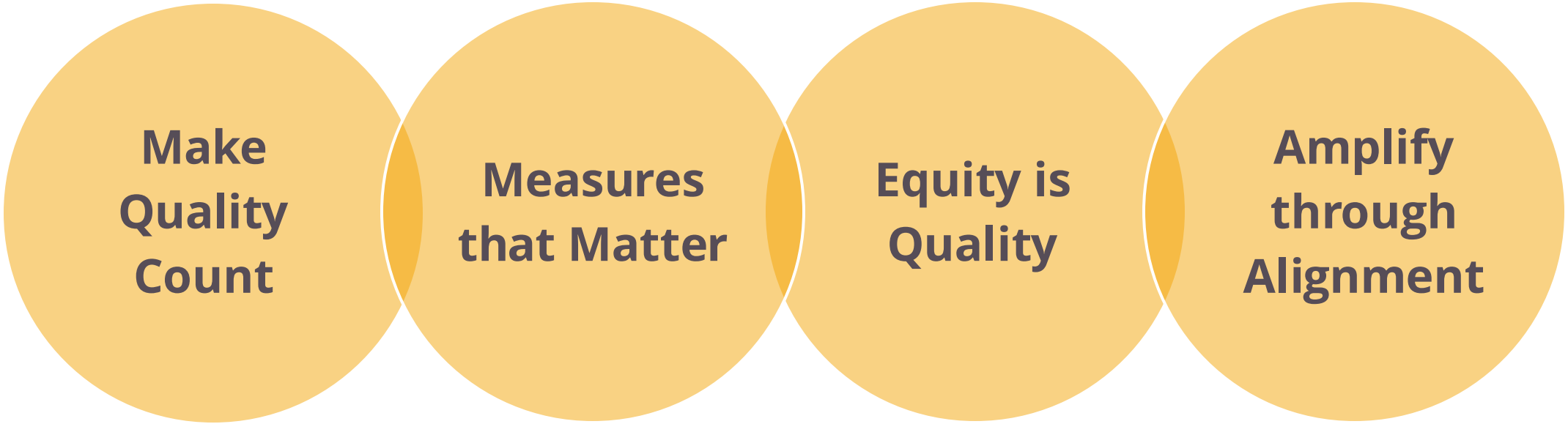
- 2028 QHP and QDP Contract Drafts and Comment Templates will be posted to HBEX today, **August 13, 2026**
- Stakeholders will have until COB, Friday, **September 11, 2026** to provide comments on all contract documents

Any questions please email PMDContractsUnit@covered.ca.gov

Update On 2025 & 2026 Population Health Investments

Joy Dionisio, MPH
QI Manager, Health Equity and Quality Transformation (EQT)

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

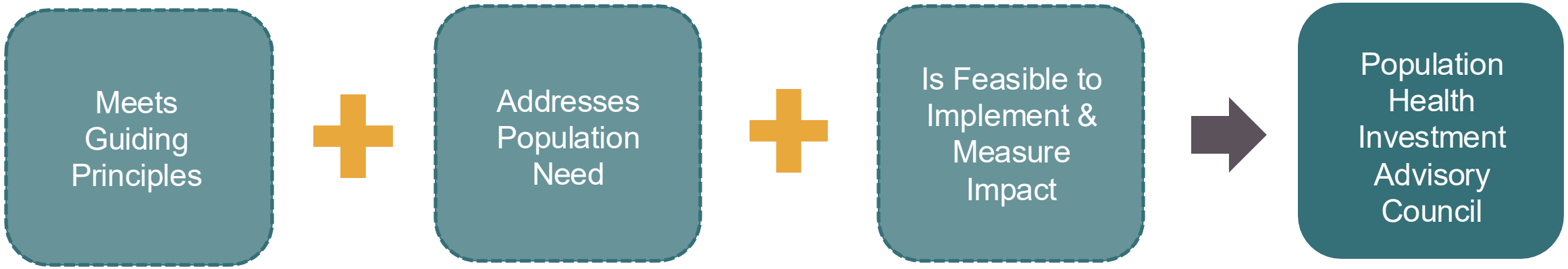
Equity First: funds should preferentially focus on geographic regions or communities with the largest identified gaps in health and quality among California subpopulations

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



Current Population Health Investments

1

Early Investments in Childhood Health and Wellness

- Funds deposited directly into CalKIDS Child Scholarship Account to incentivize timely vaccination and well-child visits
- Targets families with newborns enrolled in Covered California and children under 2 years old

2

Direct Investments to Enhance Food Security

- Reusable cards loaded with funds available for use at grocery stores and other retailers with food facilitated by a third-party for disbursement and data collection.
- Targets Covered California members with income levels below 250% of the Federal Poverty Level (FPL), with certain chronic conditions

3

Equity and Practice Transformation

- Funds will accelerate adoption of practice transformation through high-quality, 1:1 coaching, subject matter expertise, and foster sustainable practice change and disseminate innovative models statewide.
- Targets primary care practices enrolled in DHCS EPT program and serving Covered California enrollees

4

Health Professions Pathways Program

- Targets California workforce by focusing on select health professional shortage areas which most impact Covered California members
- Leverages HCAI's HPPP infrastructure to invest $4.8M in a health workforce

Child Savings Account Program

Program and Evaluation Update

Child Scholarship Account (CSA) Program

Enrollment Highlights

843
Households enrolled

324
Unique participants newly claimed their CalKIDS account

$300,200
Deposited into CalKIDS accounts

2,497
Program steps completed

Key Learnings

- ~35% of enrolled members did not complete the first step necessary to claim funds (CalKIDS registration)
- Direct outreach found program not being viewed as current priority a barrier to completion
- Broader awareness of CalKIDS needed

Adaptive Outreach Strategies

- Refined outreach cadence, including increased attempts, peak-day scheduling and IVR primer to all
- Conducted two separate targeted messaging campaigns to test different language and cadence for enrolled members not claiming steps
- Continue to explore use of delegated enroller agents for direct outreach encouraging step completion

CSA Program External Evaluation Update

Led by Adam Schickedanz, MD PhD, and Monique Holguin, LCSW PhD, from UCLA Dept of Pediatrics

Participant Perceptions & Experiences	Implementation & Process Assessment	Care Quality Outcomes Evaluation	Other Health Outcomes Evaluation
What is the participant experience?	How to improve the process?	More visits and vaccinations	Other changes in family health?
• Confirm feasibility • Understand barriers and facilitators • Improve experience	• Examine program processes, including uptake, reach, delivery approach, and follow-through • Overall and by sub-population to understand process equity • Informs future implementation and sustainability	• Examine program impact on primary outcomes at the individual and population levels • Equity - impact for whom?	• Examine program impact on health and health care for parents and children • Equity – Impact for whom? Process eval improvements? • Spillover effects on quality of life, parenting, finances, satisfaction?

Learning Directly From Participants

Interviews offered direct insight from participants in their own words

Key Informant Interviews

Conversations with 20 parent participants covered questions about perceptions of, attitudes toward, and experiences with the CSA Program

Participants Were:

- CSA Program Enrollees
- Recruited by email and phone
- English-speaking

The Interviews:

- Lasted 20-30 minutes
- Structured with standard questions and prompts
- Transcribed, de-identified at transcription, and coded for themes

The CSA Program Was Well-Accepted Among the Busy Parent Enrollees

Perceptions of CSA Program Among Most Participants:

- Participants supported the program initiative and saw it as aligned with Covered California's mission and role
- The program did not change participants' view of Covered California
- Main barrier to milestone completion: being busy with infant caregiving, competing parental and work priorities
- Main feedback for uptake and engagement: find ways for participants to hear about the CSA Program in the usual course of care or plan onboarding from trusted messengers (not just emails and texts at the time of enrollment outreach)

"I just never heard of it ever, and no one's ever mentioned it. I think it's a really cool program. So, why is it secret?"

- CSA Program Parent Participant

The CSA Program Target Population is Busy Parents

Interview participants (and program enrollees) appear to be more proactive, more likely to have a CSA than the general population

Applying these insights:

- Interview results suggest participants were more likely to be activated, aware of CSAs/CalKIDS, and open to taking up programs generally
- Enrollee self-selection may limit generalization of evaluation results beyond program enrollees
- Information from non-enrollees, including demographics and interviews, would help determine the degree to which enrollee self-selection may be affecting eval results
- Reaching future potential participants who are more marginalized (or simply wary of text/email offers that seem too good to be true) may require more personalized and relational outreach strategies

Equity and Practice Transformation

Program and Evaluation Update

Equity and Practice Transformation (EPT)

Covered California investment accelerated adoption of population health infrastructure, data sharing, and equity-focused care improvement across 45 EPT practices serving Covered California and Medi-Cal members.

45 Covered California cohort practices **26,157** Covered California enrollees **617,714** Medi-Cal lives

YEAR 1 HIGHLIGHTS

Meeting Key Performance Indicators

	Nov 2024		Dec 2025
Access Third next available appointment under 10 days	62%	→	82%
Empanelment More than 90% of patients empaneled	27%	→	48%
Continuity Practice continuity above 70%	62%	→	68%

Completing EPT Milestones at High Rates

15 of 18
prior-cycle EPT milestones have been accepted by 84% or more of Covered California practices

100%
completed data governance assessments and MCP-provided HEDIS measure submissions

96%
have accepted data implementation plans and stratified HEDIS reports

93%
adopted clinical guidelines and enhanced outreach & engagement strategies

91%
implemented pre-visit planning workflows

EPT Year 1 Program Evaluation Report

The PopHealth Learning Center (PHLC) provided in depth findings about Covered California EPT

Practices Rate Covered California EPT Highly

96.7%
of DxF Bootcamp participants found sessions a valuable use of time

90.9%
rated Approachable AI sessions 9 or higher

80%
rated EHR User Groups 8 or higher

Scores reflect likelihood to recommend the activity to other practices on a 1-10 scale (10 = very likely).

Engagement is translating into results:
15 CCA cohort practices achieved acceptance of their Data Policy & Procedure deliverable following participation in a CCA-funded DxF Bootcamp.

