TRIBAL CONSULTATION

October 12, 2020

BLESSING

INTRODUCTIONS

REVIEW AGENDA

TODAY'S AGENDA

- Covered California Executive Director Welcome and Update
- Plan Management Division Presentation
  - Plans and Rates for 2021
  - Enrollment Updates
  - Covered California Plan Networks and I/T/U Providers

  -BREAK AS NEEDED-
- COVID-19 Impact on Native Communities
- Covered California Web Refresh and Resource Toolkit
- Tribal Advisory Workgroup Update
- Open Session and Discussion
- Next Steps and Closing Remarks

WELCOME AND EXECUTIVE UPDATE

Peter V. Lee, Executive Director

COVERED CALIFORNIA IN 2020 AND BEYOND

EXTRAORDINARY TIMES

1. There is a ‘new normal’ for open enrollment 2021
2. Leaning in on what works
3. State of the State

NEW NORMAL FOR 2021 OPEN ENROLLMENT

- Remote enrollment replaces in-person enrollment
- Storefronts retro-fitted to encourage social distancing
- 1,300 Covered California call center workers fully-enabled to work from home
- COVID pandemic and recession continues throughout open enrollment and into 2021
- Fall/Winter flu season requires more vigilance and adherence to safe practices

LEANING IN ON WHAT WORKS

- Increased spending on marketing and outreach
- State subsidies for middle income consumers and individual mandate and penalty
- Keeping the special enrollment door open for job loss, loss of income and wildfire victims
- Ensuring access to care during stay-at-home orders with telemedicine

$140 MM for Marketing and Outreach in 2021

Extra marketing spend during special enrollment helped nearly 300,000 people get coverage

STATE OF THE STATE

- Record number of people filing for unemployment insurance means record numbers of people needing to replace their employer-sponsored coverage
- Premium changes for 2021 will be .6%. And, if consumer shops and switches that increase can be -7%.
- Forced-changes like turning telemedicine on overnight demonstrates that the health care system can evolve and we can see more changes to improve efficiency, quality and equity
- California is committed to building on the Affordable Care Act

CORONAVIRUS DISEASE 2019 (COVID-19) UPDATE

COVID-19: CALIFORNIA STATEWIDE UPDATE

- Current Status
  - Total cases continue to increase, however daily growth in cases has remained less than 1% for over seven weeks and average hospitalizations have declined.
  - Testing capacity continues to increase, now over 15.3 million tests have been completed including data from include data from commercial, private and academic labs.
  - Adequate hospital capacity to absorb a new wave of COVID infections.
- What We Still Need
  - Increase our ability to conduct contact tracing, isolation, and quarantine.
  - Enhance the ability for businesses and schools to support physical distancing.

COVID-19: RACE/ETHNICITY

- There are strong indications that the clinical impact of COVID-19 are worse for Latinos and African-Americans with a disproportionate number of cases or deaths relative to their population in the state.
- There has been a significant impact to the American Indian and Alaska Native community as well.
  - Second highest mortality rate for COVID-19 nationally with 82 deaths per 100,000 people.
  - In California we have seen over 1,500 cases and about 50 deaths, this represents 0.3% of totals.

COVERED CALIFORNIA'S DIVERSITY, EQUITY AND INCLUSION INITIATIVE

UPDATE ON COVERED CALIFORNIA'S DIVERSITY, EQUITY & INCLUSION EFFORTS

- Covered California recently completed departmentwide required implicit bias awareness training with over 1,100 staff attending the course. Training was conducted by Dr. Bryant T. Marks, Sr., Founder and Chief Equity Officer of the National Training Institute on Race and Equity. We will continue to offer this course on a biannual basis for new employees and those were unable to complete the first sessions.
- Covered California is continuing our organizational implicit bias work with our leadership team who will all be engaged in a session building on the implicit bias training to develop bias mitigation efforts.
- To institutionalize efforts, Covered California has established a 15 person workgroup of diverse leaders from multiple divisions within the organization to contribute to our strategic diversity, equity, and inclusion work. The workgroup will meet on a regular basis over the next 12 months and provide advice, guidance, critical thinking and recommendations to ensure we continuously embrace and establishes ongoing process that assure diversity and inclusion at all levels of the organization.

COVERED CALIFORNIA'S EXPERIENCE IN SPECIAL ENROLLMENT

LESSONS FROM COVID-19

2020 SPECIAL ENROLLMENT PERIOD UPDATE

- COVID-19 Special Enrollment Period ended on August 31st
  - This qualifying life event allowed Californians affected by the COVID-19 pandemic to sign up for coverage between March 20th and August 31st.

- Covered California added a new qualifying life event on August 1st for individuals who lost their job or experienced a loss of income.

  - This qualifying life event is in response to the public health emergency and the economic crisis caused by COVID-19.
  - This qualifying life event is currently scheduled to be available through December 31, 2020. Covered California will evaluate the need for extending this qualifying life event later in the year.

- Covered California is also assisting consumers who have been impacted by wildfires.
  - Covered California offers a standing qualifying life event for individuals who miss their open enrollment or special enrollment sign up deadline due to a state of emergency including wildfires.

BUILDING ON EXPERIENCE TO ADDRESS THE COVID PANDEMIC AND RECESSION

- Covered California's history of broad marketing and the ongoing on-the-ground enrollment support (such as 500+ Covered California branded storefronts, 10,000+ certified agents and broad navigator targeting high-need communities) means high name recognition and avenues for enrollment year-round.
- Covered California invested over $9 million in marketing and outreach to help spread the word about the COVID SEP after March 20, 2020, including launching COVID-specific advertising content on May 04, 2020.
- California created a COVID qualifying life event, ensuring that all would have access to coverage options during the pandemic including those who may have been uninsured at the onset of the pandemic.
  - 11 other state-based marketplaces also took similar actions.
  - The Federally-Facilitated Marketplace extended some SEP deadlines for those who lost job-based coverage, but did not create a new qualifying life event in response to the pandemic.

TOPLINE – SPECIAL ENROLLMENT PERIOD

- Year-to-date special enrollment period (SEP) plan selections of **more than 357,000** is almost **90% higher** than same time last year.
- **More than 289,000** consumers have signed up since the announcement of the COVID-19 Special Enrollment. During this period, new sign-ups have grown to almost **2.2 times higher (115%)** the rate seen during same time last year.

Measures (Data as of 08/31/2020, All cells rounded to nearest 10).	2020	2019	Difference	% Change
Pre-COVID (March 19 and earlier)	67,710	54,780	12,930	24%
Post-COVID (March 20 and after)	**289,460**	**134,700**	**154,760**	**115%**
YTD SEP (As of August 31)	357,170	189,470	167,700	89%

- These new Special Enrollment sign-ups include a combination of those newly becoming aware of state subsidies or the penalty; those who have recently lost other coverage; and those who are enrolling due to the COVID-19 pandemic Special Enrollment period.*

* Due to the need to adapt the CoveredCA.com application (CalHEERS) quickly, the application uses the same drop-down value for each of: newly becoming aware of new state subsidies or the penalty; responding to the COVID-19 pandemic; and loss of job-based coverage.

COVERED CALIFORNIA ENROLLMENT BY RACE/ETHNICITY

There are not good data on the racial/ethnic impact of the pandemic on insurance coverage. The demographic profile of Covered California's enrollment during the COVID SEP period has been largely consistent with the mix in prior enrollment periods.

Covered California is doing additional research to better understand enrollment and insurance coverage by race/ethnicity.

Race / Ethnicity								
	2019 Open Enrollment[1]		2020 Open Enrollment[2]		2019 Special Enrollment[3] YTD as of 08-31-2019		2020 Special Enrollment[3] YTD as of 08-31-2020	
Race / Ethnicity	Enrollees	(column %)	Enrollees	(column %)	Enrollees	(column %)	Enrollees	(column %)
American Indian/Alaska Native	630	0.2%	890	0.2%	620	0.4%	830	0.3%
Asian	51,660	20.2%	82,640	22.4%	31,750	21.0%	60,550	21.6%
Black or African American	10,040	3.9%	13,510	3.7%	5,690	3.8%	10,660	3.8%
Latino	78,400	30.6%	120,230	32.6%	43,690	28.8%	84,290	30.0%
Multiple Races	6,950	2.7%	9,290	2.5%	3,920	2.6%	7,800	2.8%
Native Hawaiian or Pacific Islander	400	0.2%	520	0.1%	240	0.2%	450	0.2%
Other	20,100	7.8%	27,300	7.4%	13,070	8.6%	21,600	7.7%
White	88,070	34.4%	114,930	31.1%	52,500	34.7%	94,770	33.7%
Grand Total	**256,240**	**100.0%**	**369,310**	**100.0%**	**151,470**	**100.0%**	**280,950**	**100.0%**

ENROLLMENT PER REGION

	7/1/2019	3/30/2020	9/16/2020
Pricing Region		# of Individuals	
Northern Counties	814	970	1,031
North Bay	304	306	347
Sacramento Valley	530	625	628
San Francisco County	88	95	105
Contra Costa County	121	132	151
Alameda County	155	186	195
Santa Clara County	75	114	116
San Mateo County	30	47	51
Monterey County	101	105	114
San Joaquin County	385	434	460
Central San Joaquin	254	261	273
Central Coast	225	269	287
Eastern Counties	34	44	30
Kern County	124	140	145
Los Angeles County, Partial	220	234	236
Los Angeles County, Partial	345	424	442
Inland Empire	426	472	507
Orange County	286	343	365
San Diego County	312	333	378
Grand Total	**4,829**	**5,534**	**5,861**

- 20% more enrollees since July 2019
- Holding steady at about .35% of total enrollment since 2017

ENROLLMENT PER ISSUER

2020 AI/AN Enrollment (Active or Pending Status) as of 09/16/2020

Issuer	# of Individuals-2019	# of Individuals-2020
Anthem Blue Cross	555	693
Blue Shield	1,801	2,011
CCHP	5	5
Health Net	296	435
Kaiser	1,826	2,279
LA Care	44	69
Molina Health Care	99	71
Oscar Health Plan	102	135
SHARP Health Plan	46	70
Valley Health	11	27
Western Health	44	66
Grand Total	**4,829**	**5,861**

DISCUSSION

TRIBAL CONSULTATION 2020
PLAN MANAGEMENT UPDATE

James DeBenedetti, Director
Plan Management Division

OVERVIEW OF BENEFITS

AMERICAN INDIAN/ALASKA NATIVE ELIGIBILITY: ZERO COST SHARE PLANS

- AI/AN applicants are eligible for a **zero cost sharing** qualified health plan (QHP) if the applicant:
  - Meets the eligibility requirements for APTC (Advance Premium Tax Credit) and CSR (Cost Sharing Reduction)
  - Is expected to have a household income that does not exceed 300 percent of the federal poverty level (FPL) for the benefit year for which coverage is requested
  - Is a member of a federally-recognized tribe
- If the AI/AN applicant meets the above eligibility requirements for Zero Cost Sharing plans, the QHP issuer must eliminate any cost sharing.
- AI/AN enrollees can only access these benefits if enrolled in a Zero Cost Sharing plan through Covered California.

