IMPLEMENTATION OF THE MEMORANDUM OF UNDERSTANDING BETWEEN DHCS AND KAISER FOUNDATION HEALTH PLAN, INC.

THE ALTERNATE HEALTHCARE SERVICE PLAN AS A DIRECT MEDI-CAL MANAGED CARE PLAN

ANNUAL REPORT 2026

CALENDAR YEAR 2025

TABLE OF CONTENTS

EXECUTIVE SUMMARY 4

BACKGROUND 4

REPORTING PERIOD 5

I. ENROLLMENT OF MEDI-CAL MEMBERS 6

Total Membership by Aid Category 6

Foster Care Children and Youth & Dual Eligibles 7

Race 7

Age Category 9

Gender 10

II. ENROLLMENT GROWTH 11

Summary Enrollment Growth 11

III. SUPPORT OF FQHCS ON POPULATION HEALTH MANAGMENT AND CLINICAL TRANSFORMATION 12

Population Health Management Initiative Overview 12

Support and Measures 14

Team-Based Models of Care 15

Patient Outreach & Engagement 16

Addressing Social Need and Risk 16

Data & Analytics Support 17

Improved Population Health Management Capabilities 18

IV. OUTPATIENT SPECIALTY CARE AND SERVICES BY REGION AND DEMOGRAPHICS 20

V. COLLABORATION WITH COUNTIES AND LOCAL STAKEHOLDERS 28

Local Stakeholders 28

Memoranda of Understanding (MOUs) with Third Parties 30

Community Advisory Committee 31

Quality Improvement Health Equity Committee (QIHEC) & Health Equity Activities 32

Population Needs Assessment (PNA) 36

Board of Supervisors and Courts 37

VI. IMPLEMENTATION OF ECM AND COMMUNITY SUPPORTS....66
Enhanced Care Management....66
Community Supports....77
CONCLUSION....91

EXECUTIVE SUMMARY

Department of Health Care Services (DHCS) entered into a Memorandum of Understanding (MOU) with Kaiser Foundation Health Plan, Inc. (Kaiser) as an alternate health care service plan (AHCSP), effective May 30, 2023, in accordance with AB 2724 (Chapter 73, Statutes of 2022). AB 2724 requires DHCS to publish an annual report on our website describing implementation status for the standards and requirements imposed by the MOU. This report fulfills the requirement by providing information on:

- Enrollments of Medi-Cal members by county, geographic area, aid code, and select demographics;
- Enrollment growth starting from baseline enrollment effective July 1, 2024.
- Specialty care services through certain pilot programs in partnership with certain federally qualified health centers.
- Efforts to engage local counties and stakeholders in accordance with the DHCS-approved stakeholder engagement plan.
- Implementation of ECM and Community Supports.

BACKGROUND

DHCS entered into a Memorandum of Understanding (MOU) with Kaiser Foundation Health Plan, Inc. (Kaiser) as an alternate health care service plan (AHCSP), effective May 30, 2023, in accordance with AB 2724 (Chapter 73, Statutes of 2022). The MOU applies to the geographic areas of the 32 counties where Kaiser is directly contracted to serve and licensed by the Department of Managed Health Care.

As defined in AB 2724, Kaiser is subject to all of the same standards and requirements as other full-risk MCPs as part of the 2024 MCP contract, except those related to member enrollment. The MOU identifies DHCS' and Kaiser's responsibilities and obligations to each other in accordance with AB 2724; it memorializes commitments and requirements in the following areas:

- Enrollment processes, including, but not limited to, enrollment growth from geographic expansion, foster care children and youth and former foster care children and youth who elect to enroll in Kaiser, and members dually eligible for Medi-Cal and Medicare residing in Kaiser's geographic service areas, as well as annual enrollment growth through default enrollments in specific counties
- CalAIM's Enhanced Care Management and Community Supports implementation

- FQHC assistance with PHM and clinical transformation
- Specialty care services through certain pilot programs in partnership with certain FQHCs in identified geographical areas and specialties of need
- Reporting
- Collaboration with counties and local stakeholders
- Primary care physician assignment
- Behavioral health network adequacy and readiness

REPORTING PERIOD

This annual report includes updates for calendar year (CY) 2025.

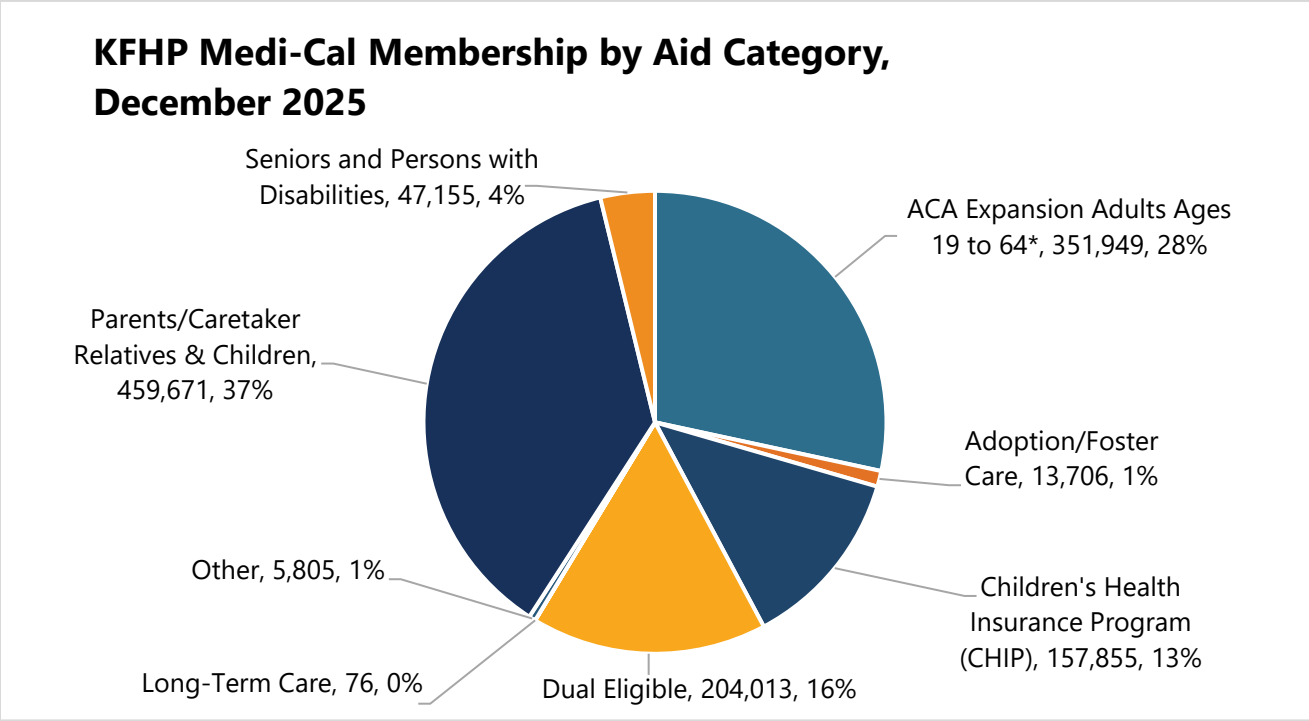
I. ENROLLMENT OF MEDI-CAL MEMBERS

As of December 31, 2025, Kaiser Foundation Health Plan, Inc. (Kaiser) has 1,240,230 members enrolled in the Medi-Cal program across the 32 counties it serves. The following information provides a demographic breakdown of Kaiser's Medi-Cal membership by aid code category and county.

Total Membership by Aid Category

Aid Category represents the criteria by which a member qualifies for the Medi-Cal program. Possible categories include Affordable Care Act (ACA) Expansion, Adoption/Foster Care, Children's Health Insurance Program (CHIP), Long-Term Care, Parents/Caretaker Relatives & Children*, Seniors and Persons with Disabilities (SPD), and Other. Kaiser serves members across various aid categories, including 13,706 Adoption/Foster Care members in 2025. Parents/Caretaker Relatives & Children comprises the highest share of Kaiser's Medi-Cal membership, with 459,671 members or 37% of the total. Some aid categories include both adults and children – 279,815 members, or 23% of Parents/Caretaker Relatives & Children are under the age of 19, while 14,628 or 1% of Seniors and Persons with Disabilities (SPDs) are under the age of 19. In alignment with the Section I supplemental data file and DHCS-defined aid categories, Kaiser's Medi-Cal membership totaled 1,240,230 members as of the end of 2025. Please refer to the supplemental data for a detailed breakdown of population by aid categories.

Figure 1: KFHP Medi-Cal Membership by Aid Category, December 2025



*The aid category, Parents/Caretaker Relatives and Children, provides full scope Medi-Cal coverage to citizens/lawfully present parent/caretaker relatives and their children with income at or below 109% of the FPL.

Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2025

Foster Care Children and Youth & Dual Eligibles

As of December 31, 2025, Kaiser's Medi-Cal Membership is approximately 1% foster care children and youth. In comparison, the percentage of foster care children and youth in other managed care plans was approximately 0.5%.

Kaiser's Medi-Cal Membership is approximately 16% full dual members meaning they have Medi-Cal and Medicare Part A and B. In comparison, the percentage of full dual members in other managed care plans is about 12%.