"Honestly, everything has been very helpful and informative. I haven't come across anything yet that was either a waste of time or that I couldn't use."
- Vishwa Kapoor, participating practice

Practices Improved Across All Eight PhmCAT Domains

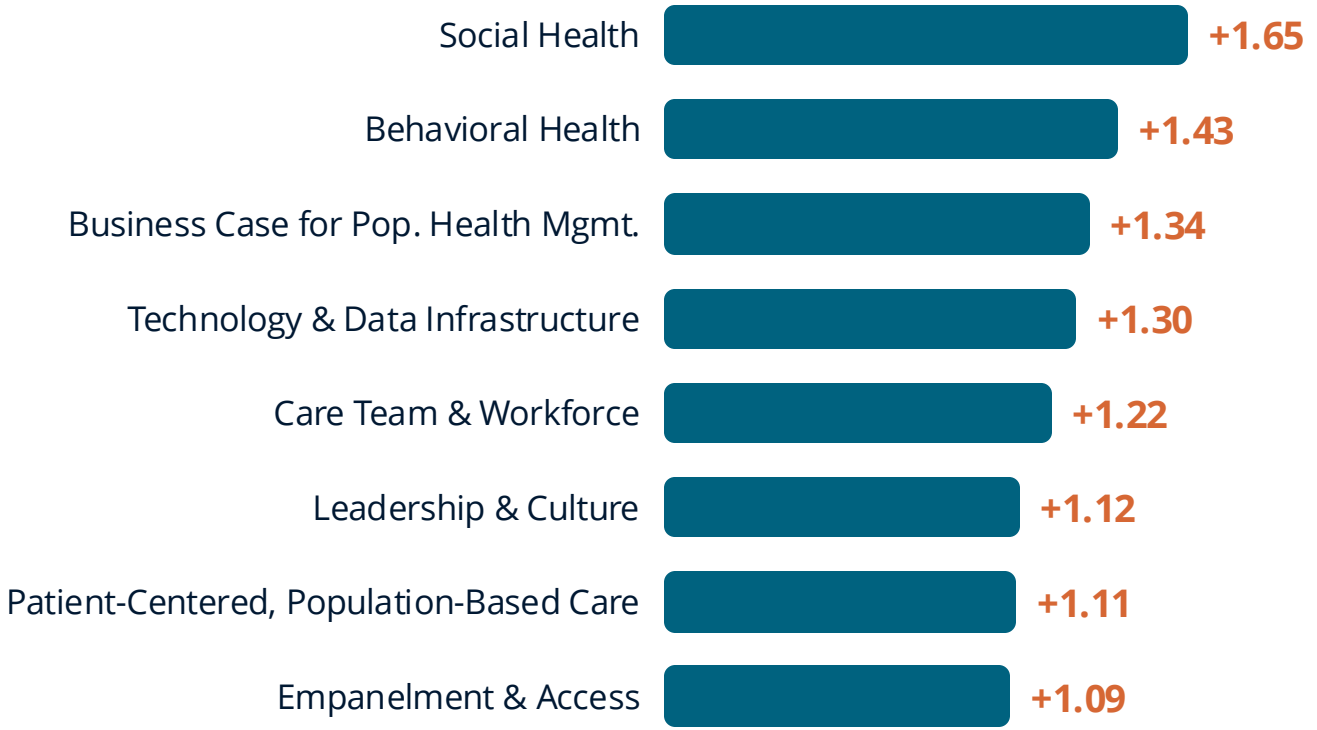
The PhmCAT is a practice self-assessment scored 1 to 10 across eight population health domains, completed annually (baseline May 2024).

64%

of practices improved their composite score

+1.10 average gain from a 6.09 baseline

Average score gain by domain, May 2024 to Sept 2025



PhmCAT: Population Health Management Capabilities Assessment Tool. Average gain in self-assessed domain score among 45 CCA practices.

Practice Impact: Closing Equity Gaps in Care

Doctors on Duty: Depression Screening Follow-Up

The gap: Spanish-speaking patients were less likely to receive follow-up after a positive depression screening than English-speaking patients (43% vs. 58%).

The response: With support from enhanced TA and Design Studio participation, the practice:

- Developed a standardized Epic work queue to ensure timely follow-up outreach
- Leveraged bilingual staff for patient outreach and engagement
- Expanded telemedicine options to reduce transportation and scheduling barriers
- Reinforced equitable follow-up workflows through staff training

The result: Follow-up rates among Spanish-speaking patients increased from **43% to 52.4%** in the subsequent reporting cycle, narrowing the disparity and improving equitable access to behavioral health follow-up care.

"Previously, we were losing data. Now, we can easily share data, helping us screen and follow up for depression. We are seeing measurable improvements. Overall, PHLC is supporting us, not just evaluating us."

- Cedars Family Medicine

"It was an eye-opening experience to be required to stratify our data in ways that we would not have done on our own. Identifying those disparities in certain patient populations has been an important step."

- Serve The People

2026: Driving Sustainable, Scalable Solutions

Phase II builds on 2025 outputs to drive sustainable, data-enabled workflows at the site level, **packaging tested solutions for wider scalability across PHLC's statewide learning network.**

Q1-Q2

Identify & Assess

Use EPT performance data to identify practices with the greatest opportunity for improvement on CBP, HbA1c, CIS, and COL measures

Q2-Q4

Co-Design & Activate

Co-design and activate 1-3 measurable workflow changes per practice; validate data flow and measure calculation through 8–12-week sprints

Q3-Q4

Package & Scale

Track change with run charts and feedback loops; disseminate tested solutions by December 2026

Success measures: participating practices activate 1 – 3 measurable workflows and demonstrate improvement in one of four priority HEDIS measures, alongside continued PhmCAT and KPI gains through the close of EPT.

Health Professions Pathways Program

Program Update

HCAI Health Professions Pathways Program (HPPP)

The HPPP supports and encourages individuals in shortage areas to pursue health careers and develop a needed workforce in primary care and behavioral health. To address California's healthcare workforce shortages, Covered California is investing PopHI funds – through a new partnership with the Department of Health Care Access and Information (HCAI) – to leverage their Health Professions Pathway Program (HPPP).

The goal is to correct workforce demographic imbalances and improve access to culturally and linguistically concordant providers for Covered California enrollees.

HPPP expands California's health workforce across the continuum by awarding across four (4) categories:

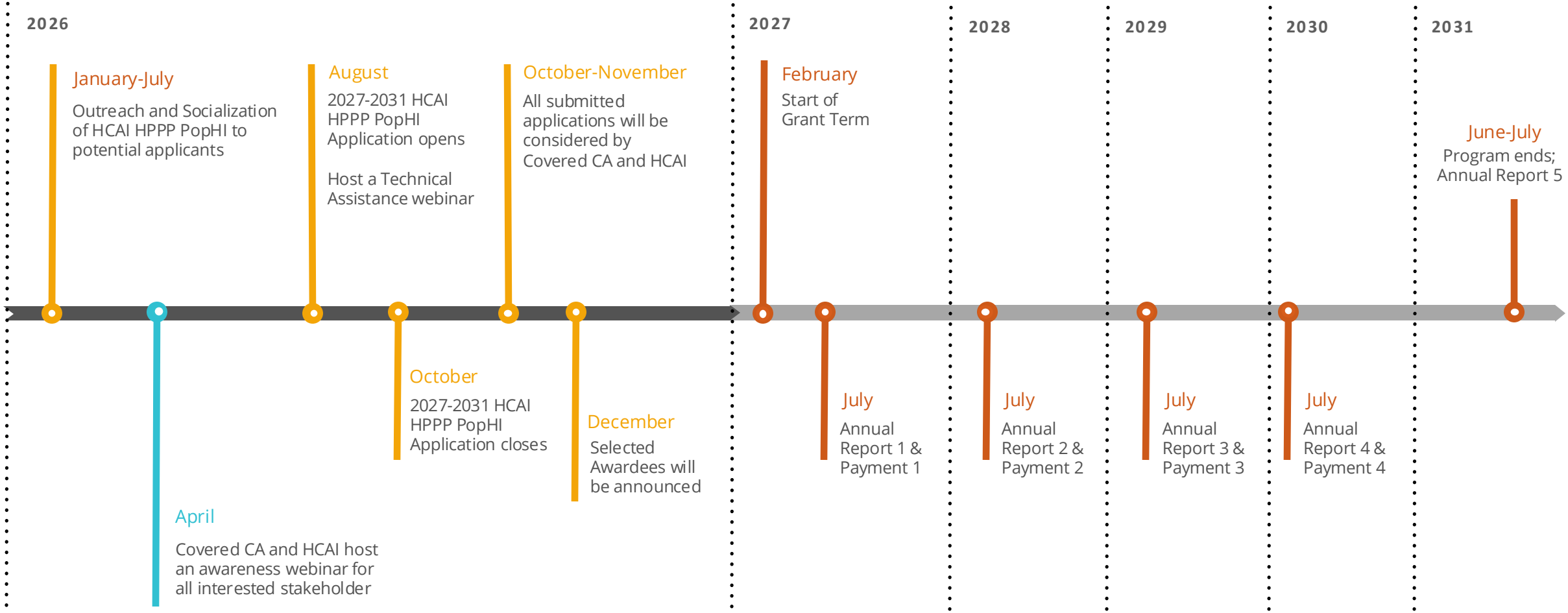
1. Award Category A: Pipeline Program
2. Award Category B: Summer Internships
3. Award Category C: Post Undergraduate Fellowships
4. Award Category D: Post Baccalaureate Scholarships

Available Funding: $4,800,000

2026-2027 Grant Application will be released in mid-August 2026.

Application Deadline: October 16, 2026 at 3 pm

HPPP Timeline



Grocery Support Program

Program and Evaluation Update

Grocery Support Program Year 1

Enrollment Highlights

6,972 **Households enrolled**

13,086 **Household members impacted**

$1,646 **Average award amount per household**

~$5M **Spent by members March 2025 - February 2026**

Member Feedback

“We can prepare meals together, which we were not doing, because we're not just eating rice and beans, we're eating veggies & fruits. We're unified now, because now they're like, well, what are we having for dinner? We didn't do that before.”

“Before I was living you know on ramen, cheap stuff... Now I can eat leafy greens, and I can have a snack if I want. I don’t have to think maybe I can’t afford this.”

"We used to go to the Food Bank, but with the card we don't anymore. That's a big change. We'll buy fresh food. At the food bank it is whatever they have over there. With the card, you can choose where to go.”