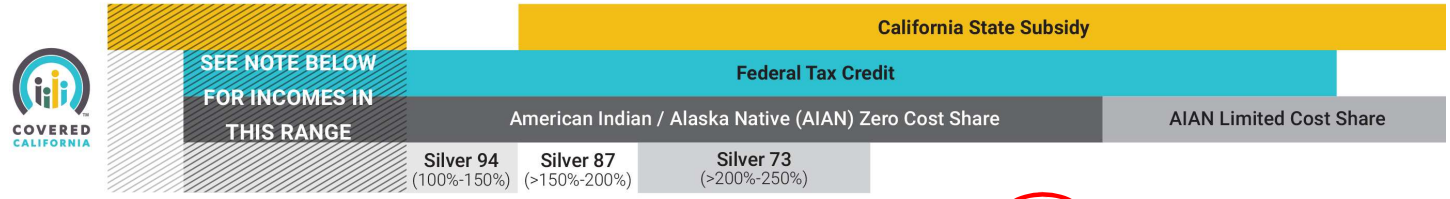
AMERICAN INIDIAN/ALASKA NATIVE ELIGIBILITY: LIMITED COST SHARE PLANS

- AI/AN applicants are eligible for **Limited Cost Sharing** plans at every metal level if the applicants:
  - Household income exceeds 300 percent of the FPL for the benefit year for which coverage is requested, or income is not reported
  - Are a member of a federally recognized tribe
- If the AI/AN applicant meets the above eligibility requirements for Limited Cost Sharing plan, the QHP issuer must:
  - Eliminate any cost sharing under the plan for the services or supplies received directly from an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through Purchased Referred Care
  - Apply standard cost sharing for the QHP's provider network outside of Indian and Tribal providers
- AI/AN enrollees can only access these benefits if enrolled in a Limited Cost Sharing plan through Covered California.

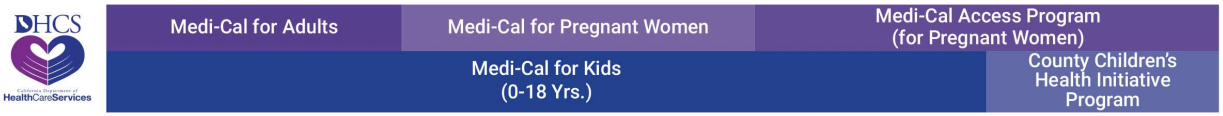
AMERICAN INDIAN/ALASKAN NATIVE PROGRAM ELIGIBILITY

Program Eligibility by Federal Poverty Level-2020 Plan Year

Note overlapping programs by income level



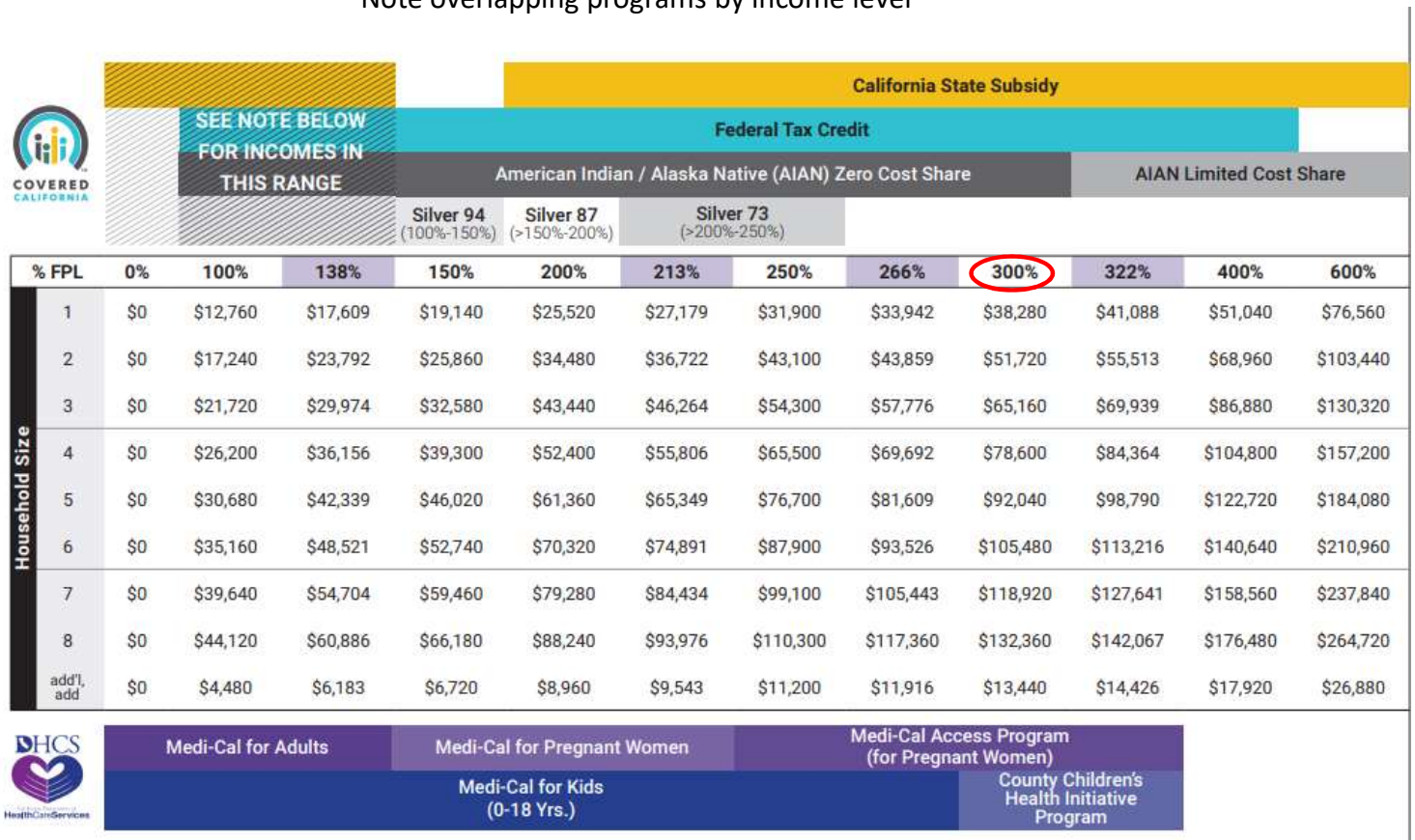
Household Size	% FPL	0%	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%	600%
	1	$0	$12,490	$17,237	$18,735	$24,980	$26,604	$31,225	$33,224	$37,470	$40,218	$49,960	$74,940
	2	$0	$16,910	$23,336	$25,365	$33,820	$36,019	$42,275	$44,981	$50,730	$54,451	$67,640	$101,460
	3	$0	$21,330	$29,436	$31,995	$42,660	$45,433	$53,325	$56,738	$63,990	$68,683	$85,320	$127,980
	4	$0	$25,750	$35,535	$38,625	$51,500	$54,848	$64,375	$68,495	$77,250	$82,915	$103,000	$154,500
	5	$0	$30,170	$41,635	$45,255	$60,340	$64,263	$75,425	$80,253	$90,510	$97,148	$120,680	$181,020
	6	$0	$34,590	$47,735	$51,885	$69,180	$73,677	$86,475	$92,010	$103,770	$111,380	$138,360	$207,540
	7	$0	$39,010	$53,834	$58,515	$78,020	$83,092	$97,525	$103,767	$117,030	$125,613	$156,040	$234,060
	8	$0	$43,430	$59,934	$65,145	$86,860	$92,506	$108,575	$115,524	$130,290	$139,845	$173,720	$260,580
	add'l, add	$0	$4,420	$6,100	$6,630	$8,840	$9,415	$11,050	$11,758	$13,260	$14,233	$17,680	$26,520



AMERICAN INDIAN/ALASKAN NATIVE PROGRAM ELIGIBILITY

Program Eligibility by Federal Poverty Level-2021 Plan Year

Note overlapping programs by income level



Household Size	% FPL	0%	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%	600%
	1	$0	$12,760	$17,609	$19,140	$25,520	$27,179	$31,900	$33,942	$38,280	$41,088	$51,040	$76,560
	2	$0	$17,240	$23,792	$25,860	$34,480	$36,722	$43,100	$43,859	$51,720	$55,513	$68,960	$103,440
	3	$0	$21,720	$29,974	$32,580	$43,440	$46,264	$54,300	$57,776	$65,160	$69,939	$86,880	$130,320
	4	$0	$26,200	$36,156	$39,300	$52,400	$55,806	$65,500	$69,692	$78,600	$84,364	$104,800	$157,200
	5	$0	$30,680	$42,339	$46,020	$61,360	$65,349	$76,700	$81,609	$92,040	$98,790	$122,720	$184,080
	6	$0	$35,160	$48,521	$52,740	$70,320	$74,891	$87,900	$93,526	$105,480	$113,216	$140,640	$210,960
	7	$0	$39,640	$54,704	$59,460	$79,280	$84,434	$99,100	$105,443	$118,920	$127,641	$158,560	$237,840
	8	$0	$44,120	$60,886	$66,180	$88,240	$93,976	$110,300	$117,360	$132,360	$142,067	$176,480	$264,720
	add'l, add	$0	$4,480	$6,183	$6,720	$8,960	$9,543	$11,200	$11,916	$13,440	$14,426	$17,920	$26,880

AMERICAN INDIAN/ALASKA NATIVE BENEFIT EXAMPLE

The following is an example of the differences in cost sharing between a Silver 70 standard plan, a Zero Cost Share AI/AN plan and a Limited Cost Share AI/AN plan for some covered services.