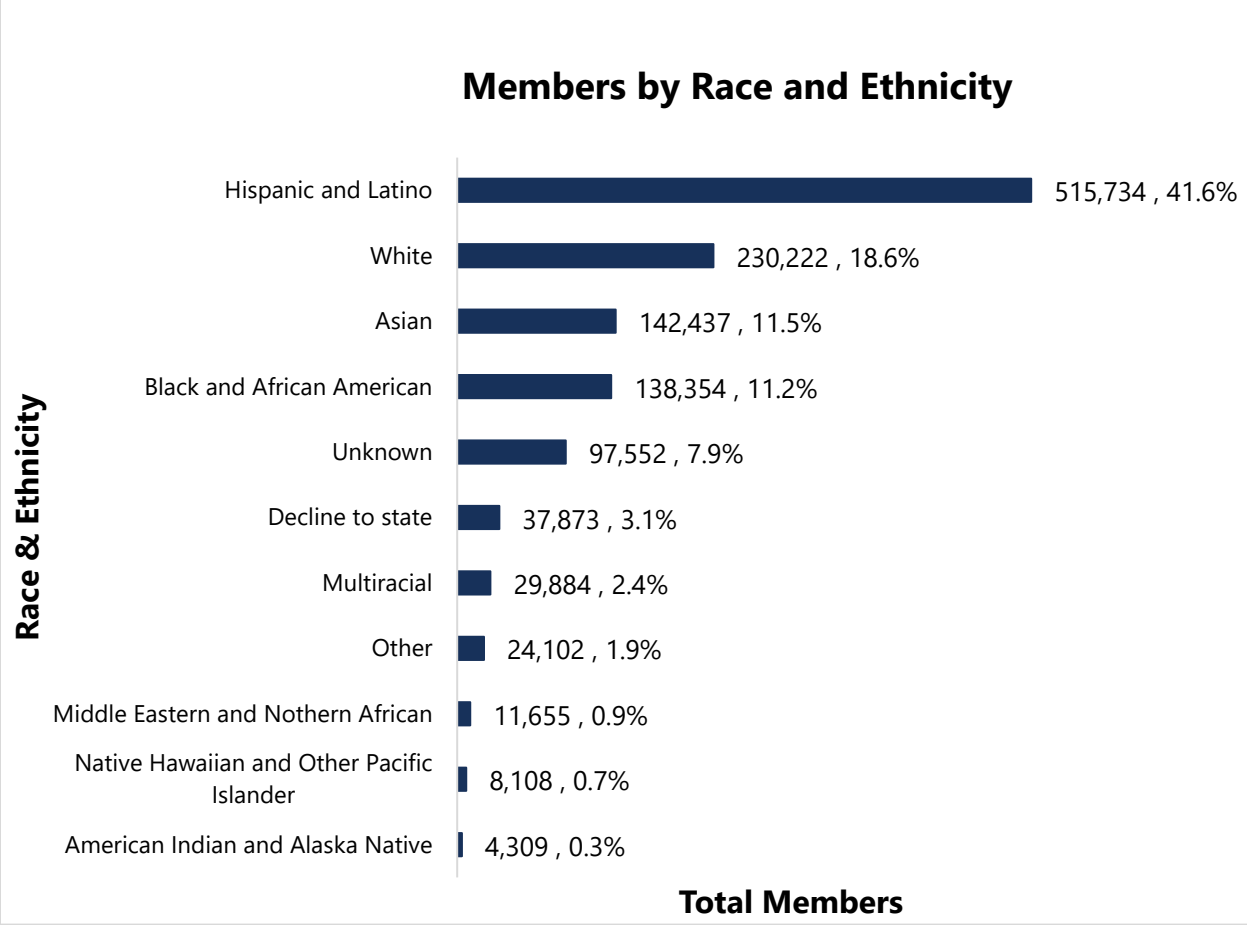
Race

Reported categories include American Indian and Alaska Native (AIAN), Asian, Black and African American, Hispanic and Latino, Middle Eastern and Northern African (MENA), Multiracial (MULTI), Native Hawaiian and Other Pacific Islander (NHOPI), White, and Other.

The exact percentages for each category are as follows: 41.6% identified as Hispanic, 18.6% identified as White, 11.5% identified as Asian, 11.2% identified as Black, 2.4% identified as multiracial, 1.9% identified as Other, 0.9% identified as MENA, 0.7% identified as NHOPI, and 0.3% identified as AIAN.

Some also declined to state (DECL, 3% or are unknown (8%)).

Figure 2: Members by Race and Ethnicity

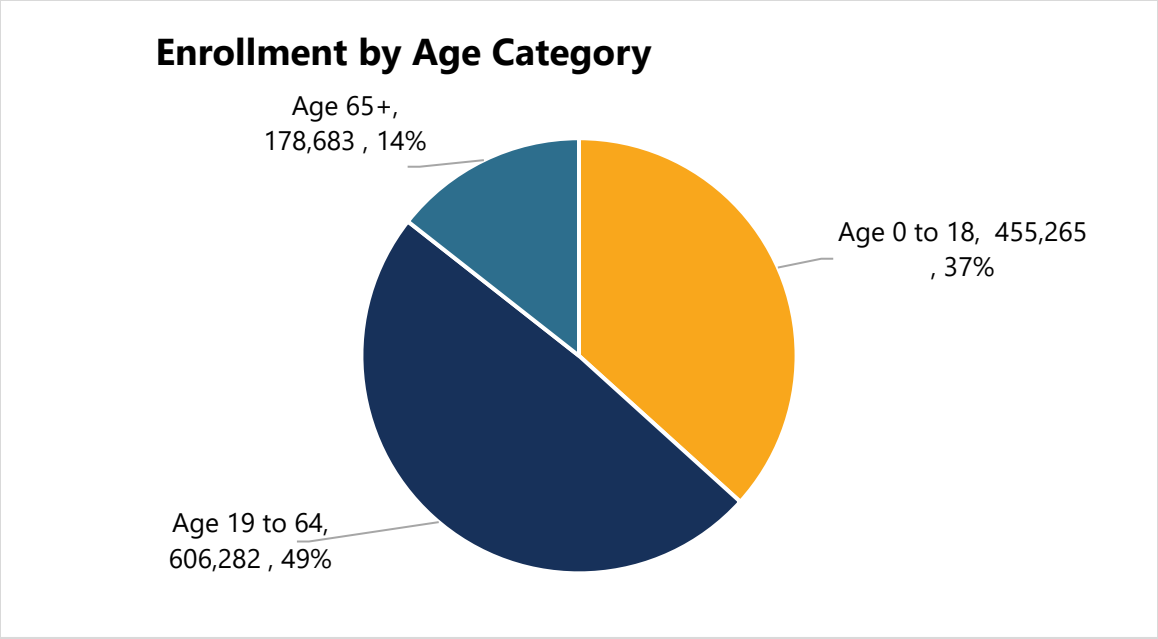


Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2025

Age Category

Age is categorized into three groups: (1) 0-18; (2) 19-64; and (3) 65+. Overall, 455,265 or 37% of members are 0-18 years of age, 606,282 or 49% of members are ages 19-64, and 178,683 or 14% of members, are 65 years or older.

Figure 3: Enrollment by Age Category



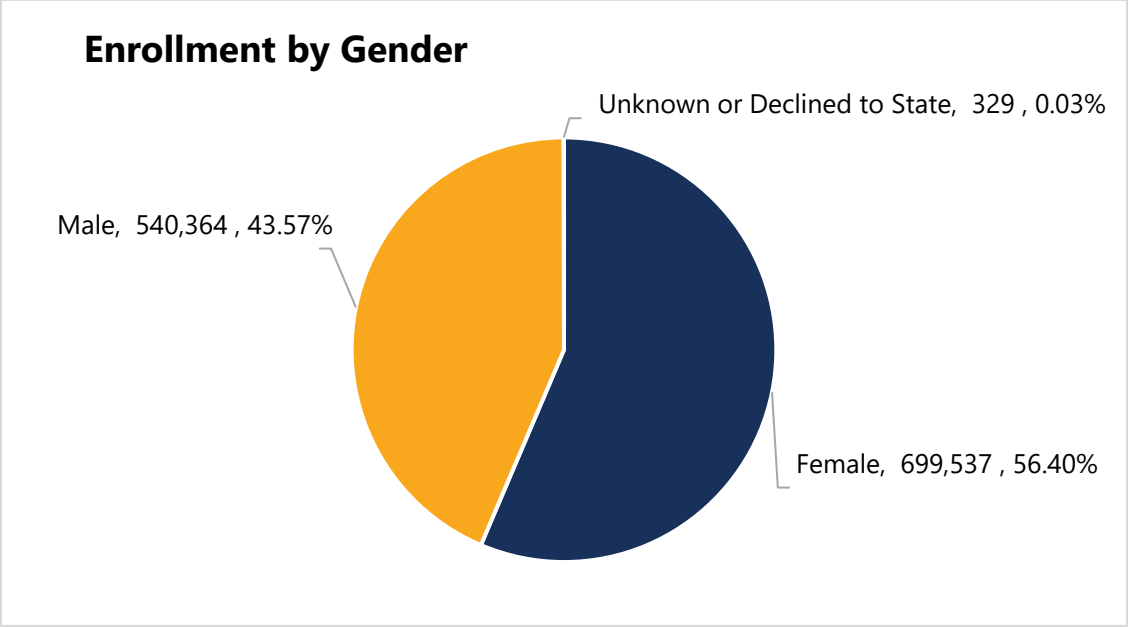
Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2025.

Gender

Reported categories include Male, Female, Other, and Unknown, as reported by DHCS' enrollment files.

As of December 31, 2025, a majority (56%) of members are female, 44% are male, and less than 0.03% of members are unknown or declined to state.

Figure 4: Enrollment by Gender



Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2025

II. ENROLLMENT GROWTH

This section summarizes enrollment growth starting with the baseline enrollment as of July 1, 2024. Per the MOU, July 1, 2024, baseline for enrollment growth would exclude any population changes from January 1, 2024, to June 30, 2024, resulting from growth in duals, foster children and youth, default enrollment, managed care plans exiting a county as of December 31, 2023, and Kaiser's expansion into new geographic areas as a Prime Plan.

Summary Enrollment Growth

Pursuant to AB 2724 (2022) and the MOU between DHCS and Kaiser, Kaiser is to target growth in its Medi-Cal membership by 25% through the initial term of the primary agreement. DHCS considers the baseline enrollment point in time to be July 1, 2024, and Kaiser must have a goal of 25% growth of Medi-Cal member enrollment from the baseline by December 2028.

Between July 1, 2024, and December 31, 2025, Kaiser's total Medi-Cal Membership increased from 1,019,525 to 1,240,230, equaling a growth rate of 21.65%. If this growth rate is sustained, Kaiser is on track to reach the 25% growth target prior to the end of December 2028. Of the 220,705 members that joined Kaiser between July 1, 2024, and December 31, 2025, 2,474 were foster care children and youth and 33,404 were Dually Eligible members.

Table 1: Enrollment Growth Summary

Enrollment Growth Summary	Baseline (July 1, 2024)	Year End 2024 Membership	Year End 2025 Membership	Growth	Growth Rate
KP Medi-Cal Membership	1,019,525	1,156,579	1,240,230	220,705	21.65%

Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2025

III. SUPPORT OF FQHCS ON POPULATION HEALTH MANAGMENT AND CLINICAL TRANSFORMATION

Per the MOU, this section provides a narrative and process-based metrics specified by DHCS to measure engagement and support of Federally Qualified Health Centers (FQHCs). For example, narrative and metrics as specified by DHCS describing investments, technical assistance, and other support to develop capabilities among FQHCs on Population Health Management (PHM) and clinical transformation efforts.