Grocery Support Program Year 2

Enrollment Highlights

6,041

Total households enrolled

4,664

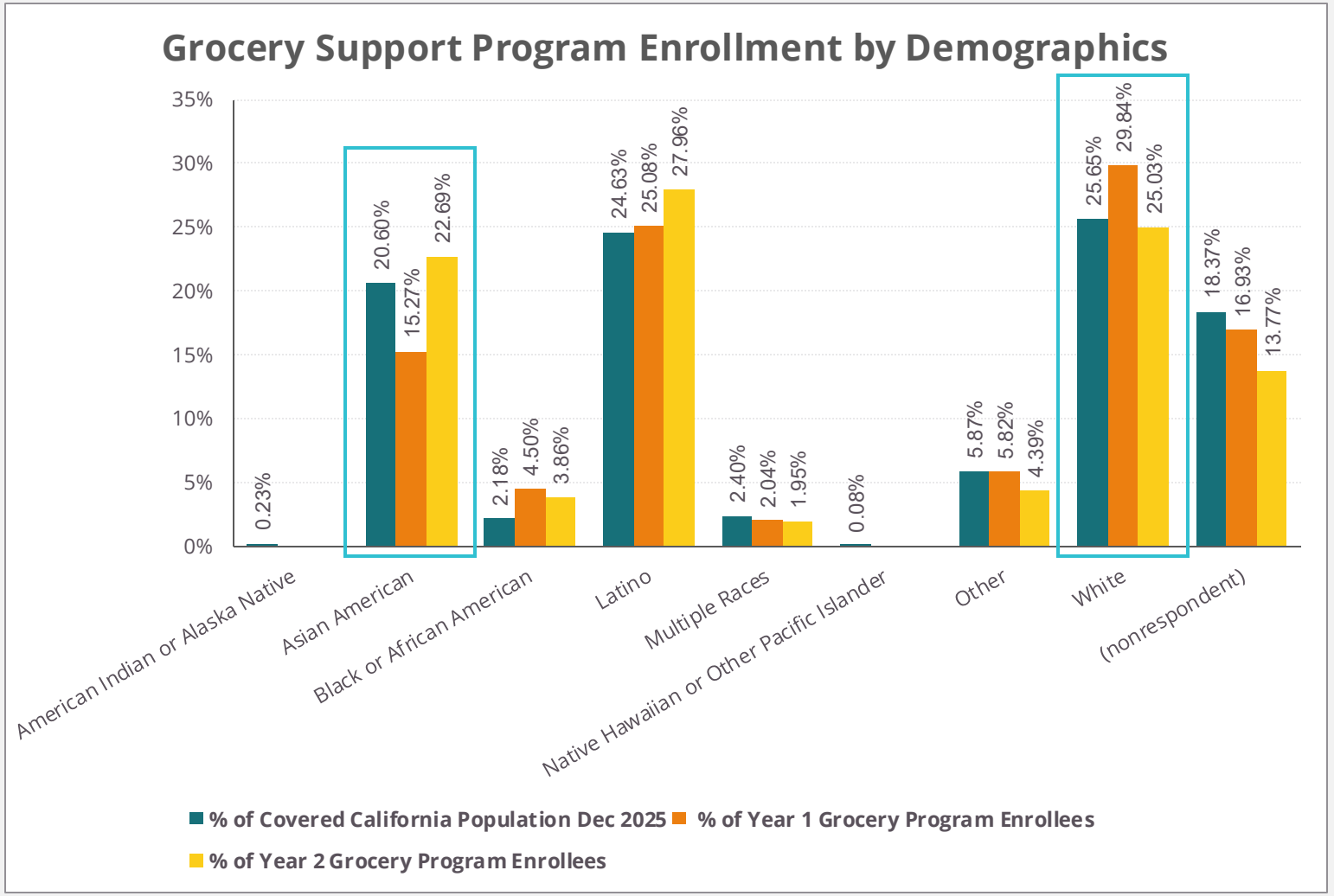
Households continuing from Year 1

12,006

Household members impacted

$1,839

Average award amount per household



Blank areas are suppressed data due to counts too low to report.

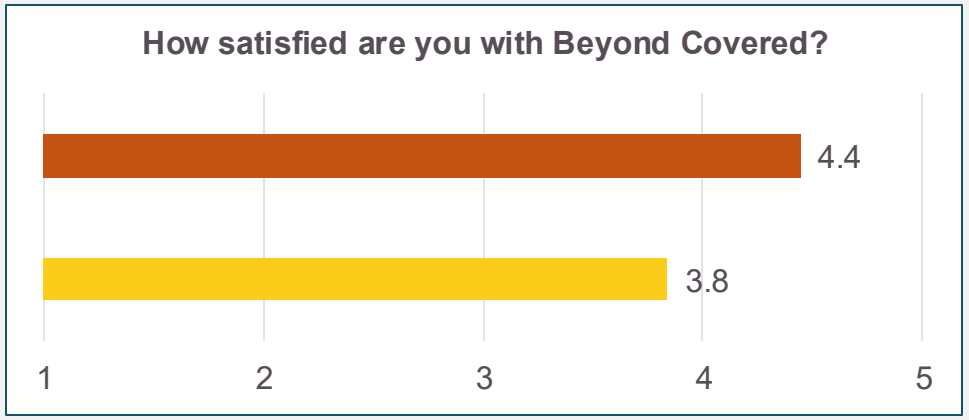
Grocery Support Program Year 1 Evaluation

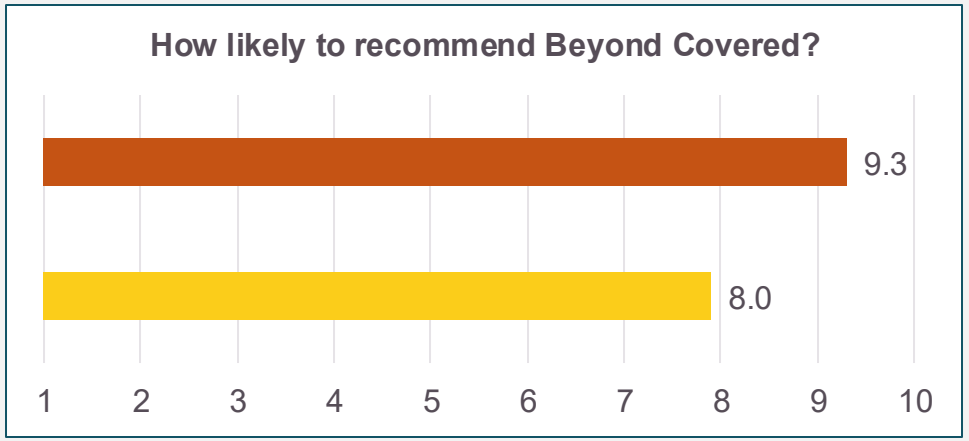
Overview

- Covered California commissioned an independent external evaluation of the Year 1 Grocery Support Program, conducted by UCSF SIREN (Social Interventions Research and Evaluation Network)
- Rigorous randomized waitlist-control design; enrolled population of ~6,975 households (Feb. 2025)
- Data sources: baseline and 12-month surveys (74.7% and 68.6% response rates), FORWARD program spend data, and qualitative interviews at midpoint (n=25) and 12 months (n=20)

The UCSF SIREN team will present their findings at the August 2026 Board meeting. The presentation and materials will provide a deeper look at the evaluation methodology, demographic findings, and outcome data.

Program Satisfaction





Source: Covered California 12-month Survey Complete Sample (n=4,246)

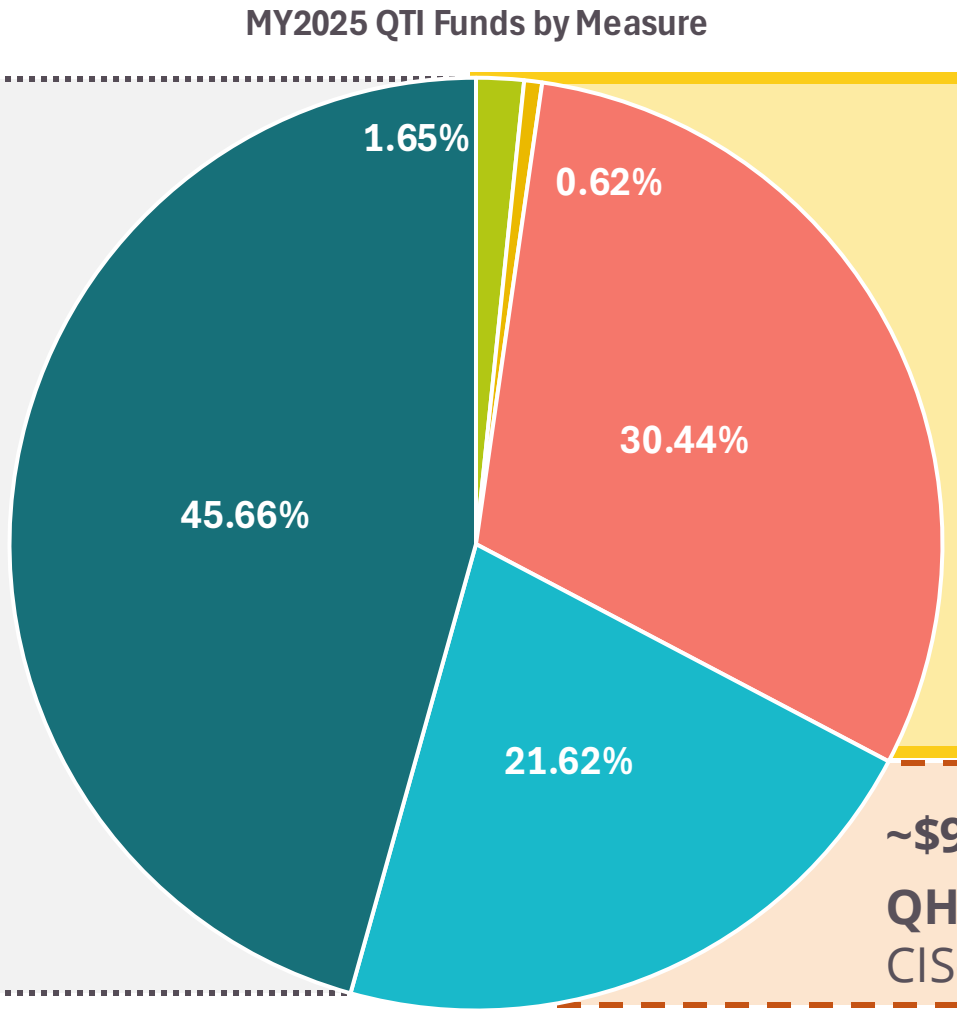
Proposed 2027 Population Health Investments

Barbara Rubino, MD
Associate Chief Medical Officer
Health Equity and Quality Transformation (EQT)

Estimated 2027 QTI Payment

~$19 Million

QHP Issuers to **Retain** 60% of MY2025 CIS-10 Funds (after QTI Allowance) for use in permissible Issuer-led Quality Improvement Activities



~$13.6 Million

To be allocated to **Covered California** selected **2027 PopHIs**

~$9 Million

QHP Issuers Savings through CIS-10 Allowance Program

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.