	Silver 70 Standard Plan	Zero Cost Share AI/AN Plan	Silver 70 Limited Cost Share AI/AN Plan	Silver 70 Limited Cost Share AI/AN Plan if Member Goes to an AI/AN Provider*
Primary Care Visit	$40	$0	$40	$0
Specialist Visit	$80	$0	$80	$0
Laboratory Tests	$40	$0	$40	$0
Urgent Care Visit	$40	$0	$40	$0

*Indian Health Service (IHS), an Indian tribe, Tribal Organization, Urban Indian Organization, or receives a referral to a QHP provider from an IHS clinic.

AMERICAN INDIAN/ALASKA NATIVE QUALIFIED HEALTH PLAN (QHP) REQUIREMENTS

- Covered California requires QHP issuers to offer the lowest cost AI/AN Zero Cost Share plan variation in the standard set of plans for each product (HMO, PPO, EPO).
- The QHP issuer may not offer the Zero Cost Share AI/AN plan variation at the higher metal levels within the set of plans for each product .
  - For example, if a QHP issuer offers a PPO product for Platinum, Gold, Silver and Bronze metal tiers, the issuer must offer a Bronze AI/AN Zero cost share plan because it's the lowest cost premium.

AMERICAN INDIAN/ALASKA NATIVE QUALIFIED HEALTH PLAN (QHP) ISSUER REQUIREMENTS

- QHP issuers offering additional plans, that do not include a Bronze plan, must offer the AI/AN Zero Cost Share plan variation at the lowest cost.
- If a QHP issuer offers a HMO product for Platinum, Gold and Silver metal tiers, the QHP issuer must offer a Silver AI/AN Zero Cost Share plan because it's the lowest cost premium.
- QHP issuers are required to offer Limited Cost Share plans at all metal levels for all product types.

COVERAGE FOR OUT-OF-NETWORK SERVICES

- The requirement for a QHP issuer to offer Zero Cost Share or Limited Cost Share benefits applies to “covered services” under the plan.
- QHP issuers are not required to offer Zero Cost Share or Limited Cost Share benefits for services received by out-of-network providers.
- American Indian/ Alaska Native enrollees would be responsible for 100% of the cost of services received from out-of-network providers when enrolled in a plan with a closed provider network.
- Closed provider networks include:
  - Health Maintenance Organizations (HMO)
  - Exclusive Provider Organizations (EPO)

AMERICAN INDIAN/ALASKAN NATIVE ENROLLMENT UPDATE

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CURRENT MIXED AMERICAN INDIAN/ALASKA NATIVE HOUSEHOLDS

Issuer	# of Individuals
Anthem Blue Cross	402
Blue Shield	1,034
Chinese Community Health Plan	0
Health Net	250
Kaiser	1,058
LA Care	21
Molina Health Care	44
Oscar Health Plan	56
SHARP Health Plan	44
Valley Health	12
Western Health	22
Grand Total	**2,943**

Mixed Households
1,172

*2020 Enrollment Active or Pending for Consumers indicating they are a member of AI/AN Tribe and are in a mixed AI/AN household (AI/AN and Non-AI/AN as of September 2020)

INDIAN HEALTH SERVICE (IHS), TRIBALLY OPERATED, AND URBAN INDIAN HEALTH PROGRAMS

COVERED CALIFORNIA QUALIFIED HEALTH PLANS

- Covered California contracts with individual health plans to offer health insurance plans to consumers.
- Each Qualified Health Plan (QHP) curates and manages their own network of hospitals and providers.
- State regulators ensure that QHPs meet network adequacy requirements in providing consumers with reasonable access to a sufficient number of providers and hospitals in each applicable service area.
- Covered California does not manage or have authority over the contracted networks. However, Covered California do set standards for access, quality, and cost that each QHP and their network providers must meet.
- Covered California regularly assesses and engages with QHPs to ensure that QHPs are holding its contracted hospitals and providers accountable for improving quality, managing or reducing cost, and that consumers receive high-quality equitable care.
- Covered California encourages its QHPs to include Indian Health Service (IHS), tribes and tribal organizations, and urban Indian organization providers in their networks.
- Covered California's QHP model contract includes language that references the Model QHP Addendum for Indian Health Care Providers which is the CMS guideline for inclusion of Indian health care providers in QHP networks.

COVERED CALIFORNIA ECP REQUIREMENT

- The Affordable Care Act stipulates that Qualified Health Plans (QHP) are required to have "a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the plans' service area, in accordance with federal network adequacy standards"
  - An Essential Community Provider (ECP) is a health care provider that serves high-risk, special needs, and underserved individuals
  - Indian Health Service (IHS), Tribally operated, and Urban Indian health programs are included as Essential Community Providers (ECP)
- Covered California requires that a QHP's network include at least 15% ECPs in each applicable rating region
  - Covered California does not mandate provider-specific ECPs that a QHP includes in its network

COVERED CALIFORNIA DEFINED ECP

Major ECP Category	Provider Types
340B Entity (Defined by Human Resource Services Administration)	• Health Centers: FQHC & FQHC look-alikes, Native Hawaiian Health Centers, Tribal / Urban Indian Health Centers • Ryan White HIV / AIDS Program Grantees • Hospitals: Children's Hospitals, Critical Access Hospitals, Disproportionate Share Hospitals, Free Standing Cancer Hospitals, Rural Referral Centers, and Sole Community Hospitals • Specialized Clinics: Black Lung Clinics, Comprehensive Hemophilia Diagnostic Treatment Centers, Title X Family Planning Clinics, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics
Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs	Indian health care providers, which include providers participating in programs operated by 1) the Indian Health Service; 2) a Tribe or Tribal organization under the authority of the Indian Self Determination and Education Assistance Act; and 3) an urban Indian organization under the authority of Title V of the Indian Health Care Improvement Act
California Disproportionate Share Hospital	DSH eligibility is determined annually by the Department of Health Care Services using the established Medicaid Utilization Rate (MUR) and Low-Income Utilization Rate (LIUR) formulas.
Community Clinic or health centers licensed as either a "community clinic" or "free clinic" or exempt from licensure under Health and Safety Code § 1204(a)*	(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure: (A) "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. (B) A "free clinic" means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services.
Providers approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program*	Under the CMS Electronic Health Record Incentive Program, eligible providers (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) receive incentive payments when they have shown that they are able to implement certified EHR technology and have demonstrated "meaningful use" as defined by CMS.

COVERED CALIFORNIA

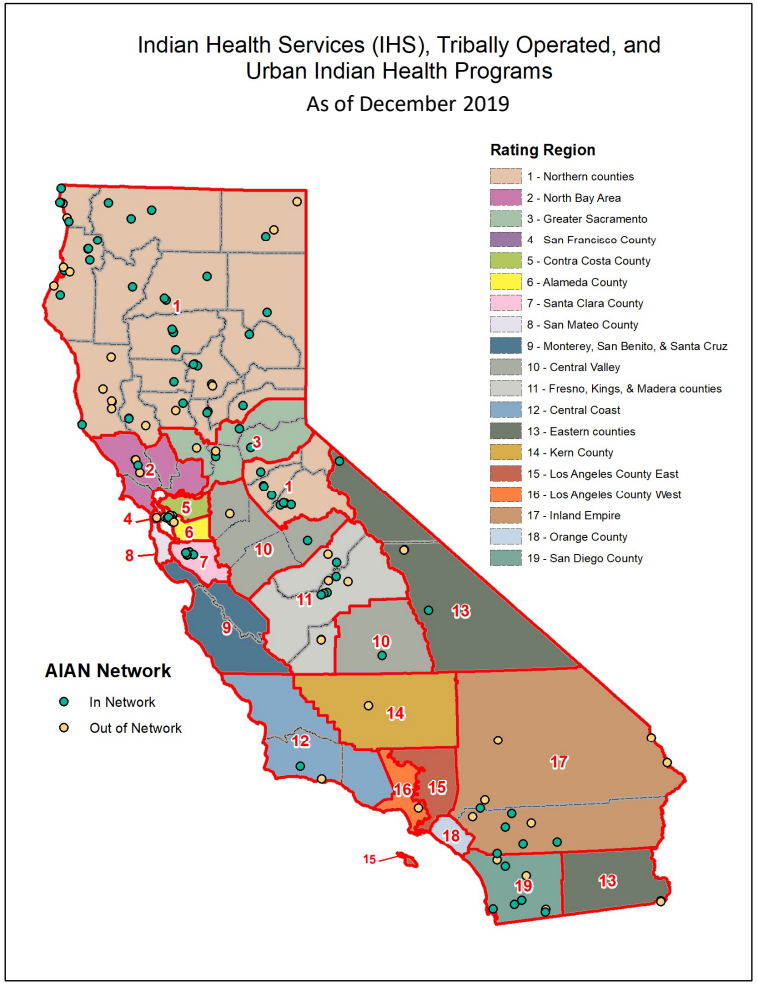
*ECPs in addition to CMS ECP Categories

FEDERALLY DEFINED ECP

Major ECP Category	Provider Types
Federally Qualified Health Center (FQHC)	FQHC and FQHC "look-alike" clinics, outpatient health programs/facilities operated by Indian tribes, tribal organizations, program operated urban Indian organizations
Ryan White Provider	Ryan White HIV/AIDS program providers
Family Planning Provider	Title X family planning clinics and Title X "look-alike" family planning clinics
Indian Health Provider	Indian Health Service (IHS) providers, Indian tribes, tribal organizations and urban Indian organizations
Hospital	Disproportionate share hospital (DSH) and DSH-eligible hospitals, children's hospitals, rural referral centers, sole community hospitals, free-standing cancer centers, critical access hospitals
Other ECP Provider	Sexually transmitted diseases/infections (STD/STI) clinics, tuberculosis (TB) clinics, hemophilia treatment centers, black lung clinics, and other entities that serve predominately low-income, medically underserved individuals