Population Health Management Initiative Overview

The Population Health Management Initiative (PHMI) is a collaboration between DHCS, the California Primary Care Association (CPCA), and Kaiser to support 32 Community Health Centers (CHCs) across eight (8) counties, which serve 1.1 million patients total, including Medi-Cal members and other individuals who make up the CHC's patient population.

The PHMI's goals are to improve the CHCs' quality measure performance, improve patient engagement and experience of care, improve access to primary care measures through team-based care redesign, reduce disparities in care, and improve identification and management of patients assigned to the CHC.

After a collaborative design period with DHCS, CHCs, and Kaiser, the group developed solutions addressing people, process, and technology. Implementation of solutions began in early 2023. CHCs received grant funding from Kaiser to participate in the initiative. Clinical practice transformation support began with an initial gap self-assessment (via a survey), support for data reporting, and support for one other area of the participating CHC's choice. Implementation guides outlining a comprehensive set of evidence-based practices were created. These included empanelment[1], data quality and reporting, care teams and workforce, business case, and five (5) additional guides, one (1) for each of the key populations of focus (pregnant people, children, adults with preventive care needs, adults living with chronic conditions, and people with behavioral health conditions). Each CHC's progress was marked by achievement of practice change milestones, starting with the foundational domains of empanelment, data quality and

1 Empanelment refers to a clinic's process to formally link patients to a specific primary care provider and/or care team within the clinic.

reporting, care teams and workforce, and business case. In mid-2024, CHCs began working on additional milestones related to their chosen population focus.

Kaiser provides directly or invests in various supports to CHCs including one-on-one (1:1) subject matter expertise and coaching support tailored to each CHC's starting point. Additional support is provided through group meetings. The details of this engagement, including investments by Kaiser for PHMI, with technical assistance and support provided to develop capabilities among CHCs, are outlined below.

Summary of methods delivering practice transformation support include:

- A set of implementation guides available on the PHMI public website
- Practice coaching support focused on addressing gaps identified in the initial and follow-up assessments, provided via 1:1 coaching
- Consulting support and 1:1 assistance by subject matter experts in the following areas: populations of focus, care teams, data quality, data reporting, empanelment, financial planning, clinical support for populations, health equity, technology enablement, social need and risk
- Web-based curriculum, including webinars, e-learnings, and resources
- CHC attendance at an in-person statewide learning session and an in-person regional learning session for peer learning and implementation supports
- CHC participation in peer learning affinity groups
- Workflow engineering and technical assistance for the PHMI platform.[2]

2 The PHMI Platform is an opt-in population health management technology platform designed to support the management of patient populations alongside existing HIT solutions. The Platform integrates CHC data sources (e.g., clinical data) with third-party data sources (e.g., claims and admission, discharge, and transfer data) to provide a comprehensive, holistic view of the patient. This enables more seamless coordination across a CHC's clinical, quality, and operational teams.

Support and Measures

PHMI seeks to improve empanelment of assigned patients to a primary care provider and improve continuity of patient care.

Efforts in this area tie to the following larger initiative goals:

- Improve identification and management of the population of patients assigned to the CHC for primary care
- Improve patient engagement in primary care and patients' experience of care

The Kaiser team working with the CHCs undertook the following activities:

- Developed an implementation guide detailing empanelment processes
- Conducted an initial self-assessment of CHC empanelment practices and developed a customized workplan for each CHC
- Provided 1:1 subject matter expertise support to implement workflows

The following are process-based measures demonstrating the outcomes of Kaiser team's work effort thus far:

- 100% of CHCs identified a panel manager (who helps manage the empanelment process)
- As of July 2025, 88% of established patients were assigned to a PCP at the participating CHCs

Team-Based Models of Care

PHMI seeks to identify and implement best practice team-based models of care, with attention to birthing care, pediatrics, behavioral health, and adult disease prevention and chronic condition management. This includes ensuring teams have the right team members, and that roles/responsibilities, workflows, and operational processes are developed and implemented. This also helps ensure that CHCs leverage DHCS-covered benefits and services where possible, including, but not limited to, community health workers, dyadic services, and doulas.

Efforts in this area are tied to the larger initiative goal of improving performance on access to primary care through team-based care and care redesign.

The Kaiser team working with the CHCs undertook the following activities:

- Development and publishing of implementation guide with best practice team-based models of care
- Development of guides for each population above with specific care team member role guidance that leverages DHCS-covered benefits
- Having each CHC complete a self-assessment survey of care team practices and customized action planning
- Provision of subject matter expertise and coaching support

In terms of process outcomes related to this work as of July 2025, the Kaiser team working with CHCs found the following:

- 100% of CHCs have defined and established a core patient care team
- 100% of CHCs have assured that care teams know their patient panels
- 100% of CHCs have assured that patients know their care team

Patient Outreach & Engagement

PHMI seeks to improve patient outreach and engagement, through effective outreach methods and tools, especially for patients assigned to the CHC for primary care but not seen, incorporating patient experience measurement and feedback loops into CHC care delivery and quality improvement ("QI") work.

Efforts in this area are tied to the larger initiative goal of improving identification and management of the population assigned to the CHC.

The Kaiser team working with the CHCs undertook the following activities:

- Provision of subject matter expertise, coaching support, and peer learning opportunities to support the creation of outreach protocols to engage all attributed patients
- Provision of subject matter expertise, web-based curriculum, coaching support, and peer learning opportunities to support, gather and incorporate input from patients into quality improvement efforts

These activities led to the following process outcomes by the end of 2025.

- By end of 2025, 93% of CHCs had implemented an outreach protocol to reach and engage all assigned patients, while 7% were still in progress of finalizing their protocol

Addressing Social Need and Risk

PHMI seeks to assist CHCs in identifying and implementing best practices to address health-related social need and risk (HRSN) by expanding regular and systematic HRSN screening and referrals to available local resources. This process includes connecting patients with services through Community Supports in each geography. HRSNs are social drivers of health, which, when addressed, can enable a patient to achieve better health outcomes.

Efforts in this area tie to the following larger initiative goals:

- Improve CHCs ability to reduce measurable health disparities
- Improve patient engagement and experience of care

To improve in this area, the Kaiser team working with the CHCs undertook the following activities:

- Development and publishing of HRSN screening guidance in each Population of Focus implementation guide

- Provision of one-on-one subject matter expertise, practice coaching, and peer learning opportunities to improve screening and referral processes

In terms of process outcomes related to this work, Kaiser found that, as of July 2025, 75% of participating CHCs were screening for social needs and risks. Furthermore, an increasing number of CHCs were specifically screening within their Population of Focus.

Data & Analytics Support

PHMI seeks to provide support to CHCs in order to do the following: assess the risk of their patients (risk stratification), establish lists of patients with specific needs/conditions (registries and gaps in care reports), create data dashboards, and analyze data effectively. The goals of using data are to identify health outcomes, evaluate the need for and effectiveness of interventions, provide better care management and care coordination, and learn to better capture and report on data.

Efforts in this area tie to the following larger initiative goals:

- Improve quality
- Capture and improve measurable disparities

To improve in this area, the PHMI team working with the CHCs undertook the following activities:

- Development and publishing of implementation guides detailing data reporting methodology, approach to care coordination, Health Information Technology (HIT) such as registries, gaps in care reports, and dashboards. Multiple implementation guides are published on PHMI's website
- Development of measures to align with DHCS' final Population Health Management Strategy and Roadmap and Comprehensive Quality Strategy
- Provision of a subject matter expert's assessment of each CHC's data reporting capability and health information technology capability and customized action planning
- Provision of subject matter expertise support in data quality and reporting, utilizing data for improvement, and HIT support

As a result of these activities, the following process outcomes were observed:

- Improvements in the percentage of CHCs that could produce and submit HEDIS-like measures of high quality (increasing from 50% in October 2023 to 84% in July 2025)

» CHCs more completely captured data regarding the race and ethnicity of their patients, which is a necessary piece of data to reduce health disparities

Improved Population Health Management Capabilities

PHMI developed the Population Health Management Capability Assessment Tool (PhmCAT) to assess CHC capabilities related to eight core domains associated with effective population health management and value-based care. CHCs participating in PHMI complete the PhmCAT self-assessment annually and discuss ratings and results with their practice coaches.

PhmCAT has shown statistically significant improvements across all eight (8) domains from baseline. The majority (88%) of CHCs have increased their overall population health management capability score, which is an aggregated score of all domains. Additionally, there has been continued improvement year-over-year across all domains.

Table 2: PhmCAT Improvement

PhmCAT Domains	Cohort avg (scale 1-10)		CHCs Improving (n=32)
	April 2023 (Baseline)	Nov. 2025 (Most Recent)	
Leadership & Culture	7.0	7.6	78%
Business Case for PHM	6.4	7.0	66%
Technology & Data Infrastructure	6.3	7.2	84%
Empanelment & Access	6.5	7.4	84%
Care Team & Workforce	6.2	7.5	94%
Patient-centered, Population-based Care	7.0	7.5	75%
Behavioral Health	6.7	6.9	56%
Social Health	6.4	7.1	75%
Overall Capability Score	6.5	7.3	88%

PHMI Statewide Learning Session

In March 2025, PHMI stakeholders, including representatives from our cohort of Community Health Centers (CHCs), Regional Associations of California (RAC Consortia),

DHCS, CA Primary Care Association (CPCA), and Managed Care Plans (MCPs), came together for an in-person Statewide Learning Session aimed at supporting CHCs in developing a robust set of practical ideas and next steps towards achieving improved population health outcomes.

PHMI Regional Learning Sessions

In 2025, PHMI also organized four (4) in-person Regional Learning Sessions (RLS) in Fresno, Los Angeles, Santa Rosa, and Ukiah. The RLS included regional CHCs, Consortia, CPCA, DHCS, and MCPs. The regional convenings are designed to build a community of peers, and support CHCs as they share identified promising practices and emerging challenges for population health management.

Table 3: The Regional Learning Sessions schedule is below:

Event	Date	Location
PHMI Central Valley Regional Learning Session	July 15, 2025	Fresno
PHMI North Coast Regional Learning Session	August 28, 2025	Ukiah
PHMI Sonoma County Regional Learning Session	September 16, 2025	Santa Rosa
PHMI Los Angeles Regional Learning Session	September 30, 2025	Los Angeles

Affinity Groups

CHCs also participated in affinity groups in 2025. PHMI affinity groups are virtual peer learning forums that enable CHCs to share challenges, successful strategies for implementation, and emerging best practices across key population health management and clinical transformation topics. As a core component of PHMI's peer learning approach, the affinity groups facilitate CHC-to-CHC learning supported by subject matter expertise, with a focus on generating practical, actionable improvement strategies aligned with PHMI objectives. In 2025, the affinity groups addressed topics including behavioral health integration, social health, data utilization, and more.