2027 Population Health Investments

2026 PopHI Budget: **$18.9M** → 2027 Estimated PopHI Budget: **$13.6 M**

1 Early Investments in Childhood Health and Wellness

- No new funds will be directed to this PopHI in 2027; focus is on spending down original funds allocated in Year 1
- Continued incentivization of timely vaccination and well-child visits for families with children under 2 enrolled in Covered California

2 Direct Investments to Enhance Food Security

- Reusable cards loaded with funds available for use at grocery stores and other food retailers, facilitated by a third-party for disbursement and data collection
- ***New in 2027***: Transportation as a permissible card use, expanding access for members facing mobility barriers

3 Equity and Practice Transformation

- Continue building on Year 1 infrastructure to drive sustainable, data-enabled workflows at the practice level and package tested solutions for wider scalability across PHLC's statewide learning network
- Targets primary care practices enrolled in DHCS EPT program serving Covered California enrollees, with priority given to those with the greatest opportunity for improvement on CBP, HbA1c, CIS-10, and COL measures

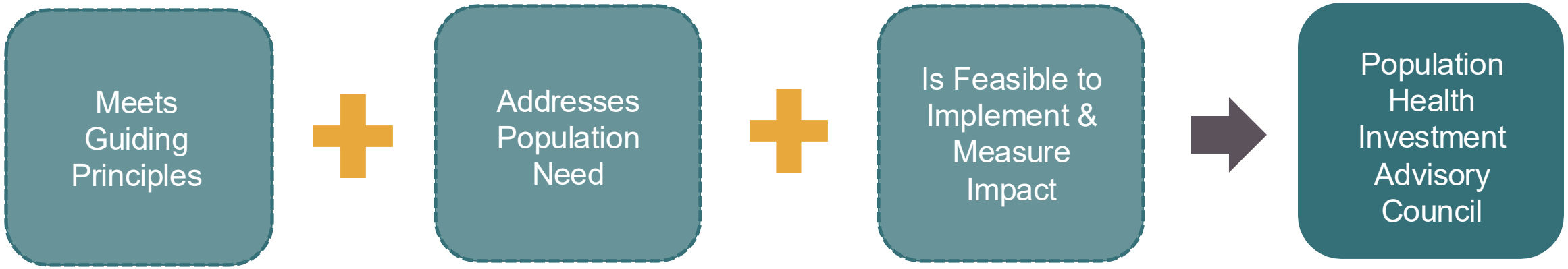
4 Health Professions Pathways Program

- No new funds will be directed to this PopHI in 2027; the initial 2026 investment of $4.8M is structured to be spread over 5 years through HCAI's HPPP infrastructure
- Targets California workforce by focusing on select health professional shortage areas which most impact Covered California members

5 Public Health for All Californians Together (*NEW*)

- Invests in the Public Health for All Californians Together (PHACT) Coalition, to build trust and strengthen statewide health communications
- Addresses vaccine hesitancy, declining childhood immunization rates, and low trust in healthcare through community-centered, culturally appropriate outreach
- Targets regions and populations with the greatest gaps in vaccination rates and healthcare engagement

Population Health Investments: Selection Criteria



Population Needs Assessment

Conducted to collect themes and indicators of where investment is needed

Qualified Health Plan Engagement

- Hesitancy and families repeatedly declining vaccinations

Consumer Advocate & Community Based Organization Engagement

- Trust & relationship-based interventions successful – CHWs
- Desire aligned communications from clinic, health plan, and health departments
- Want sources of consistent, trusted information

Patient Engagement

- Confusion about vaccine recommendations
- Challenges with accessing timely pediatric appointments
- Many, disparate sources of information with conflicting advice

Provider & Practice Engagement

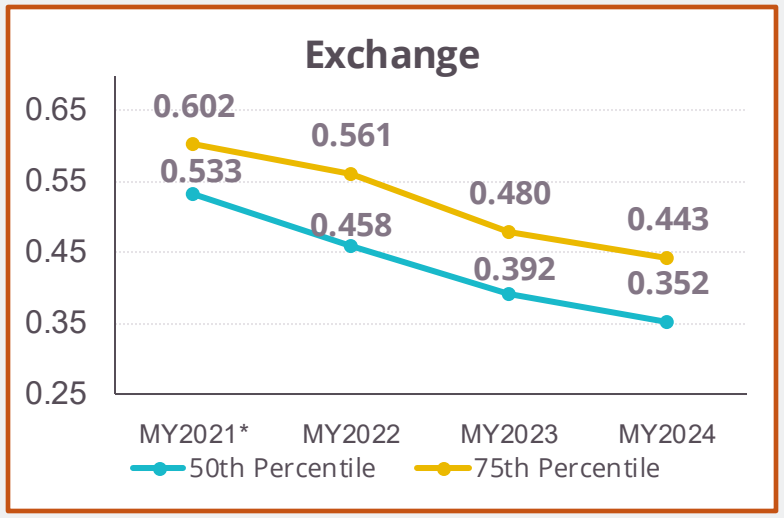
- Need more time during visits to discuss points of confusion / questions that families bring
- Inconsistent systems to identify patients proactively due for vaccines
- Inconsistent workflows across practices

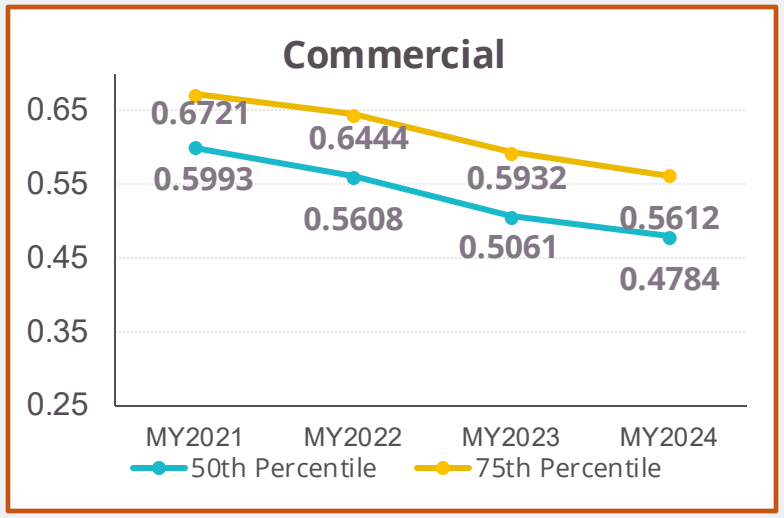
Population-level Geo-mapping

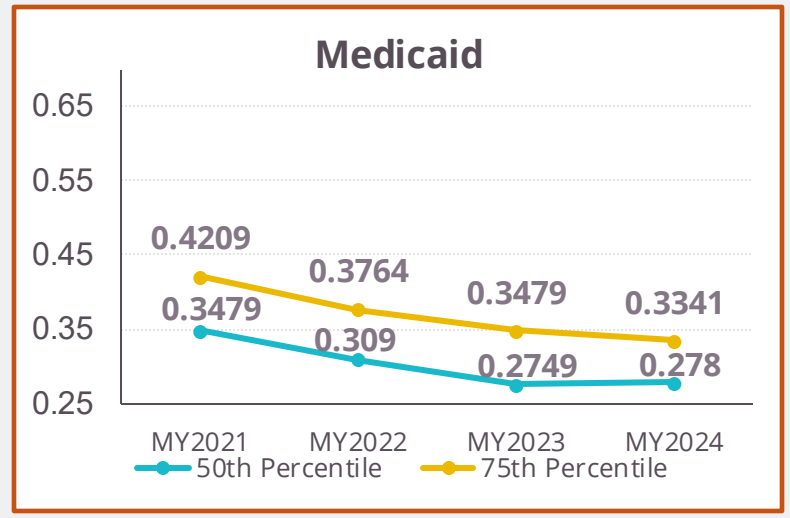
- Declining vaccination rates in White population, rural communities such as Northern Counties, Central Valley, Inland Empire

National Declines on Childhood Immunization

National CIS-10 Trends







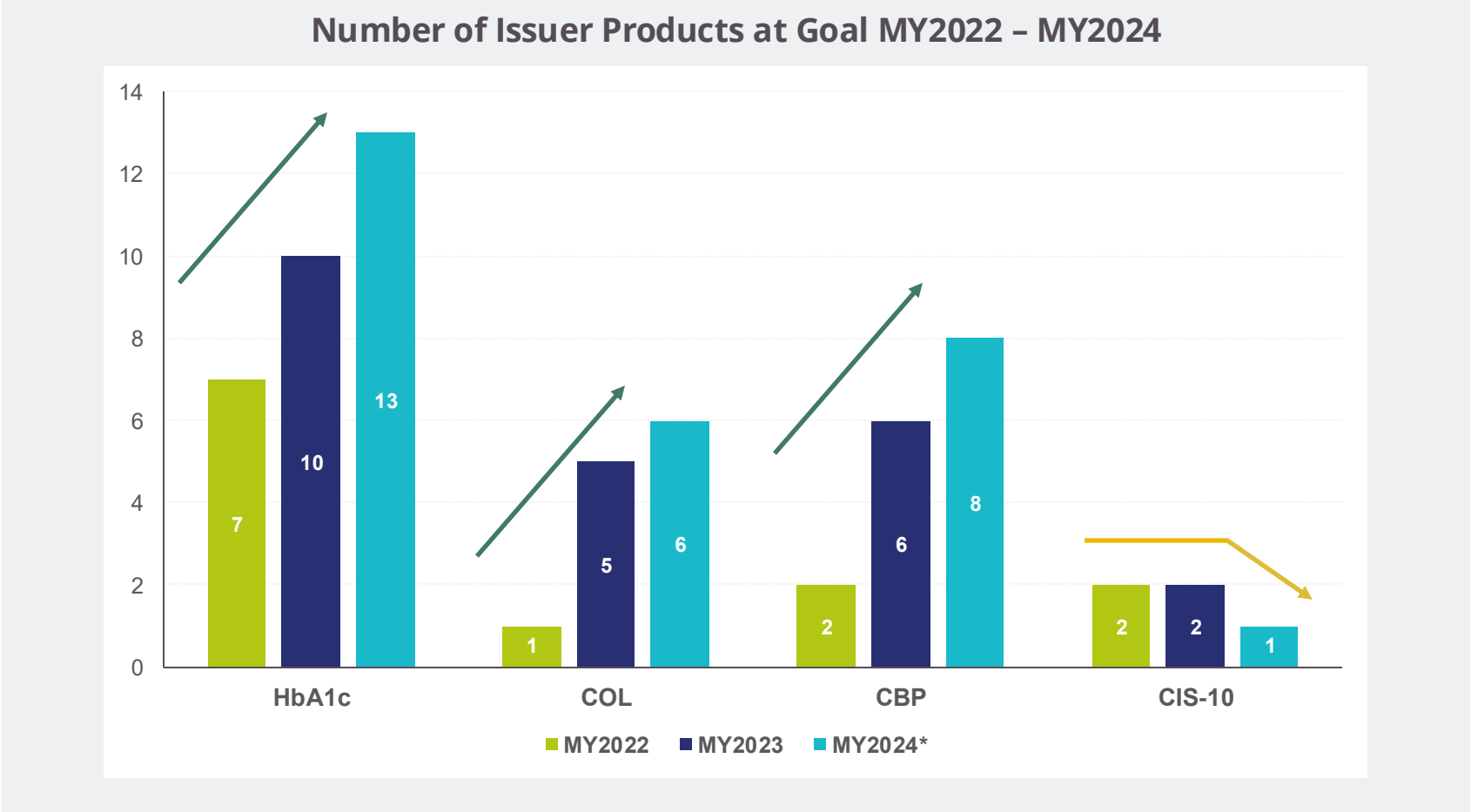
Factors that contribute to low performance on CIS-10 measure:

- Caregiver vaccine fatigue after COVID-19
- Healthcare systems are struggling with access in primary care and declines in usual source of care persist
- Declining vaccine confidence
- Variation in immunization guidance (federal vs state)
- CDC allowable catch-up schedule is not fully captured in CIS-10 measure specifications

*MY2021 Only reported, not scored.