COVERED CALIFORNIA QHP AI/AN NETWORK

- There are currently 81 Indian Health Service (IHS), tribally operated, and urban Indian health programs in Covered California's QHP networks
  - Majority are in Region 1 (Northern CA) and Region 17 (Inland Empire)
- Covered California continues to encourage QHP Issuers to include and expand the number of Indian Health Service (IHS), tribally operated, and urban Indian health programs in their networks
- A list of Indian Health Service (IHS), tribally operated, and urban Indian health programs that are currently in Covered California's QHP networks will be available on the AI/AN toolkit this week. (https://hbex.coveredca.com/california-tribes/)



FEEDBACK

- Covered California welcomes feedback regarding how it can improve and expand its QHP network of Indian Health Service (IHS), tribally operated, and urban Indian health programs

- Please send any comment or feedback to Thai Lee at thai.lee@covered.ca.gov

QHP ISSUER MODEL CONTRACT
2022 AMENDMENT AND 2023-2025 REFRESH

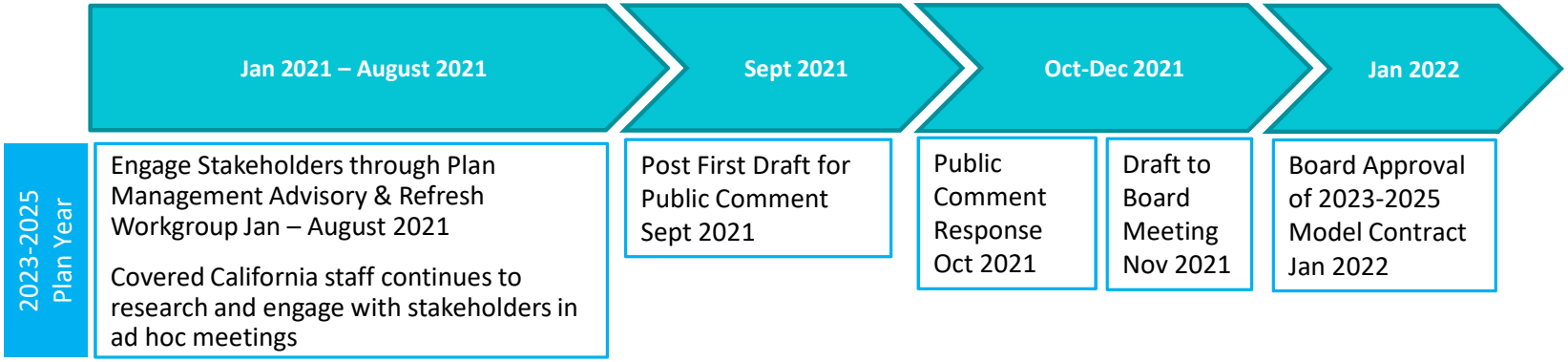
QHP ISSUER MODEL CONTRACT AMENDMENT 2022

- Covered California is in the process of updating its Qualified Health Plan (QHP) issuer contract requirements related to Quality, Network Management, and Delivery System Standards (Attachment 7) for 2022
- A full refresh of the contract was delayed to 2023-2025 due to the COVID-19 pandemic
- The 2022 Attachment 7 Amendment draft contract will be available on the Plan Management webpage on October 15th at https://hbex.coveredca.com/stakeholders/plan-management/
- **There will be a public comment period from October 15 – November 12, 2020**
- Covered CA is providing the following documents during the public comment period:
  - Draft 2022 Attachment 7 Amendment
  - Summary of Changes from 2021 to 2022 Attachment 7 Amendment
  - Crosswalk of Requirements from 2021 to 2022 Attachment 7 Amendment
  - The summary and crosswalk are companion documents to facilitate your review of the Attachment 7 amendment
- Please submit comments and feedback to PMDContractsUnit@covered.ca.gov by November 12, 2020

QHP ISSUER MODEL CONTRACT REFRESH 2023-2025

- The full 2023-2025 Attachment 7 model contract refresh workgroup will conduct monthly meetings starting in January 2021 with diverse stakeholders to discuss areas related to Attachment 7
  - Stakeholders include: health plans, provider groups, consumer advocates, and subject matter experts
- Objective of the workgroup is to make recommendations on changes to the QHP issuer model contract for 2023-2025.
- Areas of priority and examples of requirements for discussion:
  - Individualized Equitable Care
    - Require issuers to achieve 80% capture of Covered CA member race/ethnicity self-identification data
    - Require issuers to participate in a collaborative effort to identify and align statewide disparity work
  - Behavioral Health
    - Require issuers to offer telehealth for behavioral health services
    - Require issuers to promote behavioral health integration with primary care
  - Primary Care
    - Require all Enrollees to be assigned to a Primary Care Provider (PCP)
    - Require issuers to support or provide quality improvement and technical assistance to primary care practices
- To learn more or to join the 2023-2025 Attachment 7 Refresh Workgroup, please contact Thai Lee at thai.lee@covered.ca.gov