IV. OUTPATIENT SPECIALTY CARE AND SERVICES BY REGION AND DEMOGRAPHICS

Per the MOU, this section provides a Report of how Kaiser implemented the requirements to engage in pilot efforts to identify and provide specialty care with areas with highest needs. Specifically, this section reports on the identification of highest need specialties and Geographic Areas where outpatient specialty care and services are provided by Kaiser. This section also reports on which areas Kaiser engaged with over which time periods and the utilization rate by specialty care sites; by county/ Geographic Area; by demographics.

The Enhanced Specialty Access (ESA) pilot strives to identify and address critical gaps in access in specialty care in California for Medi-Cal members who are not assigned to Kaiser. Through the ESA pilot, Kaiser has committed to improving access to in-person, outpatient specialty care visits and, when possible and appropriate, diagnostic testing and outpatient procedures for members enrolled in other Medi-Cal Managed Care Plans. Further, Kaiser has committed to improving the capacity of primary care providers to co-manage specialty conditions through modalities such as electronic consultation and education. The ESA pilot is required in no less than three distinct geographical areas that serve a total of at least one million Medi-Cal members.

In collaboration with DHCS, Kaiser identified the highest-need specialties and geographic areas. This collaborative process included strategic discussions with DHCS, CPCA, select consortiums of CHCs, Kaiser, and (in select geographies) other MCPs and public hospitals. A "hotspot analysis" identified regions and specialties with the highest need based on the number of Medi-Cal-enrolled specialists, as compared with the needs of the Medi-Cal members in the region. In addition, analysis of CHCs' patient wait times for specialties and capabilities for pilot participation were considered, as was the availability of Kaiser resources to initiate a pilot and recruit new resources.

This collaborative process identified the following geographical areas and specialty areas of care. Work was initiated in a phased approach over the time periods indicated, starting with Kern County in December 2022.

Table 4: ESA Pilot Geographical Areas, Specialty Areas, and Timeframes

Pilot Number	Geographical Area	Specialty Area	Engagement Timeframe
1	Kern County	» Endocrinology (Omni Family Health) » Nephrology (Clinica Sierra Vista (CSV) » Rheumatology (CSV)	December 2022 – Present
2	San Joaquin and Stanislaus Counties (Golden Valley Health Center)	» Rheumatology » Endocrinology » Neurology	September 2023 – Present
3	Antelope Valley (Los Angeles County) (Bartz-Altadonna Community Health Center)	» Nephrology » Rheumatology » Endocrinology	April 2024 – Present

Participating community health centers are identified in parentheses. In Pilots number 2 and 3, all specialty areas are offered at the same participating health center.

Within the ESA Pilot, implementation has focused on identifying collaborating community health centers (CHCs) that can host Kaiser specialists and provide care to non-Kaiser MediCal beneficiaries. Kaiser specialists primarily deliver care through in-person visits, with virtual visits offered when preferred by patients, clinically appropriate, or when in-person specialist availability is limited.

The CHCs also receive technical assistance and provider education. Engagement activities across all 3 Geographical Areas include:

- Conducting physician recruitment efforts to participate as specialists providing specialty care services at host CHCs;
- Engaging with key stakeholders (e.g. DHCS, CHCs, other MCPs in the region, public hospitals, and other providers) regarding high need specialties;

- Acquiring data of specialty referral volumes from the CHCs hosting the specialty services and MCPs to inform the high need specialties;
- Staffing workgroups to implement each specialty at each host CHC;
- Establishing geographic specific steering committee meetings;
- Initiating didactic webinars for primary care providers at the host CHCs to improve Primary Care Providers' (PCPs) ability to manage specialty care conditions, and other core ESA implementation tasks needed to initiate in-person specialty care visits;
- Training an Advanced Practice Provider (APP) to become expert in the primary care management of nephrology patients and in turn support the spread of knowledge;
- Implementing specialty-specific workflows; and
- Other core ESA implementation tasks needed to initiate and improve in-person specialty care visits to meet monthly targets.

The following table summarizes each specialty area of care's launch of clinical services, the number of in-person visits as of December 31, 2025, and the stage of development for each specialty area of care in the three geographical areas. The stages are ramp-up (the time before full FTEs and schedules are in place), practice maturation (about twelve months of increasing the practice size), and stability and maintenance (after practice is mature). Please see footnote below on how FTE was calculated and.[3]

3 DHCS and KP mutually agreed to calculate the initial commitment level by defining the FTEs that would be necessary to perform 15% of the specialty encounters in the region (e.g., if 10,000 office visits occurring per year in region, then FTEs to perform 1,500 encounters per MGMA benchmarks) with a maximum of 1.0 FTEs. The calculation resulted in the following FTE commitments: Kern County: endocrine 0.75 (subsequently adjusted to 0.50), nephrology 0.40, rheumatology 0.40 (subsequently adjusted to 0.75); San Joaquin/Stanislaus: rheumatology 0.75, endocrine 1.0, neurology 0.50; Antelope Valley: nephrology 0.25, endocrinology 0.50, rheumatology 0.25.

Table 5: Specialty Areas of Care Development by Geographic Area

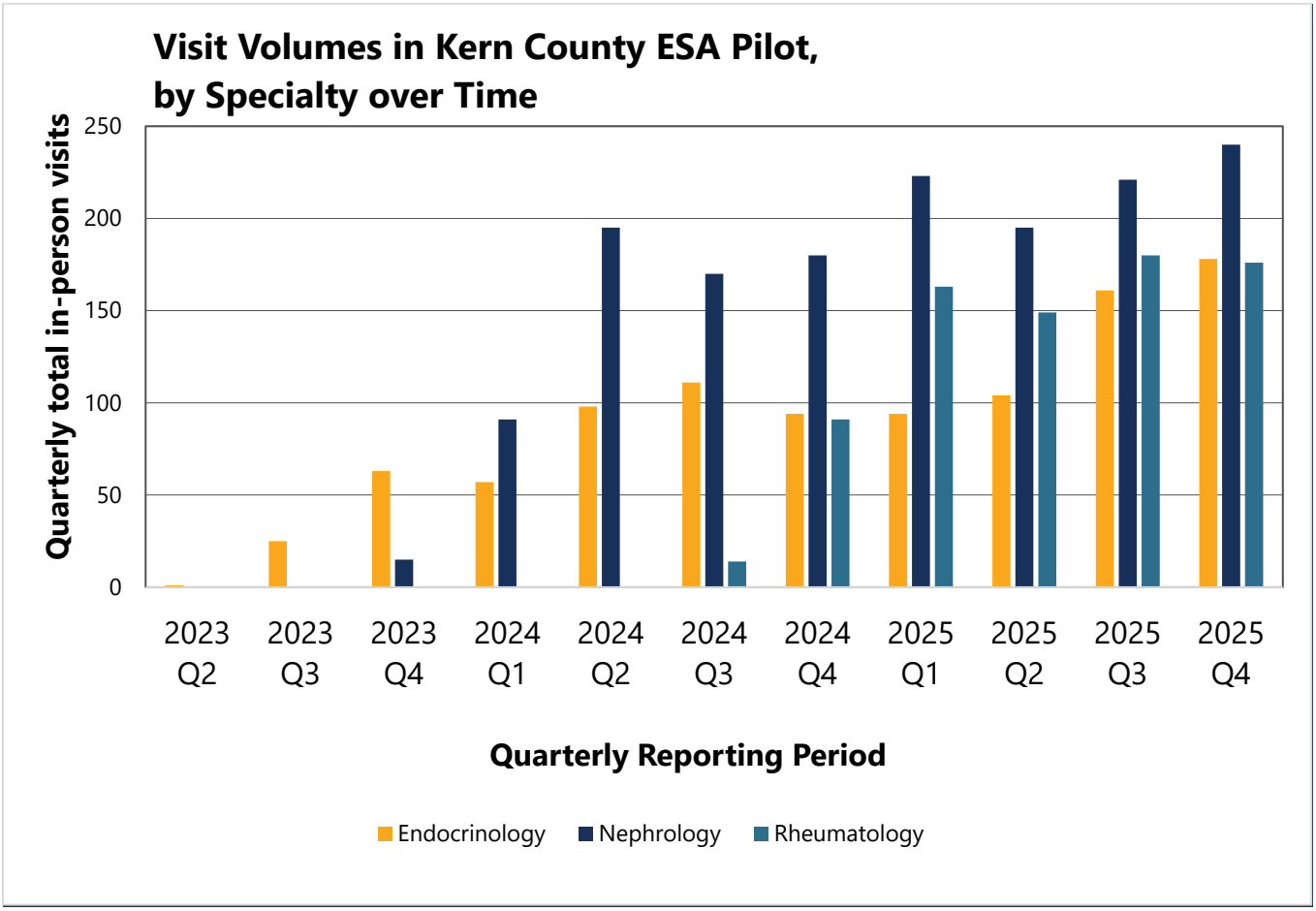
Geographical Regions	Specialty Areas of Care	Launch of Clinical Services	In-Person Visits as of 12/31/2025	Stage of Development of Specialty Pilot
Kern County	Endocrinology	6/2023	986	Stability for first 0.25 FTE Practice maturation for next 0.25 FTE
	Nephrology	10/2023	1,530	Stability and maintenance stage
	Rheumatology	8/2024	773	Stability for first 0.40 FTE Ramp up for next 0.35 FTE
San Joaquin, Stanislaus Counties	Rheumatology	9/2024	164	Ramp up
	Endocrinology	5/2025	136	Ramp up
	Neurology	6/2025	99	Ramp up
Antelope Valley (Los Angeles County)	Nephrology	4/2025	195	Practice maturation
	Rheumatology	6/2025	49	Practice maturation
	Endocrinology	6/2025	104	Ramp up

Visit volumes will continue to increase over time. This is especially true in the more recently launched pilots, which have a low volume of visits completed during their ramp up phase; as the number of days present increases the schedules are, over time, utilized more fully. Recruitment challenges in geographical areas have limited the scaling of some pilots, delaying the practice maturation stage and keeping visit volume lower. For example, the rheumatology pilot in San Joaquin and Stanislaus Counties started delivering clinical services in September 2024 and had completed 68 visits by July 2025 (10 months), for an overall average of just seven (7) visits per month. The service is still in the ramp up stage but with the full FTEs in place, 58 patients were seen in the last two months of 2025 (on average 29 visits per month). The practice maturation phase will begin when the schedules have sufficient slots to meet expected targets. Average visits per month are expected to further rise to 152 patients per month when the stability and maintenance phase is reached.