Forward Progress on All QTI Measures, Except CIS-10

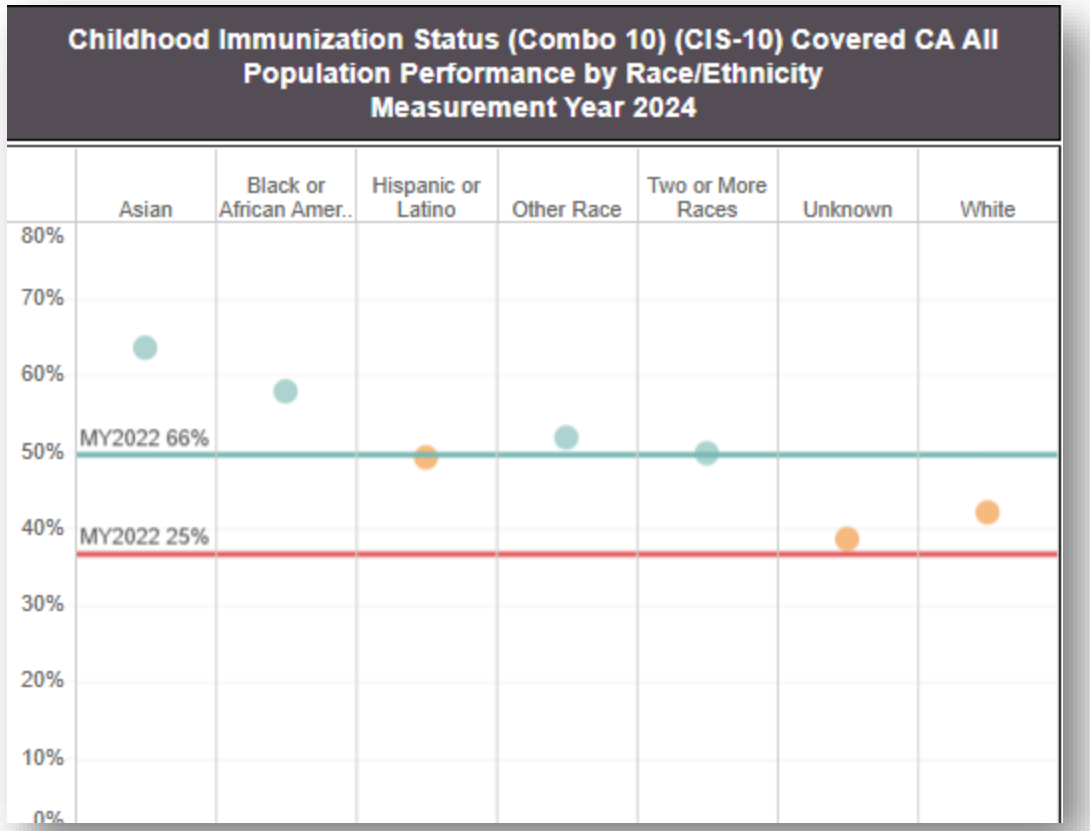
There has been a year-over-year increase in the number of products reaching the QTI goal of the 66th Percentile for HbA1c, COL, and CBP

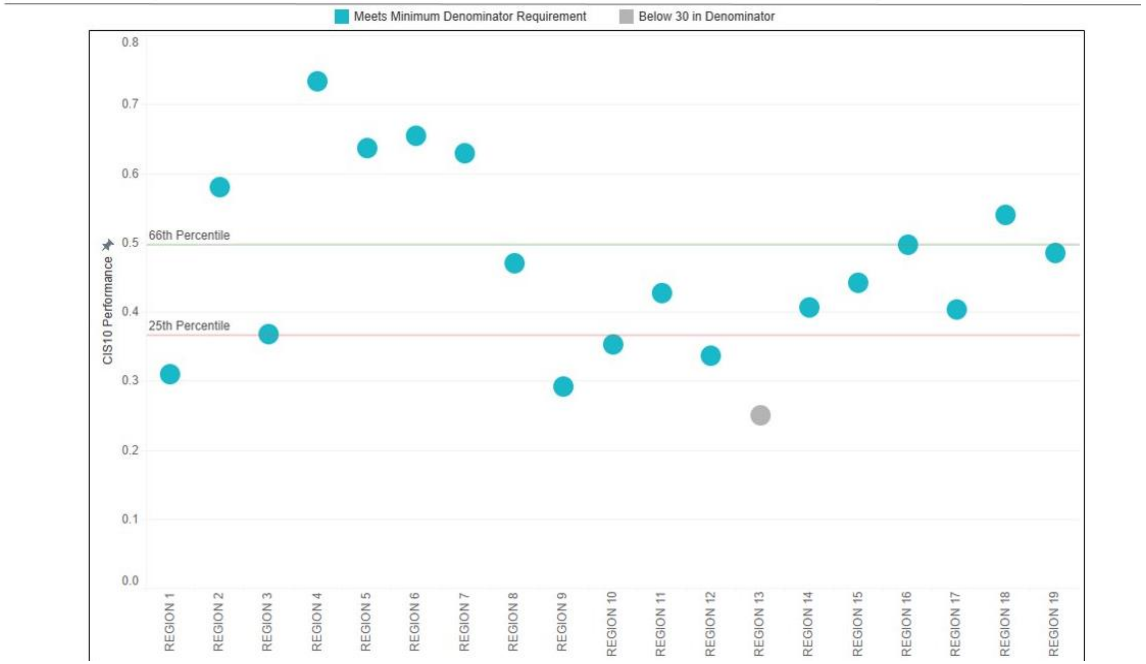


For MY2023 and 2024 13 issuer products were eligible for all QTI measures except CIS-10 where only 10 products were eligible

Declining Vaccination Rates Not Evenly Distributed Across Covered California's Population

Data shows lowest rates of CIS-10 in the White population and in regions in the far north and central California

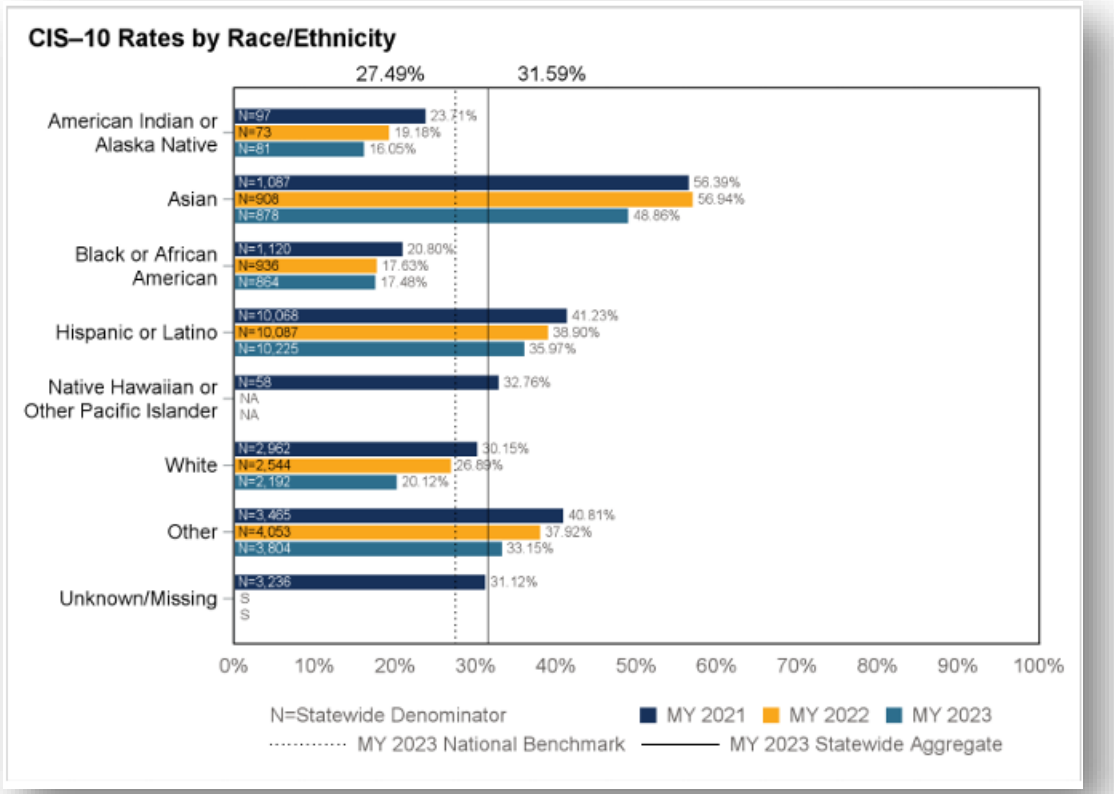


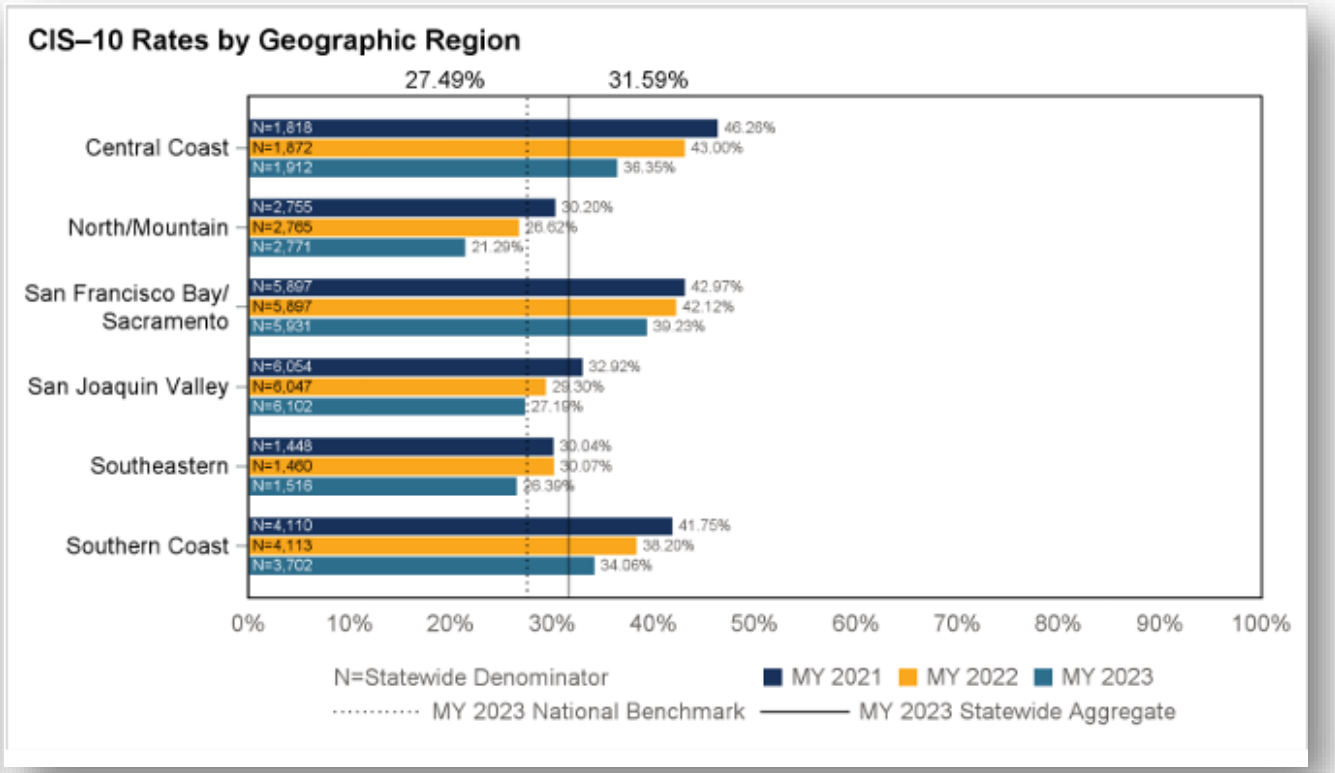


https://hbex.coveredca.com/data-research/plan-performance-reports/

Statewide Data Confirms Regional and Racial Disparities in Vaccination Rates

DHCS data also shows declining vaccination rates for the White population and those in the North/Mountain Region





https://www.dhcs.ca.gov/wp-content/uploads/2025/10/CA2023-24-Preventive-Services-Report-F2.pdf