2023-2025 QHP ISSUER MODEL CONTRACT PROPOSED DEVELOPMENT TIMEFRAME



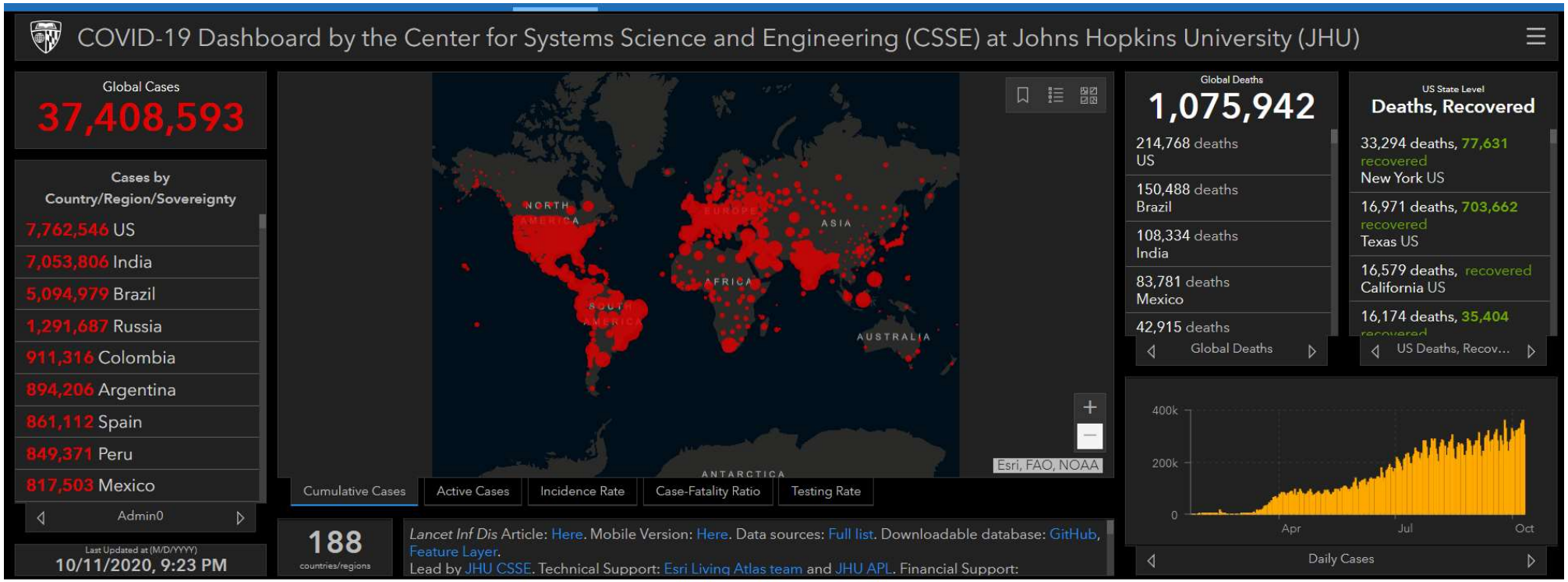
DISCUSSION

BREAK

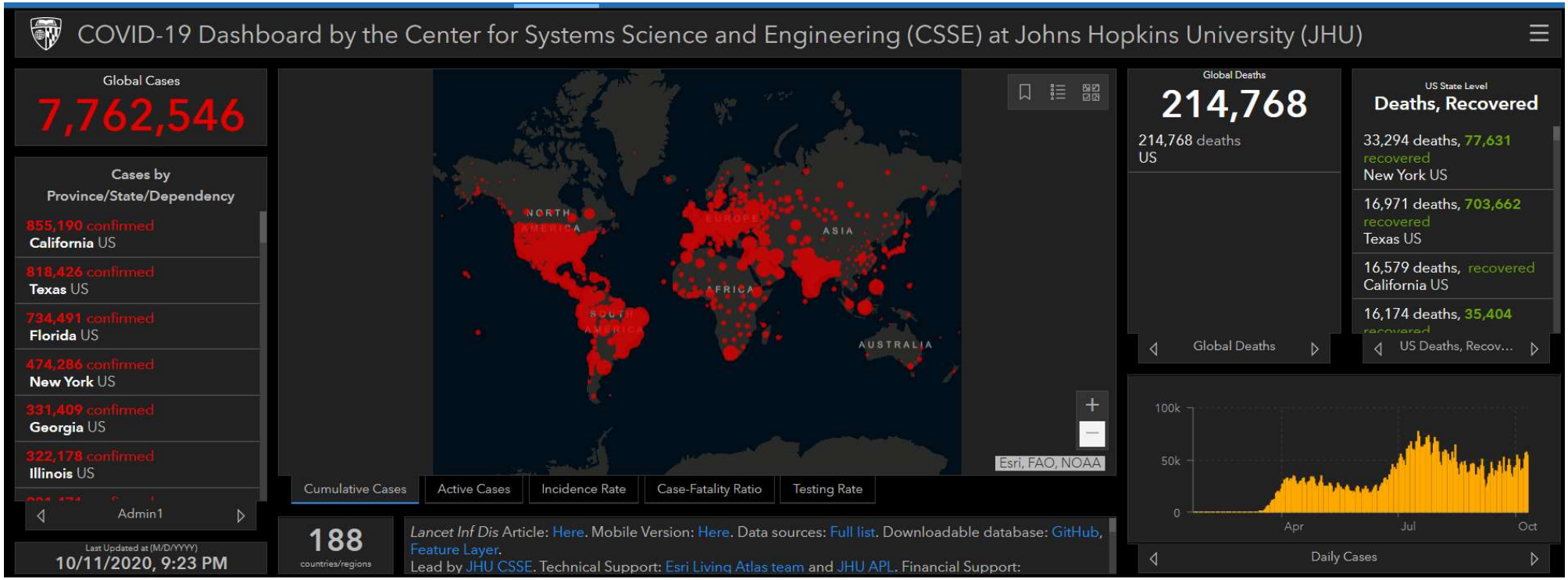
IHS COVID-19 Surveillance & Mapping Tool

IHS COVID-19 Surveillance

- IHS encourages **all** California Tribal and Urban Indian Health programs to report COVID-19 testing data and results for their health programs
- Surveillance data reported from Indian health programs provides HQ with information needed to report the impact of COVID-19 on our health programs and communities and assists HQ with determining where the greatest needs are for any available resources



Worldwide COVID-19 Surveillance Data



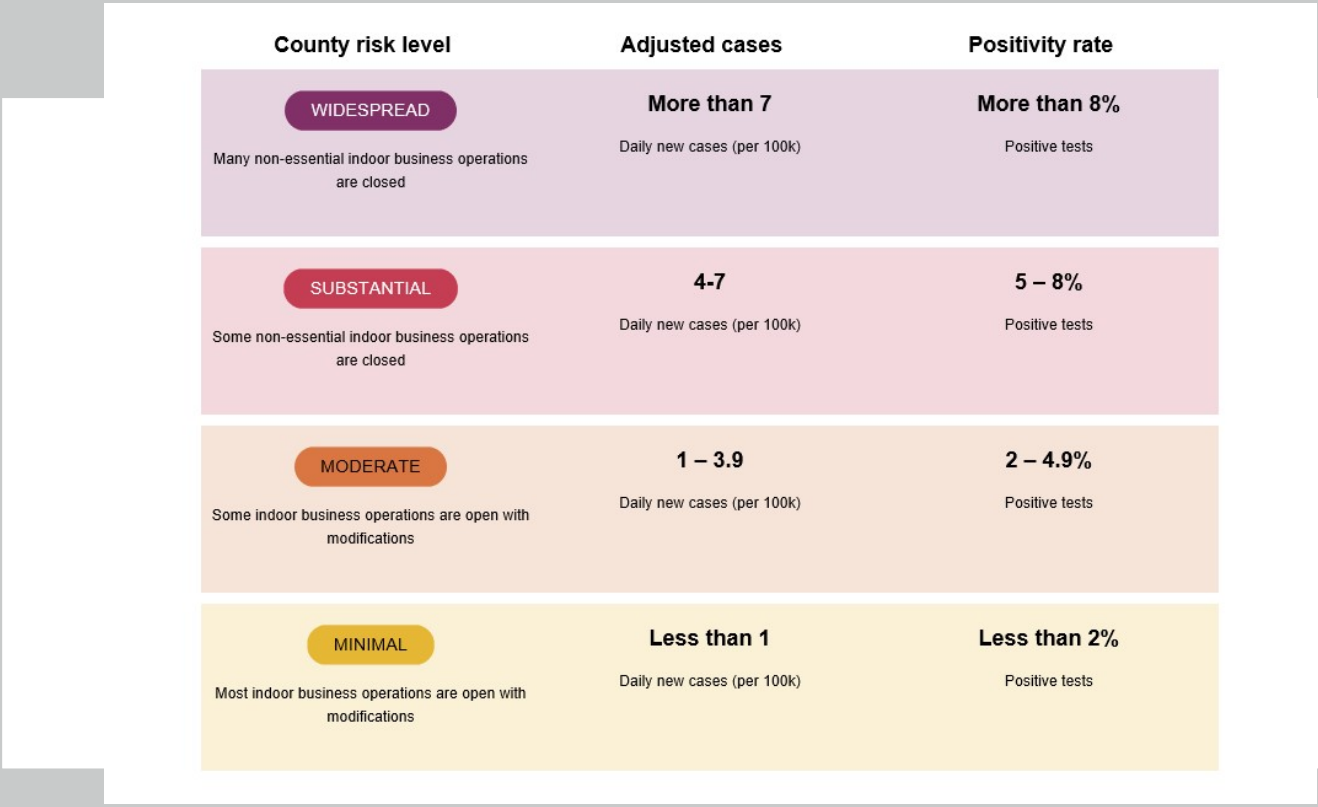
U.S. COVID-19 Surveillance Data

Current CA COVID-19 Updates & Guidance

- Updated Framework for Reopening of California
  - On 8/28/20, the CDPH updated the framework California will use to determine which counties and business sectors can safely reopen: California's Plan for Reducing COVID-19 and Adjusting Permitted Sector Activities to Keep Californians Health and Safe

  - Relies on a set of Tiers corresponding to specific epidemiological profiles based on indicators of disease burden including case rates per capita and percent of positive covid-19 tests and proportion of testing and other covid-19 response efforts addressing the most impacted populations within a county

  - Source: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/8-28-20_Order-Plan-Reducing-COVID19-Adjusting-Permitted-Sectors-Signed.pdf



Updated Framework for Reopening of California (continued)

Updated Framework for Reopening of California (continued)

Moving through the Tiers

Rules of the framework:

1. CDPH will assess indicators weekly on Mondays and release updated tier assignments on Tuesdays.
2. A county must remain in a tier for a minimum of three weeks before being able to advance to a less restrictive tier.
3. A county can only move forward one tier at a time, even if metrics qualify for a more advanced tier.
4. If a county's adjusted case rate for tier assignment and test positivity measure fall into two different tiers, the county will be assigned to the more restrictive tier.
5. The health equity metric will be the third metric applied to jurisdictions with populations greater than 106,000. Rules of the health equity metric are described below.
6. City local health jurisdiction (LHJ) data will be included in overall metrics, and city LHJs will be assigned the same tier as the surrounding county
7. An LHJ may continue to implement or maintain more restrictive public health measures if the local health officer determines that health conditions in that jurisdiction warrant such measures.

To advance:

1. A county must have been in the current tier for a minimum of three weeks.
2. A county must meet criteria for the next less restrictive tier for both measures for the prior **two** consecutive weeks in order to progress to the next tier.
3. In addition, the state will establish health equity measures that demonstrate a county's ability to address the most impacted communities within a county.

Current tier assignments as of October 6, 2020

All data and tier assignments are updated weekly every Tuesday.