In addition, DHCS and Kaiser have an agreed-upon set of key performance indicators beyond visit volume, which includes the time until the third next available specialty care appointment within the geographic area and the market share of specialty visits of the ESA pilot compared to overall Medi-Cal specialty care utilization within the geographical area. Third next available appointment (TNAA) measures the timeliness and availability of specialty care within the geographic area (i.e., how soon can I get an appointment), which is a patient-centered metric of access. Market share evaluates the extent to which the number of visits within the ESA is significant compared to total county level Medi-Cal specialty care visits, providing a concrete metric for stakeholders to understand Kaiser's impact on access.

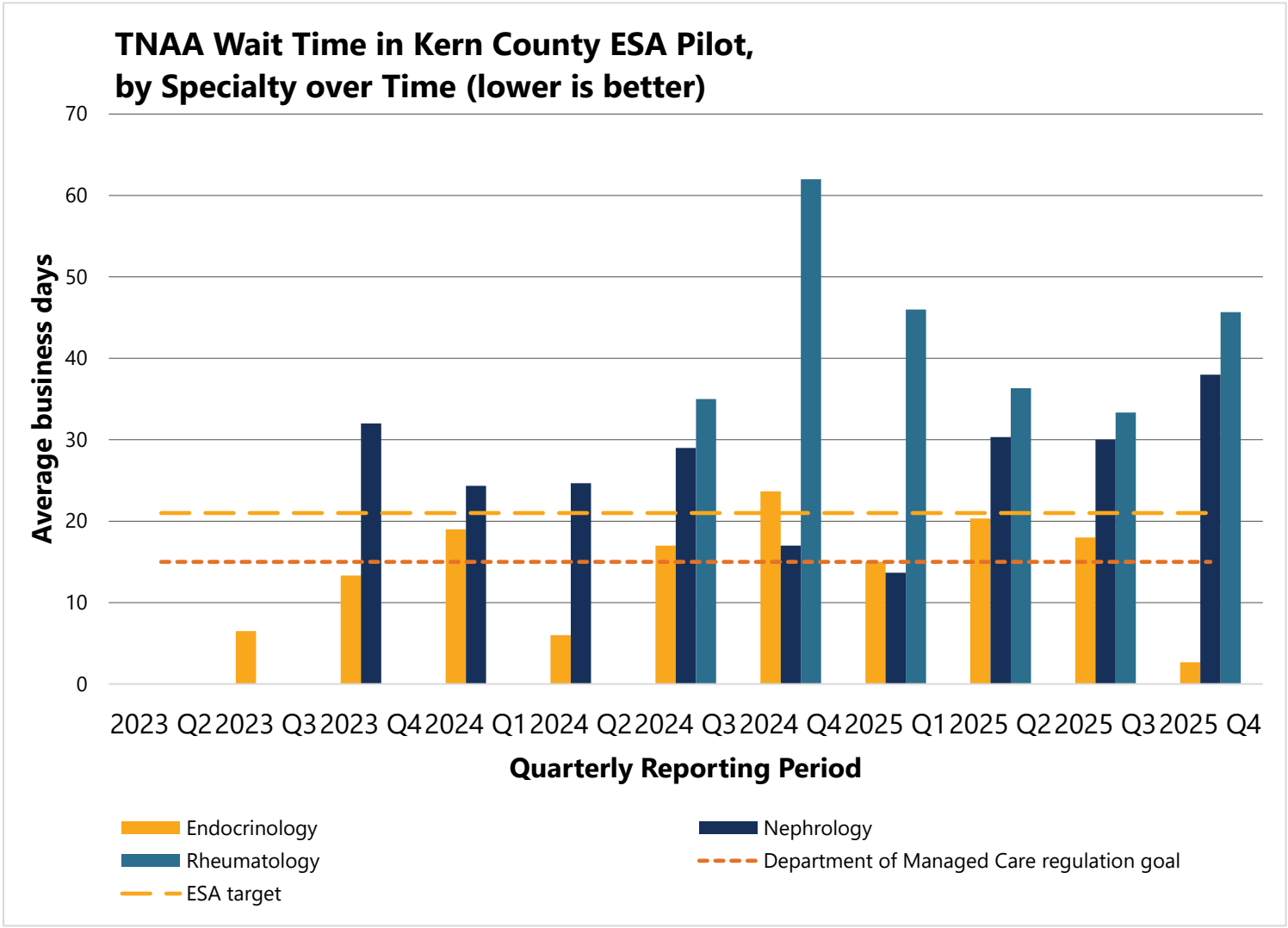
The following figures were submitted by Kaiser to DHCS and demonstrate ESA Pilot performance in Kern County, where implementation of the pilot has reached stability and maintenance stage to demonstrate trends over time.

Figure 5: Visit Volumes in Kern County ESA Pilot, by Specialty over Time



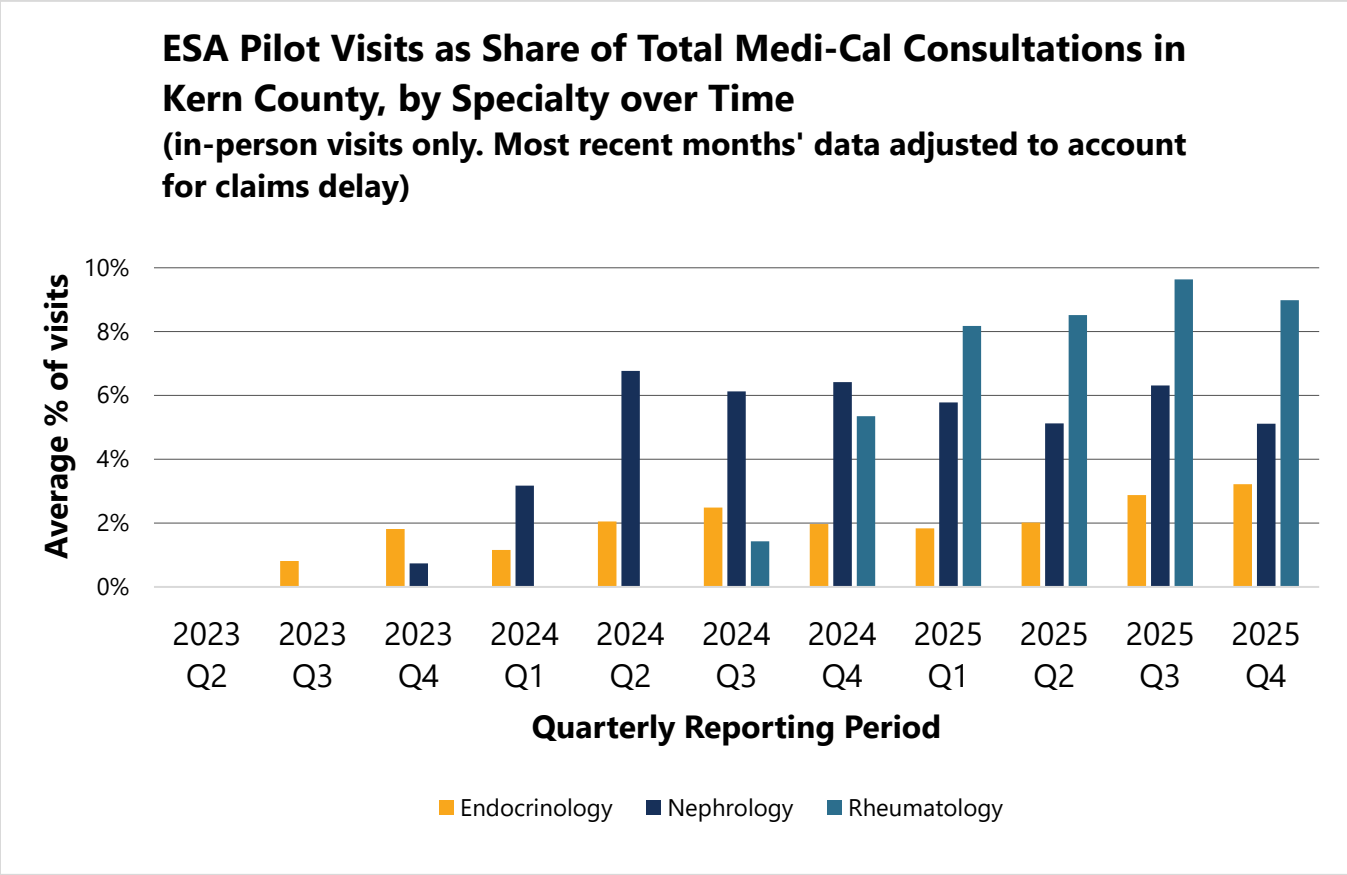
Source: Kaiser Analysis of CHC in person specialty visit data. In-person specialty visit volume increased substantially over time across all three specialties, with the most significant increase happening from 2024 into 2025. Nephrology consistently accounted for the highest number of in-person visits, showing consistent and steady growth over time and reaching peak volumes in 2025. Rheumatology visits rose rapidly, demonstrating strong growth through 2025. Endocrinology showed more gradual but sustained increases in person visits throughout the reporting period. Overall, the trend indicates expanding utilization and increasing demand for in-person specialty care in Kern County.

Figure 6: Third-Next Available Visit Wait Time in Kern County ESA Pilot, by Specialty over Time



Source: Kaiser analysis of CHC data across 2024 and 2025, Third Next Available Appointment (TNAA) varied by specialty and quarter. Endocrinology consistently demonstrated the shortest average business days, generally remaining at or below goal the ESA target. Nephrology showed moderate wait times, dropping in quarter 4 of 2024 and quarter 1 of 2025 but now frequently exceeding target goals. CSV is currently implementing "nephrology advice" to help decrease wait time. Rheumatology had the highest TNAA and started with a reported 6 month wait but began to drop over time. Overall, the data highlights sustained access challenges in Rheumatology (which should be resolved in Q2 2026 when the additional 0.35 FTEs will be past the ramp up phase).