Current Challenges Necessitate a Systems Approach

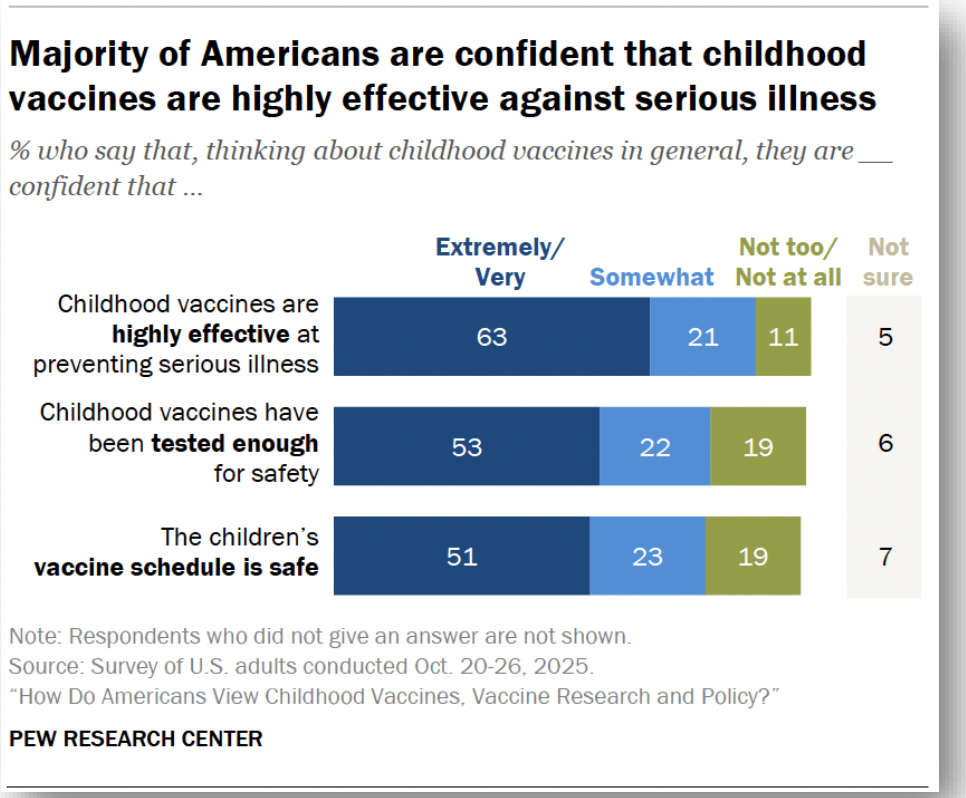
- Access challenges persist
- Vaccine hesitancy increasing in certain populations
- Declining trust in healthcare organizations
- Limited focus on long term impacts

Root Cause #1: Access challenges persist across many of our rural regions

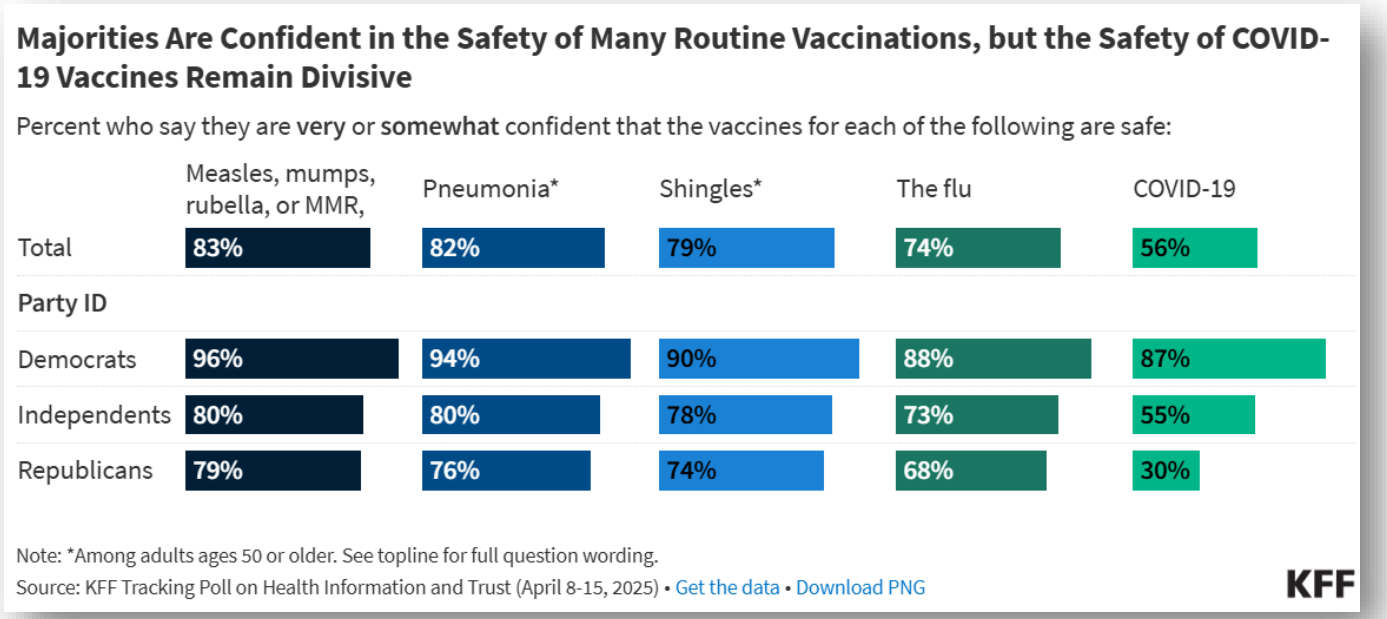
- Regions where <35% of Covered California children were up to date on Well Child Visits in MY2024:
  - Region 1 (Northern Counties)
  - Region 13 (Eastern Counties)
  - Region 14 (Kern County)
  - Region 17 (Inland Empire)

https://hbex.coveredca.com/data-research/plan-performance-reports/hei-preventive-dashboard/

Root Cause #2: The majority of people still support most vaccinations, but vaccine hesitance and reluctance is highly visible



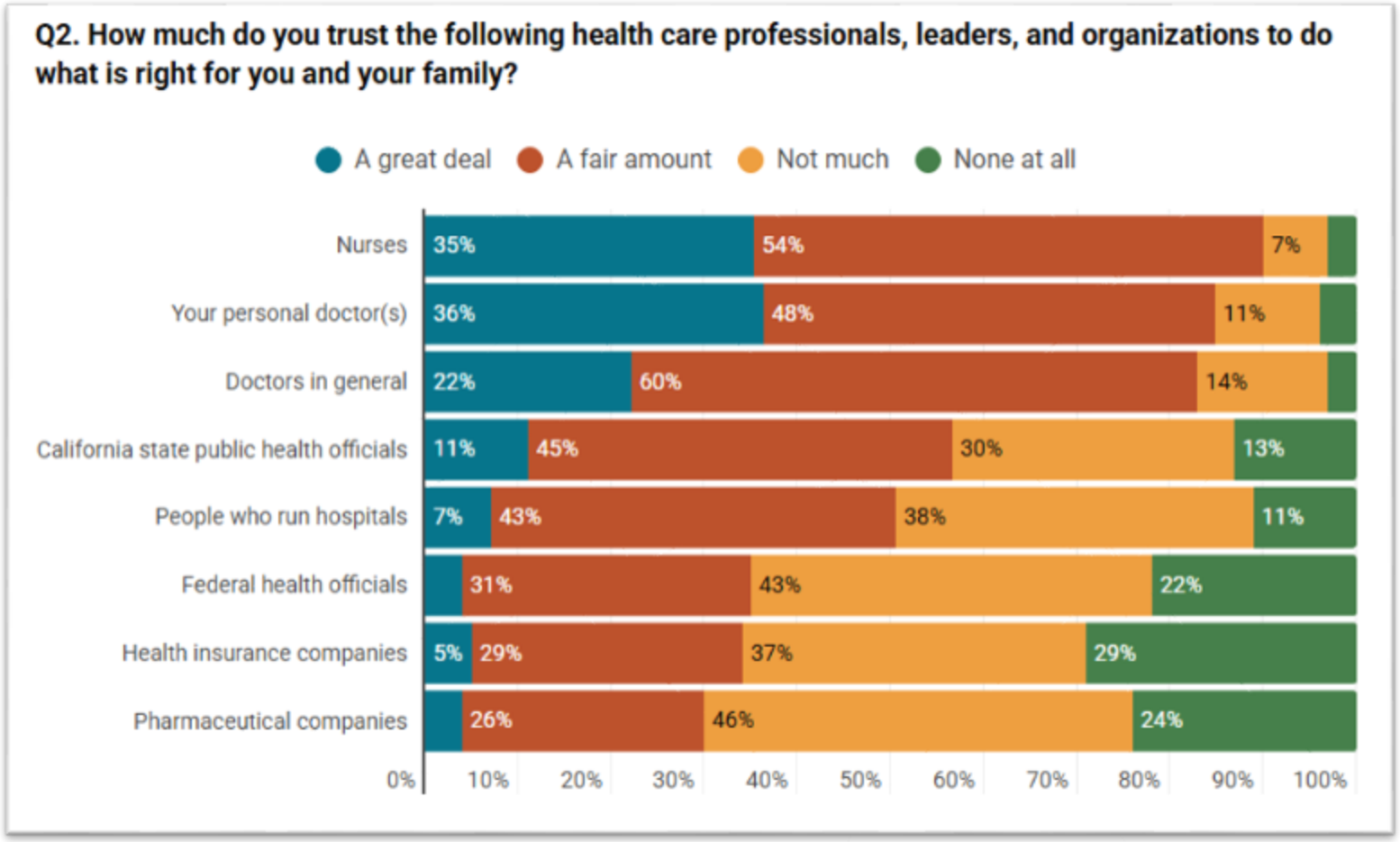
https://www.pewresearch.org/science/2025/11/18/how-do-americans-view-childhood-vaccines-vaccine-research-and-policy/



https://www.kff.org/health-information-trust/kff-tracking-poll-on-health-information-and-trust-vaccine-safety-and-trust/

Root Cause #3: Californians have low trust in healthcare organizations

While people continue to trust nurses and their personal doctor, those who run hospitals and health insurances companies hold very little trust.