Statewide metrics

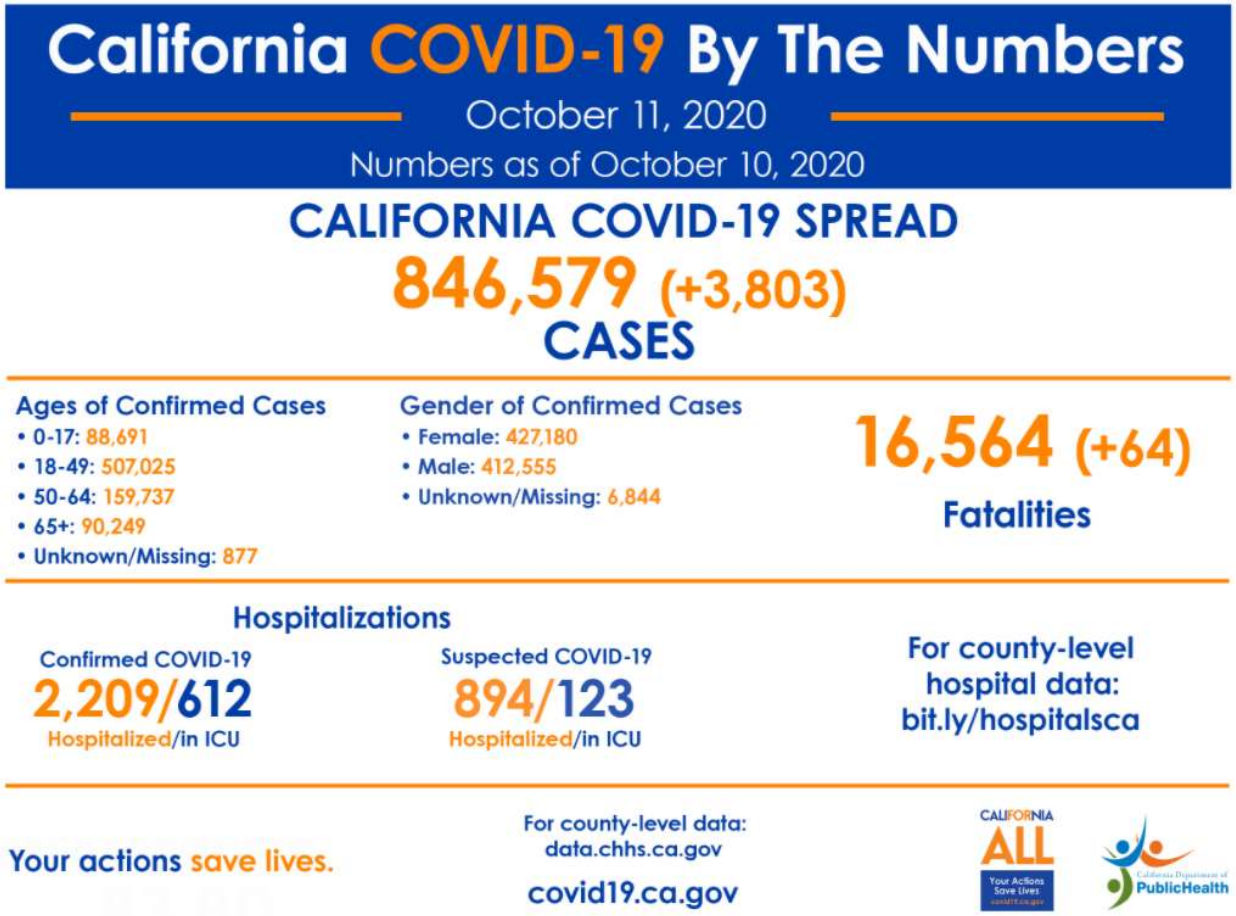
7.1
New COVID-19 positive cases per day per 100K

3.2%
Positivity rate

California Counties by Tier (as of 10/6/20)

Tier 1 (Widespread)	Tier 2 (Substantial Spread)	Tier 3 (Moderate Spread)	Tier 4 (Minimal Spread)
Colusa	Alameda	Amador	Alpine
Glenn	Butte	Calaveras	Humboldt
Imperial	Contra Costa	Del Norte	Mariposa
Kern	Fresno	El Dorado	Modoc
Kings	Lake	Inyo	Plumas
Los Angeles	Marin	Lassen	Siskiyou
Madera	Merced	Mono	Trinity
Mendocino	Napa	Nevada	
Monterey	Orange	San Francisco	
San Benito	Placer	Sierra	
San Bernardino	Riverside	Tuolumne	
Sonoma	Sacramento		
Stanislaus	San Diego		
Sutter	San Joaquin		
Tehama	San Luis Obispo		
Tulare	San Mateo		
	Santa Barbara		
	Santa Clara		
	Santa Cruz		
	Shasta		
	Solano		
	Ventura		
	Yolo		
	Yuba		

California COVID-19 Surveillance (as of 10/11/20)



Note: Numbers do not represent true day-over-day change as these results include cases prior to yesterday.

Positive Cases by County

Los Angeles	279,213
Riverside	61,845
San Bernardino	56,683
Orange	54,965
San Diego	50,145
Kern	32,338
Fresno	29,286
Sacramento	23,689
Santa Clara	22,354
Alameda	21,979
San Joaquin	20,700
Contra Costa	17,566
Stanislaus	16,960
Tulare	16,709
Ventura	13,520
San Francisco	11,663
Imperial	11,591
Monterey	10,410
San Mateo	10,218
Santa Barbara	9,417
Merced	9,105
Sonoma	8,235
Kings	8,078
Marin	6,852
Solano	6,655
Madera	4,662
San Luis Obispo	3,832
Placer	3,757
Butte	2,962
Yolo	2,939

CALIFORNIA CASES

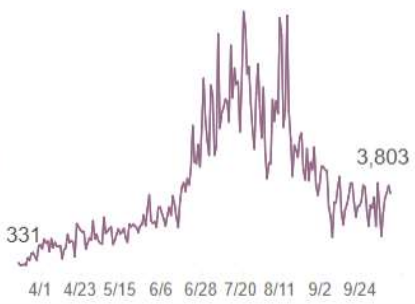
846,579

1 Day Δ	7 Day Δ	14 Day Δ
+3,803	+22,850	+44,271
+0.5%	+2.8%	+5.5%

7 Day Avg.	14 Day Avg.	Weekly % Change
3,264	3,162	6.7%

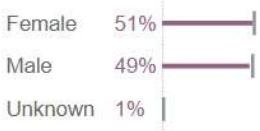
US Total Cases: 7,641,502

Day-Over-Day New Cases

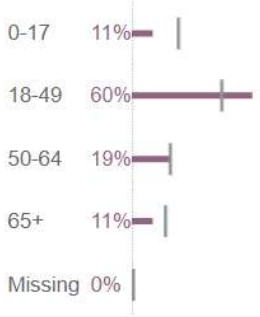


= California Population %

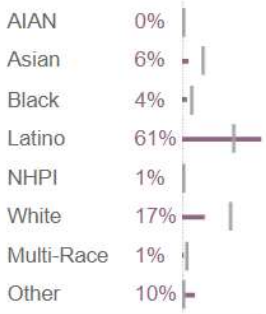
Gender



Age



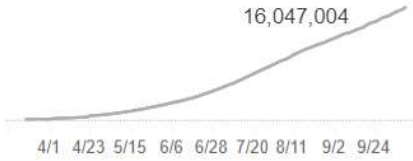
Race/Ethnicity



CALIFORNIA TESTING RESULTS

16,047,004

1 Day Δ	14 Day Δ	Positivity:
+168,559	+1,713,506	7 Day: **2.6%**
+1.1%	+12.0%	14 Day: **2.6%**



Cumulative Tests Reported by All Labs

CALIFORNIA DEATHS

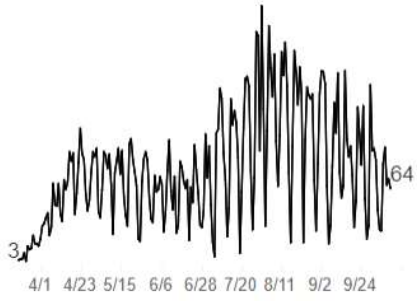
16,564

1 Day Δ	7 Day Δ	14 Day Δ
+64	+444	+977
+0.4%	+2.8%	+6.3%

7 Day Avg.	14 Day Avg.	Weekly % Change
63	70	-16.7%

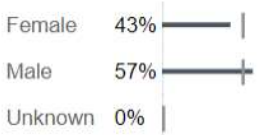
US Total Deaths: 213,037

Day-Over-Day New Deaths



= California Population %

Gender



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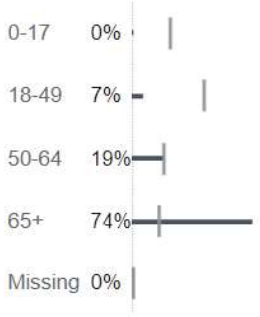
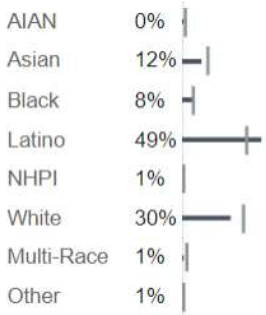


Race/Ethnicity



Note: Any instance of a negative number of cases or deaths reflects a correction to previous reporting.

Note: Demographic percentages may not add up to 100% due to rounding. Breakdown of deaths is a subset of total deaths as reported by law enforcement.

COVID-19: Hospitals

Select KPI

Positive Patients

Positive Patients by County

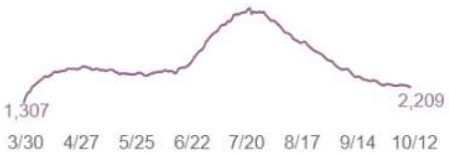
Los Angeles	693
San Diego	195
San Bernardino	192
Orange	164
Riverside	135
Fresno	85
Sacramento	78
Santa Clara	71
Alameda	64
Stanislaus	52
Kern	46
Ventura	37
San Francisco	33
Sonoma	32
Tulare	32
Imperial	31
Contra Costa	30
San Mateo	29
Monterey	26
Santa Barbara	24
San Joaquin	22
Solano	21
Kings	18
Placer	17
Santa Cruz	17
Madera	11
Yuba	9
Marin	8
Butte	6
Merced	6
Shasta	5
Humboldt	3
Mendocino	3

Positive Patients

2,209

1 Day Δ
-55
-2.4%

14 Day Rolling Avg.
2,318

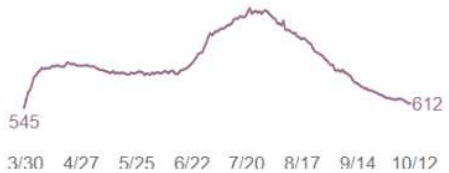


ICU Positive Patients

612

1 Day Δ
+0
+0.0%

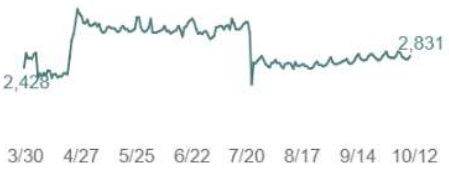
14 Day Rolling Avg.
668



ICU Available Beds

2,831

1 Day Δ
+97
+3.5%

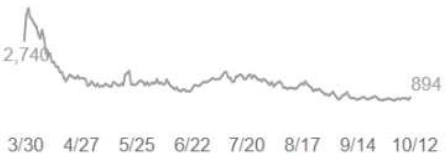


Suspected Patients

894

1 Day Δ
+74
+9.0%

14 Day Rolling Avg.
847

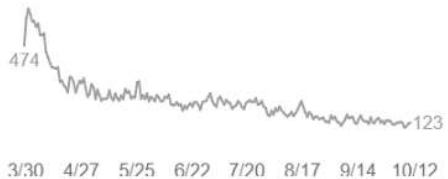


ICU Suspected Patients

123

1 Day Δ
+3
+2.5%

14 Day Rolling Avg.
121



Note: Due to a recent change by HHS, NICU bed counts are no longer provided.