Figure 7: ESA Pilot Visits as Share of Total Medi-Cal Consultations in Kern County, by Specialty over Time



Source: Kaiser Analysis of CHC and MCP Data through December 2025. In the rates above, the numerator is total in person completed visits by ESA specialists (by specialty). The utilization data for the numerator was furnished by the host CHC. The denominator is total completed visits for non-Kaiser Medi-Cal Managed Care members in the defined Geographic Area. The utilization data for the denominator was furnished by the MCPs in each Geographic Area, since the members were not Kaiser members.

Since the implementation of the ESA specialty pilots, the rate of non-Kaiser Medi-Cal member visits per specialty completed by Kaiser specialists for members assigned to Kern Family Health Systems and Anthem have increased. This improvement is seen across all three specialties, but is the greatest for rheumatology.

V. COLLABORATION WITH COUNTIES AND LOCAL STAKEHOLDERS

Per the MOU, this section reports on Kaiser's efforts and progress in engaging local counties and stakeholders in accordance with the DHCS-approved stakeholder engagement plan as described in this MOU, Section 5.F "Collaboration with Counties and Local Stakeholders".

Local Stakeholders

In 2025, Kaiser demonstrated its commitment to advancing Medi-Cal transformation through robust engagement with local stakeholders across all 32 counties. Kaiser engaged in extensive collaboration and resource development initiatives to improve access to care and foster meaningful collaborations. Examples include:

- Community Engagement: Kaiser's Medi-Cal Local Engagement team conducted more than 2,450 external engagements and 750 trainings and presentations in 2025, strengthening relationships with community leaders, county agencies, and community-based providers (see Collaboration with Counties and Stakeholders Chart [Table 6 below]). These efforts have fostered collaboration, supported resource development, and advanced county-level initiatives to expand access to care and improve outcomes for Medi-Cal members.
- Statewide Associations: Kaiser has maintained active collaborations with key statewide associations — including the California Association of Health Plans (CAHP), the County Health Executives Association of California (CHEAC), the County Welfare Directors Association (CWDA), and the California Women, Infants and Children (WIC) Association — to strengthen communication with local stakeholders and provide education and training regarding Medi-Cal programs and initiatives. Kaiser's sponsorship and leadership at the 2025 CHEAC Summit reinforced alignment of Medi-Cal objectives between county public health leaders and MCPs.
- Provider Network Expansion: Kaiser continues to work closely with Providing Access and Transforming Health (PATH) Collaboratives, MCPs, and Network Lead Entities (NLEs) to expand provider networks and improve referral processes. These collaborations have helped ensure timely access to Community Supports services while aligning with the requirements of the closed-loop referral process.

- County Engagement: Kaiser maintains strong relationships with county leaders to ensure alignment with local priorities, support the roll-out of CalAIM initiatives, and enhance coordinated member care. In 2025, Kaiser expanded and deepened these relationships through targeted local collaborations and trainings. In one such instance, Kaiser worked with Marin County health agencies and community health providers to sponsor and present at a CalAIM Forum that convened 36 community-based organizations and over 100 participants - amplifying grassroots awareness of CalAIM services and strengthening cross-sector collaboration. Kaiser also represented MCPs in the Los Angeles County Behavioral Health Services Act (BHSA) Community Planning Team, contributing to more than a dozen meetings and forums as well as reviewing behavioral health and Substance Use Disorder (SUD) data to inform LA County's Integrated Plan.

Kaiser also leveraged the 2024 Listening Sessions and ongoing feedback regarding the NLE model to enhance provider support, streamline contracting processes, and strengthen collaboration between Kaiser and community-based providers. For example, Kaiser collaborated with three MCPs supporting Sacramento County and Transform Health, the county's CalAIM PATH Collaborative Planning and Implementation (CPI) facilitator, to co-develop a universal joint-MCP ECM referral form (one for adult populations and another for child/youth populations). This joint ECM referral form streamlined and simplified the process for referring Medi-Cal beneficiaries residing in Sacramento County to ECM services. The joint-MCP universal referral form includes all four (4) MCPs' logos and supports coordination with various Sacramento County agencies, including the Department of Child, Family and Adult Services (DCFAS) and Department of Public Health. This collaboration has also resulted in joint MCP CalAIM 101 trainings that built greater understanding about ECM, Community Supports, and Community Health Worker (CHW) supports and embedded the universal ECM referral form into their department's workflows and internal portals.

Continuum of Care (CoC): In Amador County, Kaiser collaborated with two MCPs to enhance post-discharge support for patients. As part of this collaboration, a dedicated Patient Navigator was created and assigned to assist individuals transitioning from hospital care to home or other care settings, helping to ensure continuity of care, reduce readmissions, and connect patients with necessary community resources and follow-up services.

Collective Feedback: Kaiser continues engaging MCPs, county officials, community members, providers, and PATH CPI facilitators across all 32 counties, regularly sharing

insights and outcomes from these interactions. Through new events and strengthened relationships, Kaiser has broadened its efforts to elevate ECM and bolster the effectiveness of referral and service delivery mechanisms. To advance this mission, Kaiser delivers best practices, timely updates, and key resources across all 32 counties using formats tailored to meet stakeholder needs.

Through these targeted actions, Kaiser reinforced its dedication to improving Medi-Cal outcomes by building strategic collaborations and driving innovation in care delivery.

Memoranda of Understanding (MOUs) with Third Parties

All MCPs are required to have MOUs with specific third parties per the MCP Medi-Cal contract provisions. Kaiser is also subject to these same requirements; but must also report on its process for developing key relationships to enable better care management for Medi-Cal members at the local level, across the health care and social services continuum.

Kaiser adopted a comprehensive approach to MOU negotiations, focusing on collaboration and stakeholder engagement both prior to and after MOU execution. As of December 31, 2025, Kaiser fully executed 138 MOUs with third party entities, with another 129 in active negotiation. Please refer to the Collaboration with Counties and Stakeholders Chart [Table 6] for additional details per county.

After execution, Kaiser delivers comprehensive training to stakeholders, which includes a general overview of MOUs, service access pathways, and MCP responsibilities. Kaiser also establishes forums with stakeholders to co-develop MOU Operating Guidelines, which delineate processes for care coordination, data sharing, and patient referral pathways. These forums, in addition to regular meetings, ensure ongoing collaboration and alignment among all parties; meeting details made available on KP.org.

Kaiser's comprehensive MOU execution process has enhanced local organizations' confidence in the Plan by clarifying Kaiser's Medi-Cal offerings and establishing clear county-level points of contact. This improved understanding facilitates targeted training plans aligned with MOU deliverables, enabling positive community impacts even before formal MOU execution.

Kaiser reports that stakeholder engagement across all 32 counties has driven significant changes in the Health Care Delivery System (HCDS). Examples include:

Collaborative forums established during the MOU execution process facilitate discussions on training materials, the co-creation of MOU operating guidelines, and progress MOU negotiations. Throughout 2025, Kaiser partnered closely with the County

Welfare Directors Association (CWDA) and county In-Home Supportive Services (IHSS) and Child Welfare (CW) stakeholders through structured forums, county-specific engagements, and targeted technical assistance to resolve long-standing CW and IHSS MOU questions. Kaiser and CWDA co-hosted statewide CW/IHSS sessions—such as Closed Loop Referral (CLR) demonstrations—with near-full county participation; one documented session included participation from 29 of 32 counties in Kaiser's Medi-Cal footprint. These forums provided a shared venue to address common questions while reinforcing tailored county-level follow-ups. Post-session meeting summaries, distributed to all participants, captured extensive questions, responses, and defined action items, demonstrating active, bidirectional engagement rather than passive outreach. Collectively, these efforts helped move multiple counties from stalled negotiations into active progress, including advancing CW MOUs into policies and procedures phases and revising IHSS MOUs for submission to DHCS based on county–MCP discussions. These forums define steady-state operations and support improvements in care coordination, data sharing, and bi-directional patient referral processes. Agreed-upon frameworks are operationalized and reinforced through ongoing training and quarterly meetings, ensuring alignment between stakeholders and enhancing HCDS efficiency and effectiveness.

This structured, systematic approach strengthens collaborations and delivers measurable improvements in healthcare delivery.

Community Advisory Committee

Per the MCP contract, DHCS requires MCPs to maintain a diverse CAC that serves to provide feedback and recommendations to the MCPs on a variety of different topics including but not limited to quality, health equity, member satisfaction, community resources, and culturally appropriate services/program design. The CACs must meet at least quarterly and are involved in various engagement opportunities such as listening sessions, focus groups, and/or surveys. The MOU requires Kaiser to report on the outcomes of their CAC and how they are engaging with community stakeholders to maintain the CAC and meaningful engagement within the community.

Results

Kaiser hosted 36 quarterly CAC meetings throughout 2025. Meetings were held regionally across nine (9) CACs each quarter across Northern California and Southern California. Approximately eight (8) Medi-Cal members attended each meeting alongside Community-Based Organization (CBO) committee members. Three (3) non-contracted, CBO collaborators from each region represented diverse populations, including foster

children and youth, Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) individuals, and members experiencing homelessness. Information on the CAC is available here: Medi-Cal Community Advisory Committee (CAC) | Kaiser Permanente.

The meetings focused on key topics aimed at improving Medi-Cal services and member experiences. Topics included community health priorities, staff training topics, and Community Supports services. Each topic was presented with member-related context and accompanied by thoughtful questions to elicit CAC member recommendations. Feedback received on these topics took into account the cultural appropriateness of communications, collaborations, and services.

In response to state and federal policy changes in 2025, CAC meetings also included a policy update agenda item, and CAC committee member questions have been addressed regarding upcoming changes. The DHCS website "Medi-Cal Program Changes (2026-2027)" was also shared with CAC members as a resource.

Driving Change

Feedback from CAC members and participants in 2025 drove and informed the following improvements and planned changes:

- Community health priorities will be shared with local health departments for consideration in health programs and resource planning
- Development of future staff training initiatives
- Updates to information on Community Supports available on KP.org
- Improvements to the Medi-Cal experience across Kaiser

Kaiser has developed a team within the CAC and Quality Improvement departments to analyze member feedback and plan next steps. This team includes community collaborators, Medi-Cal team leadership, and physicians to ensure quality improvements across our delivery system.

Quality Improvement Health Equity Committee (QIHEC) & Health Equity Activities

Committee and Activity Results

Kaiser maintains a structured, bi-regional Quality Improvement Health Equity Committee (QIHEC) with defined agendas, quarterly meetings, and transparent reporting shared with internal and external stakeholders across all 32 counties.