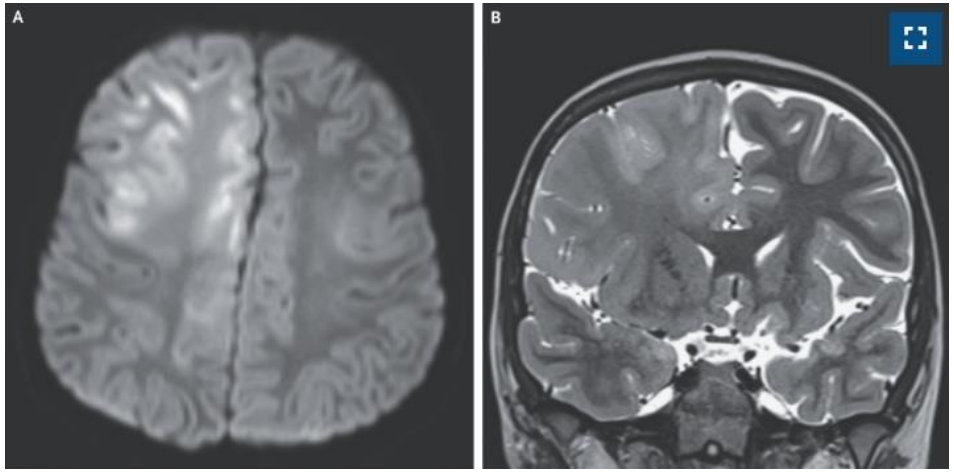


https://www.chcf.org/resource/trust-distrust-california-health-care-system-survey-2026/

Little Focus on Long Term Impacts to Health of Missed Vaccines

Measles can lead to subacute sclerosing panencephalitis 7-10 years after infection, which is uniformly fatal.

Congenital rubella syndrome can cause hearing impairment, cataracts and glaucoma in newborns, and is fatal in 1 out of 3 babies born with this. When the young children skipping the MMR vaccine eventually become pregnant, we will see a generational impact.



N Engl J Med 2026;394: e14 DOI: 10.1056/NEJMicm2504828

We will see the impacts on children for decades to come if we do not shift the conversation and our approach to ensuring children access vaccinations now.

The Maturity Arc

Plans optimize measures, but childhood immunizations demand a population & community health model.

PLANS ARE HERE
Most plans are still in Stage 1

NARROW → BROADER → ECOSYSTEM

1 Measure Optimization

- Focused on numerator–denominator performance
- Gap-closing and teaching to the test
- Siloed work within each line of business

2 Population Health

- Same barriers exist across multiple lines of business
- Break down internal silos
- Manage the population served across products — not just the denominator

3 Community & Public Health

- Information, infectious-disease risk, and community immunity flow across regions
- Collaboration across plans, providers, pharmacies, schools, families, social-media influencers, and public agencies
- Success depends on broader collaboration and shared infrastructure

Statewide health outcomes won't change by chasing numerators

Moving Beyond Numerators

Covered California recognized this structural gap and took the initiative to address it at the ecosystem level by standing up the Public Health for All Californians Together (PHACT) Coalition.

1 Measure Optimization

- Focused on numerator–denominator performance
- Gap-closing and teaching to the test
- Siloed work within each line of business

2 Population Health

- Same barriers exist across multiple lines of business
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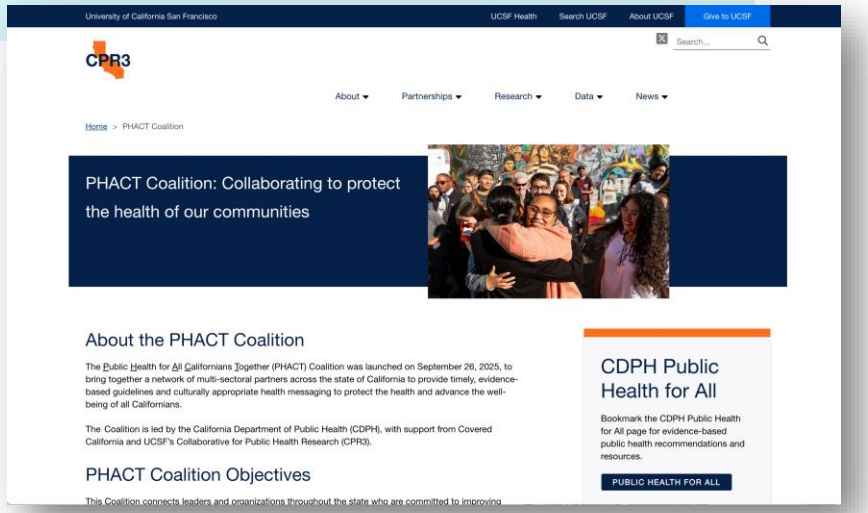
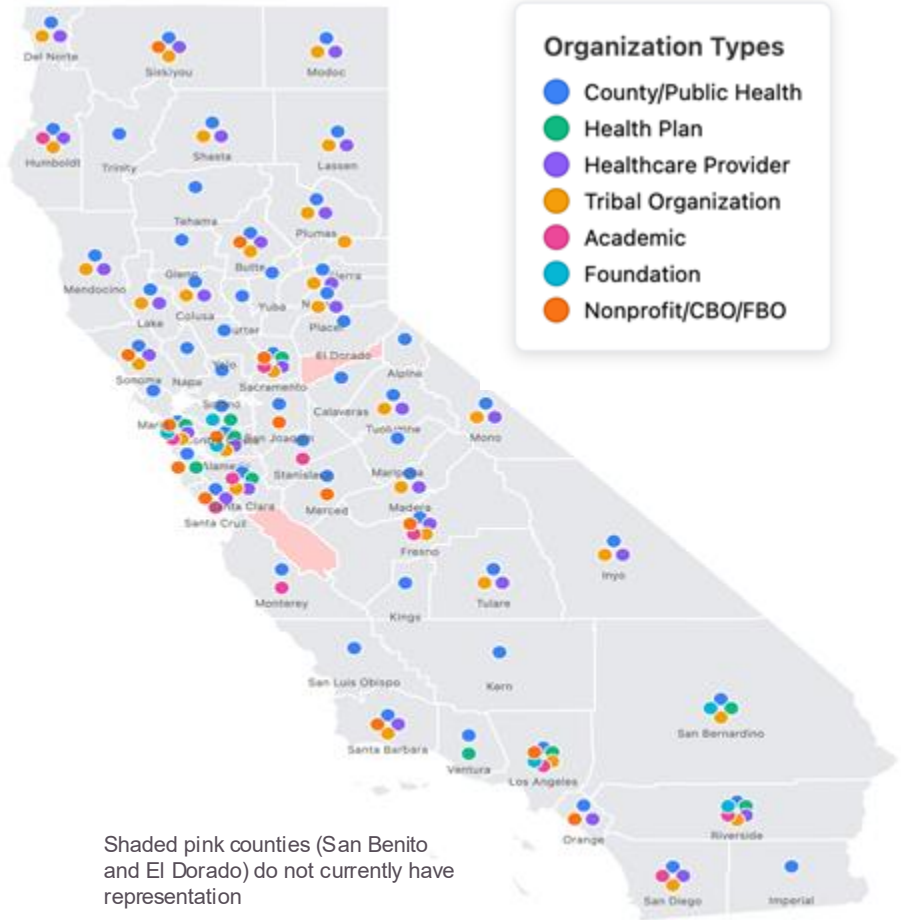
Statewide health outcomes won't change by chasing numerators

PHACT Coalition Infrastructure as a Strong Foundation

PHACT's existing membership consists of >1,300 individuals from over 400 organizations across the state

PHACT's purpose: To bring together a network of multi-sectoral partners across the state of California to **provide timely, evidence-based guidelines and culturally appropriate health messaging** to protect the health and advance the well-being of all Californians.





Shaded pink counties (San Benito and El Dorado) do not currently have representation

PHACT Coalition Early Successes and Learnings Inform PopHI Design

Community and Social Listening

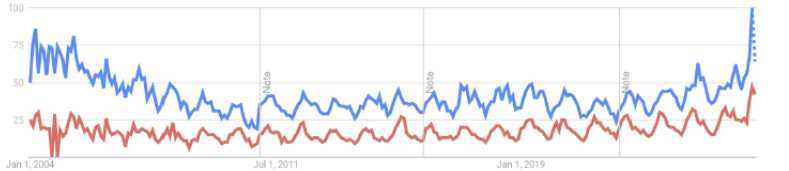


Figure 3: *Google Trends results since 2004 in California for the topics pesticide (blue) and herbicide (red), showing a significant interest in the month of March. Numbers represent search interest relative to the highest point on the chart for the given region and time. A value of 100 represents the term's peak popularity.*

Evidence Based Messaging Tools

FRAME WORKS

Less of this	More of this!
benefits outweighing risks	benefits to the common good
low rates of uptake	our responsibility for access
protection from disease	preparation for healthy childhood
how vaccines fight disease	how immune systems prepare themselves

REMOVE PRACTICAL BARRIERS TO ACCESS

"We must make sure that vaccinations are widely available, easy to find, and affordable to everyone. Whether this means changing clinic locations or changing insurance reimbursement policies, we need to remove the barriers that families run into when trying to get kids vaccinated."

Aligned Communications

California Back-to-School Vaccine Messaging 2026

Back-to-school season is a great time to encourage families to catch up on vaccines for the entire family. Here are some basic action steps you can take to help spread the word that vaccines save lives. Childhood vaccines prepare kids for a healthy childhood and benefit the community – and that's why California makes vaccines widely available, easy to find, and affordable for everyone.

5 Guiding Principles for Back-to-School Messaging for 2026

1. PREPARE

Expect and prepare for questions about California vaccine requirements. Encourage families and patients to plan early for back-to-school check-ups.

- Get comfortable with discussions about vaccines with parents and families by using resources like: American Academy of Pediatrics: Immunization Discussion Guides
- The PHACT Coalition prepared Q&A guides for parents and health care providers that answer commonly asked questions.

2. LISTEN

Acknowledge the questions and concerns of your patients and community members, and pivot toward clear explanations about how vaccines support healthy school communities.

- Trusted Health Messengers: Get curious about what your community needs, consider preferred languages and cultural norms, and acknowledge the practical barriers families face in accessing vaccines.
- Health Care Providers: Ask what questions your patients have and promote the many important benefits of vaccines at all levels in your health care delivery team.