Positive Patients by Facility/County

Daily Survey Response Rates

97%
of facilities
(382 of 393)

99%
of licensed beds
(73,272 of 73,867)

There are 416 licensed facilities (1 in suspense); one or more facilities can operate under the same license.

Last Updated on 10/10/2020

COVID-19 Race and Ethnicity Data

October 10, 2020

All Cases and Deaths associated with COVID-19 by Race and Ethnicity

Race/Ethnicity	No. Cases	Percent Cases	No. Deaths	Percent Deaths	Percent CA population
Latino	363,000	61.1	7,911	48.5	38.9
White	102,955	17.3	4,900	30.0	36.6
Asian	33,038	5.6	1,907	11.7	15.4
African American	25,312	4.3	1,238	7.6	6.0
Multi-Race	6,513	1.1	117	0.7	2.2
American Indian or Alaska Native	1,649	0.3	51	0.3	0.5
Native Hawaiian and other Pacific Islander	3,198	0.5	78	0.5	0.3
Other	58,729	9.9	105	0.6	0.0
Total with data	594,394	100.0	16,307	100.0	100.0

Cases: 846,579 total; 252,185(30%) missing race/ethnicity

Deaths: 16,460 total; 153 (1%) missing race/ethnicity

***877 cases with missing age**

****Census data does not include 'other race' category**

IHS COVID-19 Surveillance

https://www.ihs.gov/coronavirus/?CFID=210460169&CFTOKEN=92052908

COVID-19 Cases by IHS Area

Data are reported from IHS, tribal, and urban Indian organization facilities, though reporting by tribal and urban programs is voluntary. Data reflect cases reported to the IHS through 11:59 pm on October 10, 2020.

IHS Area	Tested	Positive	Negative
Alaska	260,672	3,099	234,376
Albuquerque	46,232	2,030	33,893
Bemidji	59,511	2,251	54,715
Billings	64,554	3,400	56,710
California	20,944	1,342	19,187
Great Plains	77,431	4,180	72,327
Nashville	30,334	2,201	27,129
Navajo	102,255	11,982	77,719
Oklahoma City	185,854	13,630	167,613
Phoenix	73,633	9,812	62,973
Portland	35,122	2,672	31,589
Tucson	7,738	626	7,004
TOTAL	**964,280**	**57,225**	**845,235**

COVID-19 Cases by IHS Area

Share this IHS Story Map

Data is reported from IHS, tribal, and urban Indian organization facilities, though reporting by tribal and urban programs is voluntary. These data reflect cases reported to the IHS through 11:59 pm on October 6, 2020

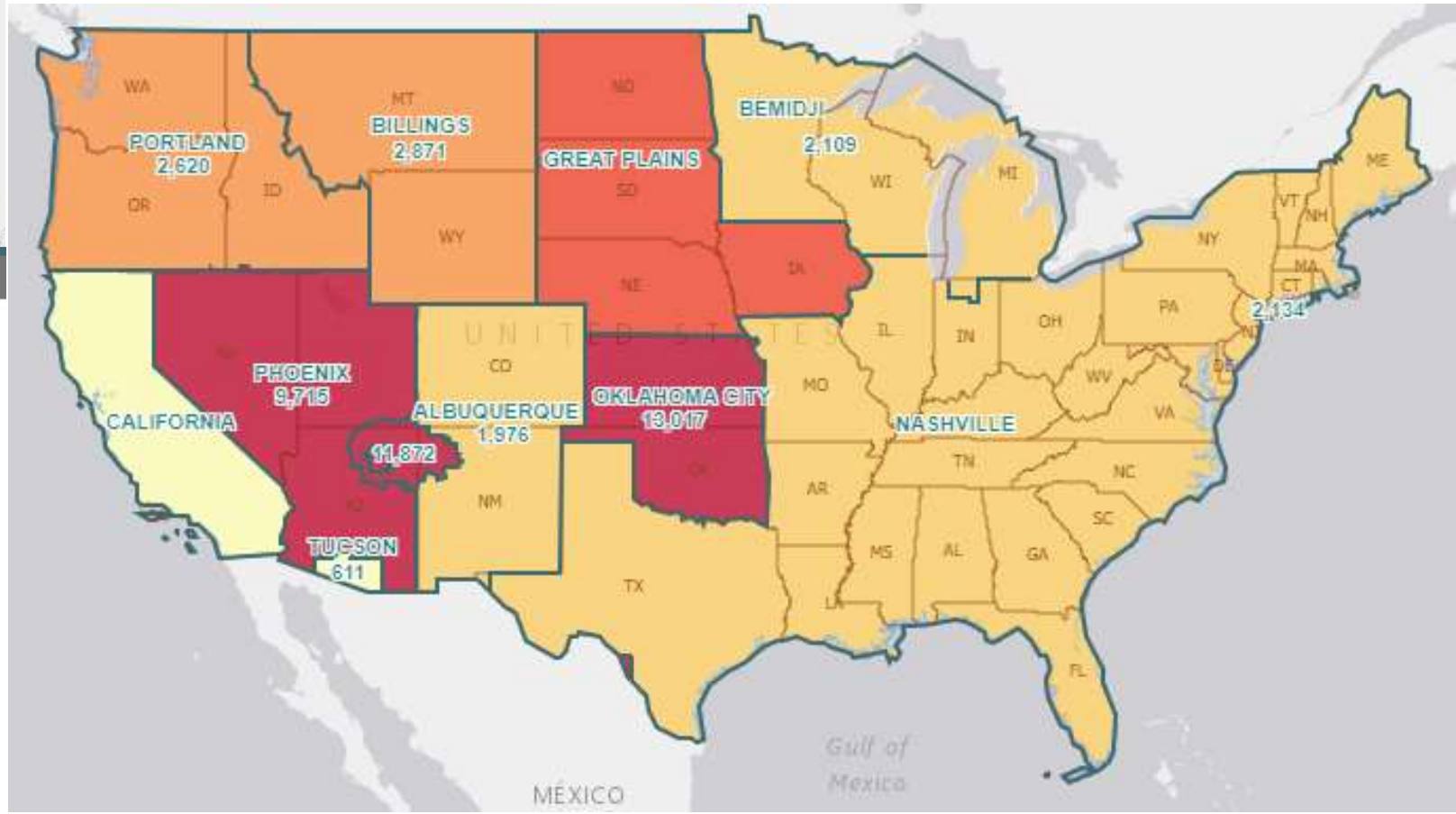
LEGEND

IHS Area Border

Aggregated by IHS Area

Number of Positive Cases

- > 3,803 – 13,017
- > 2,871 – 3,803
- > 2,134 – 2,871
- > 1,290 – 2,134
- 611 – 1,290



Questions/Comments

Christine Brennan, MPH

Associate Director, Office of Public Health

California Area Indian Health Service

916-930-3981, extension 333

Christine.Brennan@ihs.gov

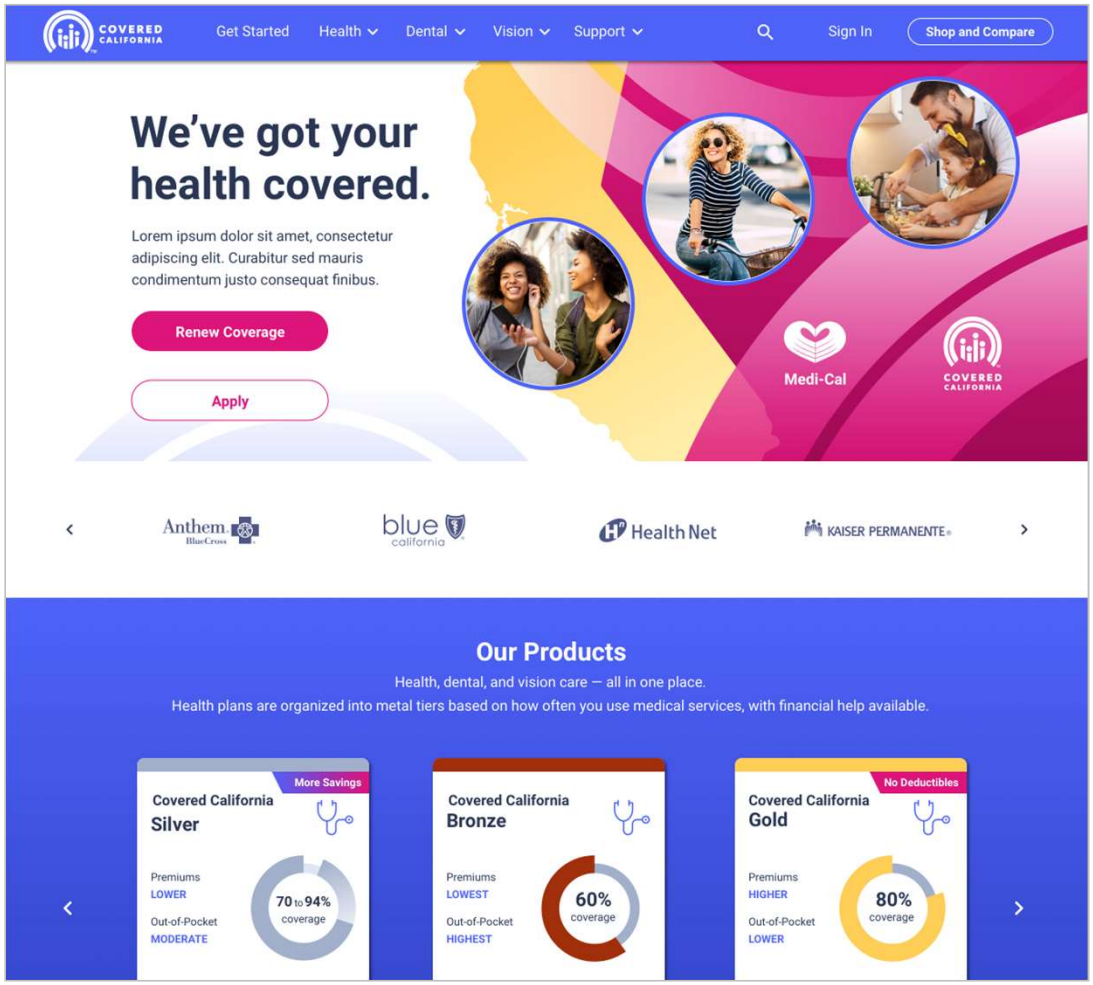
COVERED CALIFORNIA WEB REFRESH AND RESOURCE TOOLKIT