Kaiser Medi-Cal shared results and meeting minutes with internal and external stakeholders both for Northern California and Southern California. Results and outcomes from QIHEC forums are made publicly available quarterly on Kaiser's website (for the Northern and Southern California Regions respectively).

Northern California:

Medi-Cal Quality & Improvement | Kaiser Permanente

Southern California:

Medi-Cal Quality & Improvement | Kaiser Permanente

Key QIHEC mechanisms include:

- Standardized dissemination of QIHEC meeting summaries and performance data via public-facing platforms, enabling county-level stakeholders to access quarterly updates on equity performance and interventions. Example: Q2 2025 QIHEC Report – healthy.kaiserpermanente.org.
- County-specific engagement through local forums (e.g., Alameda Community Health Improvement Plan (CHIP), LA Community Health Assessment (CHA)/CHIP) to contextualize QIHEC findings and equity efforts based on regional needs.
- Improved demographic data reporting by race/ethnicity at the county level, shared with QIHEC participants and used to inform tailored interventions.
- Real-time linkage with local initiatives through participation of Kaiser Medi-Cal Quality professionals in Population Health Management and Third-Party MOU forums across all 32 counties, integrating current QIHEC strategies into county-level action.

These mechanisms ensure that QIHEC is not a stand-alone function, but a system-wide driver of equity alignment and transparency across the Medi-Cal delivery system.

New Relationships Built

To build relationships and continue engagement, the QIHEC co-chair (Kaiser Medi-Cal Medical Director) and vice chair (Kaiser Chief Health Equity Officer) were active members of the Medi-Cal external engagement governance forums. Examples of relationship-building engagements include:

- Chief Health Equity Officer (CHEO) network (quarterly, in person and monthly, virtual) and quarterly DHCS Chief Medical Officer (CMO) meetings (quarterly, in-person)

- DHCS Quality & Equity Think-Tank
- San Francisco Equity Collaborative
- California Improvement Network
- Various Population Health forums with local health jurisdictions across 32 counties
- Engagement with County Health Executives Association of California (annual conference, ad-hoc meetings, etc.)

Driving Change

Kaiser Medi-Cal leverages QIHEC engagement to translate stakeholder insights into system-level changes that impact all 32 counties. QIHEC serves as a feedback and accountability hub, where external input informs clinical practice, operational design, and equity interventions.

Key Health Care Delivery Systems (HCDS) changes driven by QIHEC-stakeholder engagement include:

- Health equity-focused care redesign — Stakeholder input catalyzed reforms in care pathways for Black Maternal Health, including risk stratification, culturally responsive prenatal care, and postpartum outreach.
- Disparity-closing initiatives — QIHEC data reviews and stakeholder recommendations informed targeted campaigns to close gaps in:
    - HbA1c control among Hispanic/Latine members, supported by culturally tailored outreach.
    - Well-Child Visits (WCV30-6) for Black/African American children, now a Clinical Performance Improvement Plan (PIP) with multi-county engagement, community-informed outreach strategies, and performance tracking embedded in QIHEC reporting.
- Evidence-based updates to clinical guidance — Stakeholder engagement prompted clinical leaders to revise internal guidelines (e.g., lead screening, pediatric behavioral health) to reflect equity-focused best practices.
- Public transparency and alignment — QIHEC outcomes and equity interventions are shared publicly each quarter, reinforcing transparency and allowing alignment with local health jurisdictions and community stakeholders.

- Advocacy for children's preventive services in the community - Coordination of care for children's preventive dental care for Oral Health.

These changes reflect an intentional strategy to move QIHEC insights from discussion to action, embedding health equity into clinical operations and delivery system performance.

Stakeholder Engagement

The Medi-Cal QIHEC charter, goals, and membership were evaluated annually to ensure continued relationship-building and engagement. Additionally, the QIHEC co-chair and vice chair actively participated in various Medi-Cal external engagement governance forums to foster these relationships.

Kaiser's QIHEC forums advance statewide health equity strategies across three priority areas: Children's Preventive Care, Behavioral Health Integration, and Maternity Care. Across each focus area, Kaiser has made measurable progress in collaborating with external community stakeholders. Since 2025, Kaiser's Quality Improvement and Health Equity team members have actively participated in local County MOU meetings and related local planning efforts, representing QIHEC priorities and aligning county-level quality and equity initiatives with statewide strategy. This engagement ensures that quality and health equity expertise directly informs county-level conversations, assessments, and planning related to community needs and opportunities for improvement. Specific improvement projects advanced through this engagement include Oral Health for Children, Lead Screening, and Well Child Visits. Within Behavioral Health, Kaiser has supported implementation of the Behavioral Health Services Act (BHSA), Specialty and Non-Specialty Mental Health (SMH/NSMH) integration, and has worked collaboratively with county agencies to monitor and respond to Behavioral Health Managed Care Accountability Set (MCAS) metrics. Additionally, Kaiser's CAC team reports quarterly minutes and member feedback summaries related to the improvement projects across the priority areas mentioned above. In addition, a CAC member sits on the QIHEC forum. The QIHEC forums have also engaged in local-level work regarding birth equity, which included a specific focus on working cross-functionally within Kaiser regarding Medi-Cal doula coverage across all 32 counties.

Population Needs Assessment (PNA)

Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs)

Under the PHM Program, MCPs are to fulfill their PNA requirements by meaningfully participating in the CHAs/CHIPs conducted by Local Health Jurisdiction (LHJs) in the service areas where MCPs operate. The requirement for meaningful participation and collaboration is intended to enhance MCPs' ability to identify and address members' needs while diminishing siloed approaches to population health management. Kaiser collaborated closely with the other MCPs in each county to support the LHJs' CHA/CHIP development and implementation. Support for the LHJs was offered through meeting engagements, discussions around data needs and what type of data Kaiser can offer to support population health, and distribution of funding and/or in-kind staffing, depending on the request and needs of the specific LHJ. Kaiser participated in a variety of meeting engagements to bolster this work and establish cohesion, including MCP to MCP-only meetings to garner alignment with Kaiser's collaborating plans and make decisions on resourcing support for the LHJs, and LHJ to MCP meetings, which are forums that have been set up to discuss the PNA requirements and describe how the MCPs can help support the LHJ. In addition, Kaiser participated in governance forums and steering committees focused on guiding the strategic implementation of the CHA/CHIP workgroups focused on topics identified in the CHA/CHIP. In addition to CHA/CHIP support, Kaiser collaborated with each LHJ to develop a shared quality goal and related activities that aligned with one of DHCS' Bold Goals.

Driving Change

- Kaiser worked closely with the other MCPs in each county to support the LHJ's CHA/CHIP development and implementation. Support for the LHJs was offered through meeting engagements, discussions around data needs and what type of data Kaiser can offer to support. Throughout the past year, Kaiser developed strong relationships with 35 LHJs and 17 MCP partners to participate in the CHA and CHIP planning and implementation efforts. Kaiser's participation in LHJ and MCP-organized forums supported CHA/CHIP initiatives and the development of shared goals around population health priorities. Representation on various steering committees and workgroups has facilitated formative discussions in all counties to understand LHJ data and resource needs.

- Kaiser's consistent presence in meeting forums organized by LHJs and MCPs has continued to support CHA/CHIP initiatives and shared goal-setting around population health priorities.
- Kaiser has integrated shared goal planning with the LHJs into its internal quality improvement efforts across several key focus areas, including: Behavioral Health (Sacramento, City of Berkeley, San Francisco, San Mateo, Sutter, Yuba, and Tulare), Maternal Health (Alameda, Los Angeles, Pasadena, Long Beach, San Joaquin, Kern), Social Determinants of Health (Napa, Sacramento), Community Health Workers (Madera and Marin), Blood Lead Screening (Santa Clara, Orange, Contra Costa), Well Child Visits & Immunizations (San Diego, Amador, San Bernardino, Solano, Placer, Fresno, Kings, Imperial, Mariposa, Stanislaus), Oral Health (Yolo, Santa Cruz).
- Representation on various steering committees and workgroups has facilitated formative discussions in all counties to understand LHJ data and resource needs. Kaiser has committed $640,843.39 in funds to 16 LHJs in support of their CHA/CHIP activities.
- These collaborative efforts underscore Kaiser's commitment to advancing population health priorities through strategic collaborations, resource contributions, and ongoing engagement with LHJs and MCPs.

Board of Supervisors and Courts

Kaiser engaged across all 32 counties with participants from across the state from elected offices at the federal, state, and county levels to provide an overview of Kaiser's approach to Medi-Cal policy. Examples in which Kaiser engages with Board of Supervisors included:

- Kaiser presented at the Alameda County Board of Supervisors Health Committee meeting to provide remarks on the agenda item: "Community Provider Advisory Group (CPAG) Priorities & Guiding Principles to Navigate a Shifting Landscape". The Board of Supervisors appreciated the remarks and Kaiser's engagement.
- Kaiser presented in collaboration with Partnership Health Plan and a local city councilmember at the Justice Impacted Symposium in Solano County.
- Kaiser presented an overview of Kaiser Medi-Cal, including membership, in Stanislaus County, changes with the Medi-Cal direct contract, and a highlight on ECM/Community Supports services.

- Engagement with Sonoma County elected officials which included individuals from the Board of Supervisors and others.
- Kaiser has met with a San Diego Board of Supervisors member regarding ECM/Community Supports and PNA initiatives in her district and KFHP's approach to implementing CalAIM.

Through our governance model, Kaiser's local Government Relations serves as the primary point of contact for engagement with the Board of Supervisors. The Medi-Cal teams at Kaiser are well-connected with Government Relations and can explore how to build upon these relationships to engage in discussions regarding Medi-Cal Transformation.

Kaiser's regional cross-functional huddles are the main forum for internal collaboration on Medi-Cal initiatives, keeping teams informed and coordinated on external collaborations. Bringing together Community Health, Government and Community Affairs, Quality, Population Health, and Medi-Cal Local Engagement, these huddles enhance alignment and support efforts to advance health equity.

Kaiser also engages with the County Board of Supervisors to advance local priorities. For example, Kaiser maintains strong, collaborative relationships with each member of the Sacramento County Board of Supervisors, engaging regularly on key public health and policy priorities. In January, a Sacramento County Supervisor co-hosted a Kaiser Public Policy Briefing at our Habitat Health Program of All-Inclusive Care (PACE) Program, underscoring our shared commitment to improving community health. Our ongoing collaboration with the Board focuses on critical issues, including Ambulance Patient Offload Time (APOT), mental health services, medical jail transports to hospitals, and comprehensive strategies to address homelessness—working together to support Sacramento County's most vulnerable residents.