PHACT PopHI's Partnership Model

Overview & Structure

- **Builds upon existing infrastructure** to invest in a **statewide omni-channel, multimodal health communications strategy** that builds trust and increases vaccine confidence among Covered California members

- Funds support: **modernizing community listening** to inform aligned health communications, **sharper social insights** fueling **real-time messages**, and partners with expertise and track records in **omni-channel health communications**

- Partners enable us to focus listening, learning, and outreach on **regions and populations with declining childhood immunization rates or longstanding disparities** with emphasis on culturally appropriate outreach across a variety of channels

- Short-term goal: Communities receive **consistent, responsive health communications** and vaccine information through community-based organizations and existing and new communications channels
- Long-term goal: **Improved childhood immunization rates** and reduced disparities in CIS-10 performance among Covered California members

Sharper Insights for Next-Gen Health Communications

1. Community & Social Listening

- Community conversations in areas with low vaccination rates to understand barriers
- Online and social listening to understand and elevate trends

inform

2. Evidence Based Messaging Approaches

- Focused messaging and storylines on what trends Community & Social Listening uncover
- Reframing vaccine conversations using evidence

generate

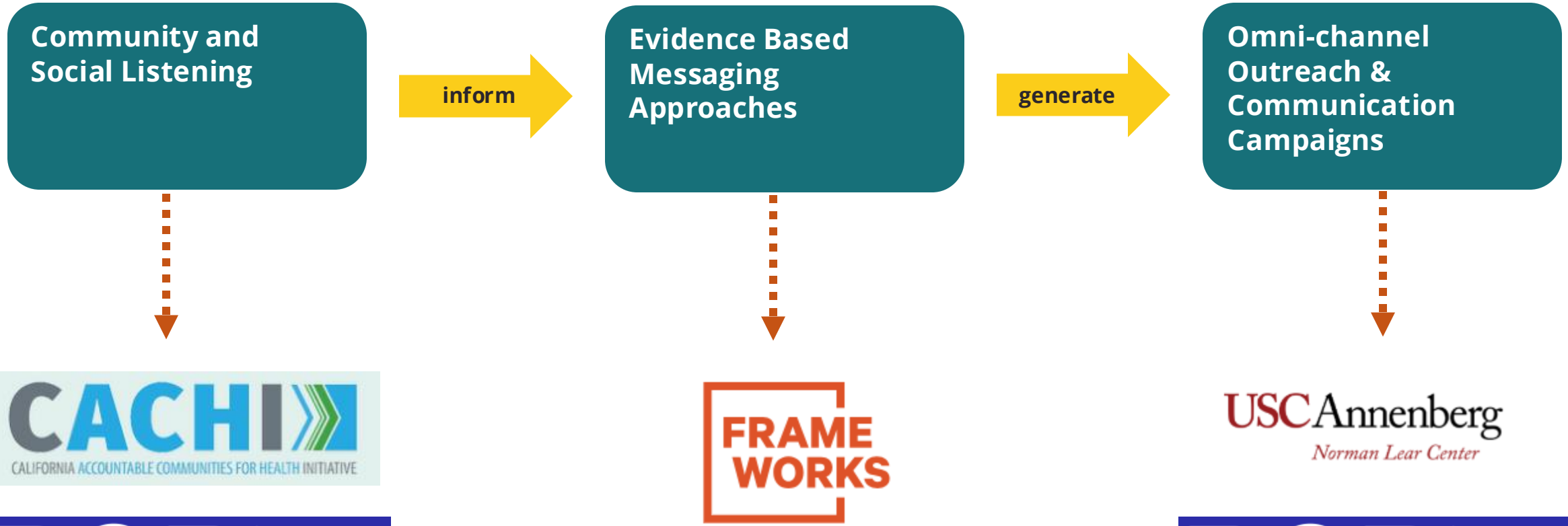
3. Omni-channel Outreach & Communication Campaigns

- Social media and online assets distributed by local, trusted partners
- Large-scale popular media with embedded messaging that aligns with CSL & Evidence-based approaches

Each component builds on learnings and evidence from the others

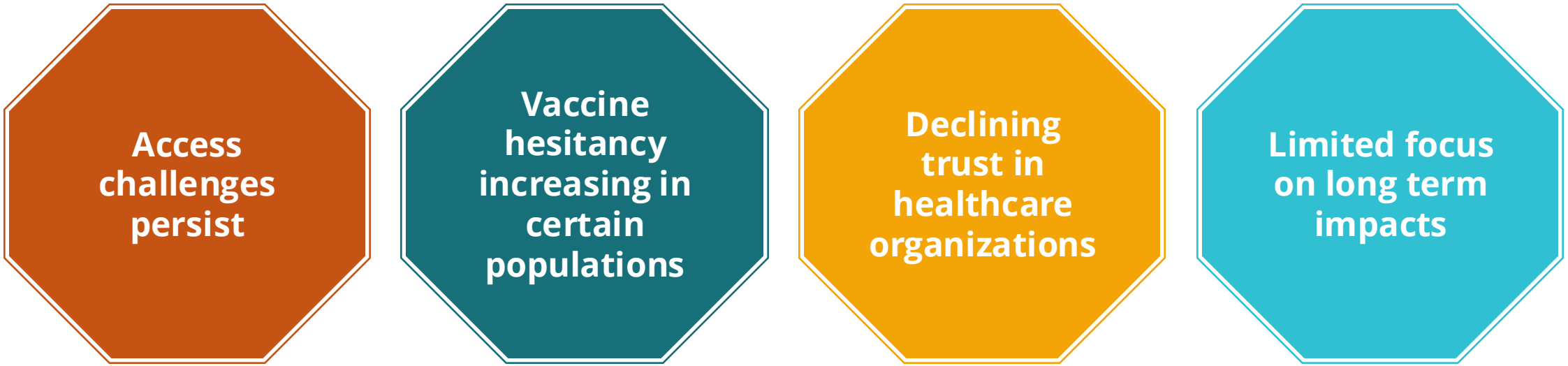
PHACT PopHI: Partner Organizations

Partner organizations bring expertise and prior success across our key areas



Where This PopHI Adds Value

Addressing hesitancy, building trust, and impacting the future



There is existing ownership and oversight for access in California (DMHC, health plans, delivery system, CDPH etc.)

No existing program systematically addresses these challenges. PHACT PopHI would fill this gap.

Proposed Metrics and Measures of Success

System Coordination & Process

- Number of listening sessions / community engagements held in areas with low vaccine rates
- Number or portion of plans & partner organizations adopting shared tools, templates, and messaging guidance
- Number of coordinated campaigns launched using shared guidance across >1 channel or with >1 partner

Communications & Narrative Change

- Message alignment score across Covered California, QHP Issuers, and community partners' materials
- Portion of vaccine-related narratives in California with positive vs negative sentiment (via social listening)
- Reach of campaigns and content: impressions, shares, likes

Attitudinal Shifts & Outcomes

- Family / parent reported clarity of vaccine recommendations pre/post in communities of focus
- Family / parent reported intention to accept vaccines pre/post in communities of focus
- Pediatric primary care well child visit rate (lagging)
- CIS-10 performance (lagging)

Proposed PHACT PopHI

Meets Guiding Principles

+

Addresses Population Need

+

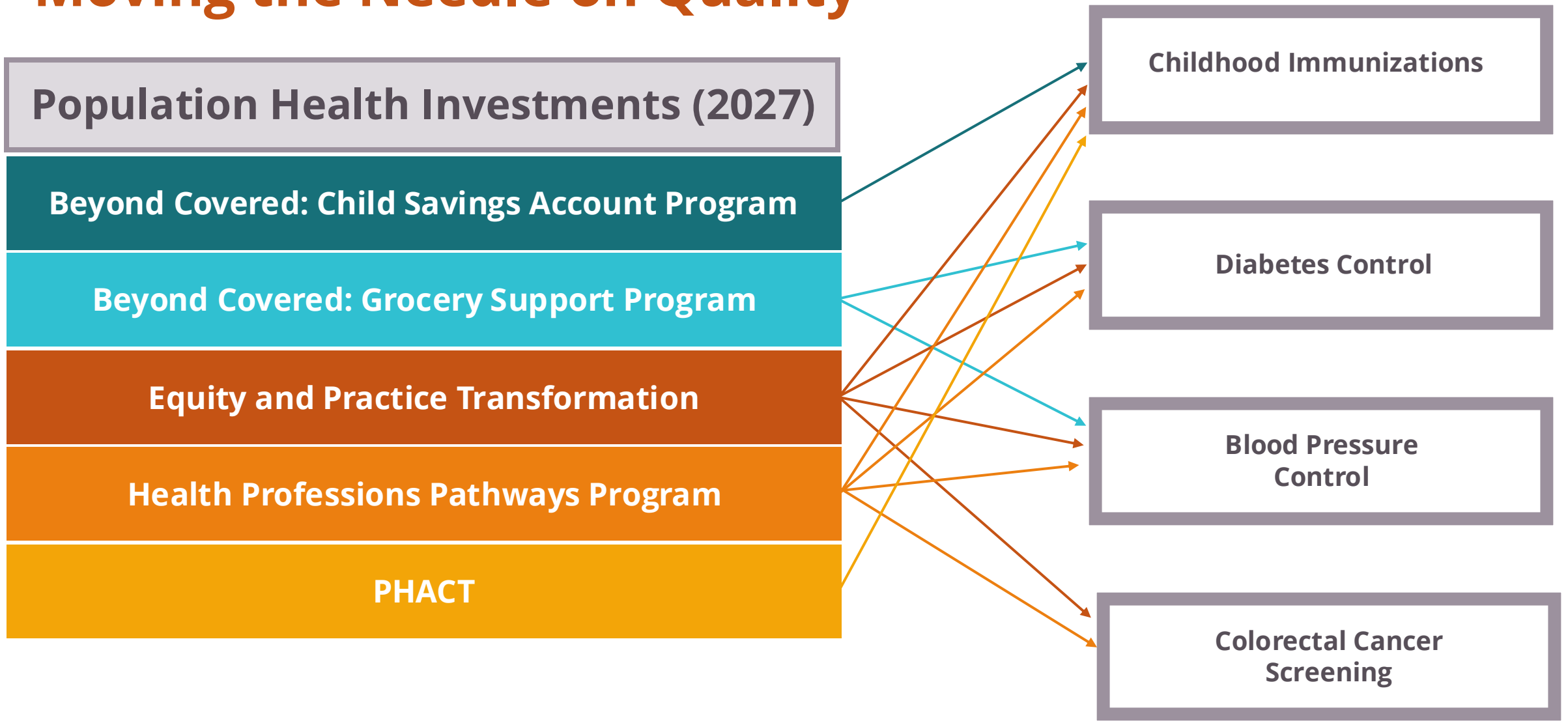
Is Feasible to Implement & Measure Impact

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

Declining childhood vaccination rates, longstanding and emerging disparities, and community-identified concerns around vaccine hesitancy & confusing guidance

✓ *Leverage existing infrastructure*
+/- Measurement challenge on impact

Moving the Needle on Quality



Thank You

Questions/Comments
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