Kelly Bradfield, Tribal Liaison

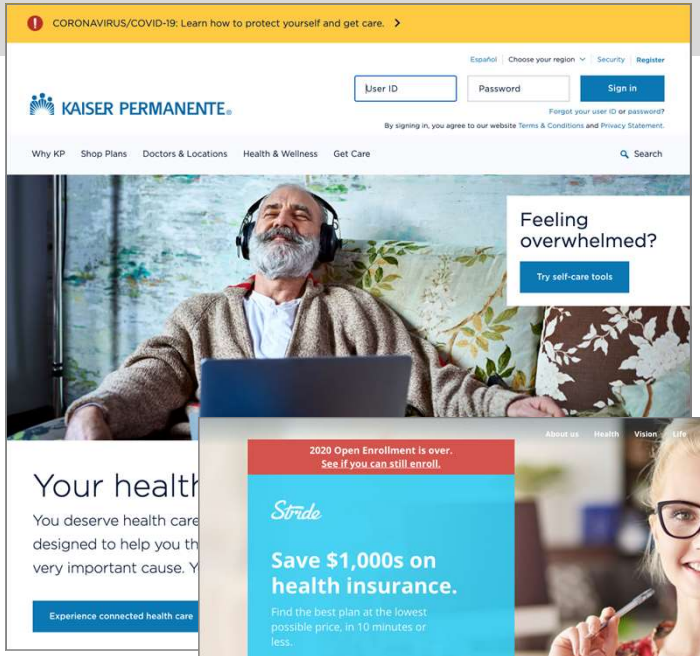
REFRESHING COVEREDCA.COM

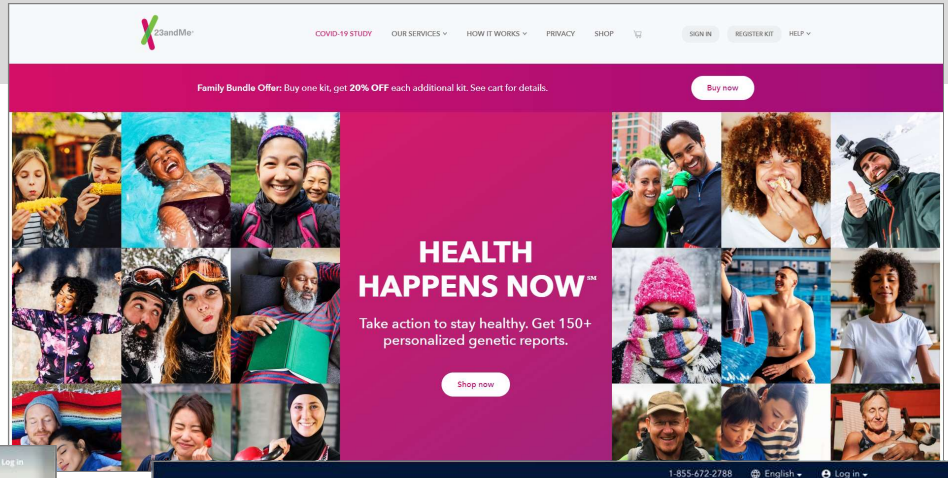
Design Goals

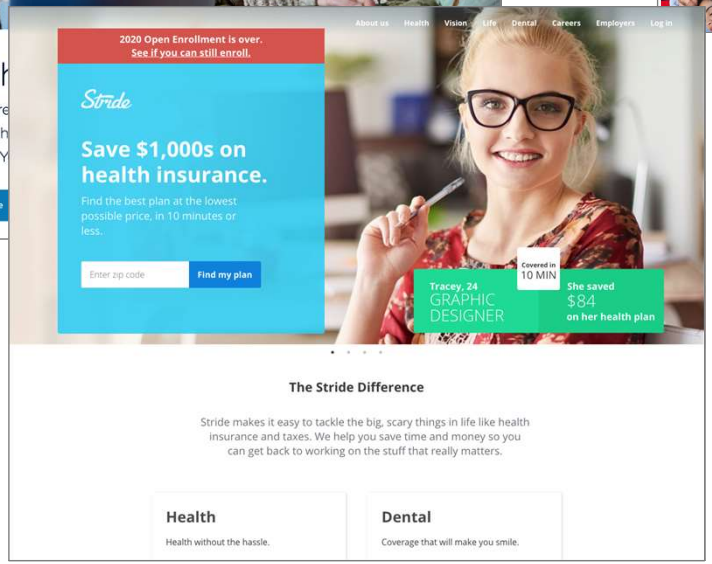
- Accessible and inclusive
- Mobile-first
- Modern, friendly and inviting
- Position product before price
- Plain language to guide users
- Mature and elevate the look and feel
- User-informed with ongoing research and testing
- Standardize design for continuity, clarity and efficiency

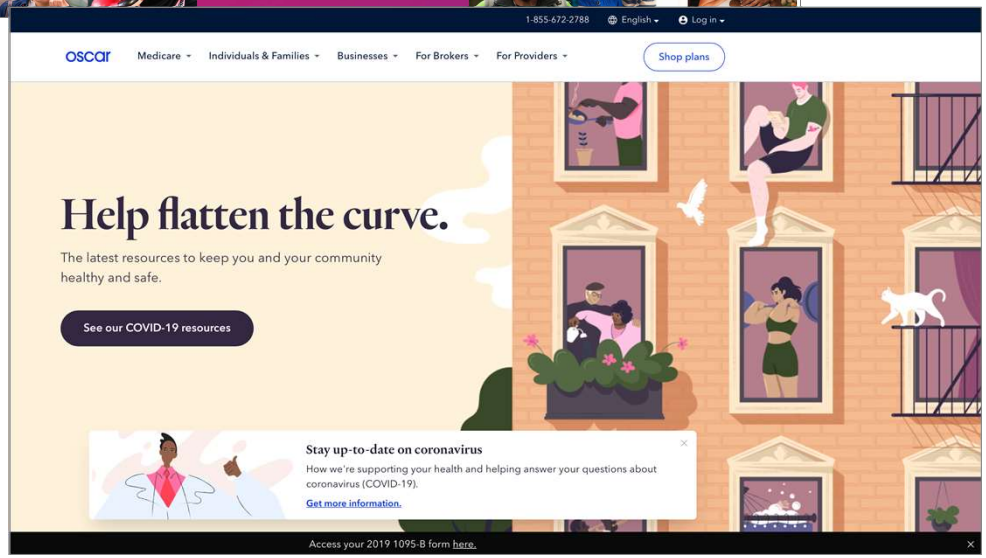


Keeping up with the Industry









Welcoming Feedback

- AI/AN page content remains the same
- Welcome ongoing feedback
- Changes and edits can be implemented much quicker under the new design

NEW RESOURCES ON HBEX

Updating HBEX Site

- New Resource Toolkit
  - Purchased/Referred Care Model Referral
  - Training/Background Slides for Clinic Staff
  - Plans and Rates for 2020
- Upcoming Resources
  - I/T/U Clinic Roster and Map
  - Consumer-focused flyers: Why Covered California Coverage, How to Use Covered California Coverage
  - User guide/Process flow for Purchased/Referred Care

TRIBAL ADVISORY WORKGROUP UPDATE

Kelly Bradfield, Tribal Liaison

Progress in 2020

- New structure designed to maximize engagement
  - How to make this group more valuable to its members?
    - Quarterly meetings set for the year to encouragement ongoing collaboration and allow members to plan ahead
    - Easier to participate remotely to encourage diverse voices from all over California
    - Help members connect to other stakeholder conversations to encourage AI/AN voices throughout agency discussions
  - New charter
    - Reflects new independence
    - Final edits are complete
    - Set to be voted on by Workgroup in January

Looking to 2021

- Approve new charter
- Utilize new structure to allow deeper engagement
- Proposed agenda items at this time?

OPEN SESSION AND CONTINUED DISCUSSION

NEXT STEPS AND CLOSING REMARKS

Thank you and stay safe!