In Los Angeles County, Kaiser worked with the LA County Office of Child Protection (OCP) to provide feedback on a report back and recommendations developed in response to a LA County Board of Supervisors' (BOS) motion on advancing CalAIM participation for Transitional Age Youth (TAY). Kaiser, along with the other MCPs and OCP, have met to discuss actions needed to move forward with some of the recommendations in the BOS report back and are in the process of planning a meet-and-greet meeting/training with local TAY advocates to provide an overview of the CalAIM services in Q1 2026.

Justice-Involved (JI) Reentry Initiative involvement with the courts has been limited as the focus has been on county probation units due to several facets of complexity.

- Kaiser is working to engage all counties to support JI go-live. Several counties are planning to go-live in 2026 and thus engagement is not as frequent in comparison to counties that are preparing for go-lives in the near future.
- Kaiser in collaboration with other MCPs has funded the Chief Probation Officers of California (CPOC) grant proposal to provide CalAIM trainings and deepen the collaboration between MPCs and Probation offices.
- Youth and children are aspects that entail additional complexity within JI.
- Kaiser's involvement with county probation units in 2025 focused on building new connections to support the implementation of the JI Population of Focus (PoF). For example, Kaiser collaborates with other MCPs in San Diego and works closely with the San Diego County Sheriff's Reentry Service Division. San Diego Sheriff and Probation hold quarterly in-person meetings, which include site visits and tours of their facility, to coordinate efforts related to Medi-Cal Transformation.

New Relationships Built

Kaiser engaged with the Board of Supervisors across all 32 counties. Engagement with stakeholders in 2025 focused on further developing relationships with Supervisors and courts, as well as convening statewide officials across the 32 counties. One example of how engagement with stakeholders has driven change in the county is Alameda County's Board of Supervisors: Kaiser has been an active participant in the Board of Supervisors' convened Community Provider Advisory Group, providing valuable insights and meaningful engagement to inform collaborative planning behavioral health, homeless care coordination, and population health management.

In May 2025, Kaiser collaborated with the CHEAC to host "Bridging Public Health and Managed Care: Building Stronger Communities" a first of its kind convening to support collaboration among MCPs and local health departments. Over 40 counties were represented, 20 Medi-Cal MCPs and over 136 attendees total. Kaiser shared key learnings with DHCS, California Department of Public Health, CHEAC, and California Conference of Local Health Officers, which have since been cited in DHCS MCP webinars and meetings. The final report is pending review and will also be shared with DHCS and other state planning stakeholders to ensure ongoing learnings are informing future planning and cross-sector engagement.

In October 2024, Kaiser Medi-Cal leaders and representatives from Kaiser's Medical-Legal Partnership team collaborated and presented to the California Commission on

Aging regarding Medi-Cal Transformation. This engagement informed work in 2025 to pilot a Medical-Legal Partnership Medi-Cal pilot program in LA County (For additional information see Collaboration with Counties and Stakeholders Chart [Table 6]).

Table 6: Collaboration with Counties and Local Stakeholders

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
Alameda	Alameda County DPH; Urban Youth Advocate; Faraji House; Alameda Care Alliance	City of Berkeley DPH; Man 2 Man; Alameda County Board of Supervisors	12	4
Amador	Amador County DPH; First 5 Amador; Sutter Health; Centene; Anthem; Health Net; Elevance; Amador County Board of Supervisors	Amador office of Education; Amador County Behavioral Health	6	2

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
Contra Costa	Contra Costa County DPH; Contra Costa Health Plan; Contra Costa John A Davis Juvenile Hall; Contra Costa Custody Alternative Facility; Marsh Creek Detention Center; Martinez Detention Center; West County Detention Facility; Contra Costa County Board of Supervisors		2	5
El Dorado	Pacific Home Care; El Dorado County Anthem; El Dorado Sherriff Office; Health Plan of San Joaquin; Anthem Blue Cross Partnership Plan -Elevance Health; El Dorado County Board of Supervisors	National Healthcare & Housing Advisors; El Dorado HH – Behavioral Health; El Dorado County Health and Human Service Agency – Public Health; El Dorado County – Office of Education	1	6
Fresno	Transform Health Master Care Plan; Kern Health System; Well Point; South Annex Jail;	Fresno County; California Health and Wellness	5	2

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Main Jail; North Annex Jail; Juvenile Justice Camps; Fresno County Board of Supervisors			
Imperial	Imperial County Behavioral Health Services; Community Health Plan of Imperial Valley; Imperial Valley Wellness Foundation; Health Net; Herbert Hughes Correctional Center; Oren R. Fox Medium Security Detention Facility; Regional Adult Detention Facility; Imperial County Board of Supervisors	Imperial County DPH	5	2
Kern	National Healthcare & Housing Advisors; HC2 Strategies; Institute for Healthcare Improvement; Anthem; Central Receiving Facility; Lerdo Pre-Tria Facility; Lerdo Justice Facility; Lerdo Max/Med Security Facility;	National Healthcare & Housing Advisors	5	5

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Mojave Jail; Ridgecrest Jail; James G. Bowles Youth Detention Center; Kern Crossroads Facility; Kern County Board of Supervisors			
Kings	Elevance; Alliance; California Health and Wellness; Kings County; SBC Global; Kings County Jail; Kings County Juvenile Center; Kings County Board of Supervisors	KT Homeless	6	2
Los Angeles	Molina; Health Net; Blue Shield CA; LA County Department of Public Health; City of Long Beach DPH; Social Good Solutions; Social Good Solutions and Education; California Community Foundation; Vision y Compromiso; First 5 LA;	BluePath; LA Partnerships for Early Childhood; Los Angeles Department of Public Social Services (DPSS); Los Angeles Department of Homeless Services and Housing (HSH); Malama; YWCA Los Angeles;	4	6

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	The Children's Partnership; USC; California Health Care Foundation (CHCF); LA Care Health Plan; Men's Central Jail; Twin Towers Correctional Facility; Century Regional Detention Facility; Pitchess Detention Center (Pdc) – North; Pitchess Detention Center (Pdc) – South; North County Correctional Facility (Nccf); Pitchess Detention Center (Pdc) – East; Los Padrinos Juvenile Hall; Barry J. Nidorf Juvenile Hall; Camp Clinton Afflerbaugh (Cba-East); Camp Dorothy Kirby Center (Dkc-East); Camp Glenn Rockey (Cgr-East); Camp Joseph Paige (Cjp-East); Campus Vernon Kilpatrick (Cvk-West);	Los Angeles Department of Mental Health Community Planning Team (CPT); Los Angeles County DPH-Substance Abuse Prevention and Control (SAPC); Los Angeles County Food Rx Collaborative		

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	California State Prison, Los Angeles County (LAC); Los Angeles County Doula Hub; Frontline Doulas; Los Angeles County Board of Supervisors			
Madera	Madera County; Transform Health; HealthNet; Anthem; California Health and Wellness; Elevance; Madera County Jail; Madera Juvenile Detention Facility; Madera County Board of Supervisors		5	3
Marin	Blue Path Consulting; Marin County Office of Education; Health and Human Services; Marin Center for Independent Living; Marin County DPH; Marin County Jail; Marin County Juvenile Hall; Marin County Board of Supervisors	Marin County Cooperation Team	0	4
Mariposa	Mariposa County DPH; Mariposa County Jail; Mariposa County Juvenile Hall;	Central California Alliance for Health	6	2

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Mariposa County Board of Supervisors			
Napa	Community Health Initiative; Molly's Angels; Napa County Commission on Aging; City of Napa, Department of Parks & Recreation Services; Napa Valley Hospice & Adult Day Services; Napa County Department of Corrections; Napa County Re-entry Facility; Napa County Juvenile Justice Center; Napa County Board of Supervisors	Community Health Initiative	4	4
Orange	Orange County HCA; Orange County DPH; CalOptima; Central Men's and Women's Jail + Intake & Release Center (IRC); Theo Lacy Facility; Juvenile Hall; The Youth Leadership Academy; James A. Musick Facility; Orange County Board of Supervisors		9	1
Placer	Placer County DPH; Chapa-De Indian Health;	Placer CoC;	5	4

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Lighthouse Counseling & Family Resource Center; Colusa County; Nevada County; Institute of Health Improvements; Partnership Health Plan; Adventist Health; Plumas County; HC2 Strategies; Health Education Council; Placer County Board of Supervisors	Homeless Resource Council of the Sierras (HRCS); Health Education Council; Placer Accountable Community for Health Initiative		
Riverside	Riverside County DPH; Blythe Jail; Cois M. Byrd Detention Center; John J. Benoit Detention Center; Larry D. Smith Correctional Facility; Robert Presley Detention Center; Riverside County Board of Supervisors		2	6
Sacramento	Sutter Health, Greater Sacramento Market; Molina Health Plan; Public Health Advocates; Dignity Health; Sacramento County DPH; Health Net;	Health Right 360; The ARC; Sacramento County – Behavioral Health Services; Sacramento County – Child Protective Services;	3	2

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Anthem; Elevance; Transform Health; California Health and Wellness; National Healthcare and Housing Advisors; Aetna; Hope Cooperative; United Way California Capital Regional; O. Community Doulas; Unite Us; Sacramento CoC; Sacramento County Board of Supervisors	Sacramento County – Adult Protection Services; Sacramento County – Department of Child Family and Adult Services; Sacramento County -DCFAS – IHSS; Sacramento Steps Forward University of California Davis Health; Sacramento Regional Center		
San Bernardino	San Bernardino County DPH; Molina Health Plan; IEHP; City of Bakersfield Recreation and Parks; Central Detention Center; Glen Helen Rehabilitation Center; High Desert Detention Center; West Valley Detention Center;		4	5

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	San Bernardino County Board of Supervisors			
San Diego	Community Health Group San Diego; Transform Health; Blue Shield of California; CA Childrens Trust; SJ Health Solutions; SD COUNTY; Molina Healthcare; San Diego DPH; Community Health Group; Council Member, City of El Centro; Openhand; Intrepid Ascent; San Diego County Board of Supervisors		7	3
San Francisco	San Francisco Department of Public Health (SFDPH); San Francisco Health Network; Anthem; Elevance Health; San Francisco Health Plan (SFHP); University of California, San Francisco; San Francisco Department of Early Childhood;		2	3

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	United Ways of California; Fresh Approach; 24Hr HomeCare; CommonSpirit Health; Mom's Meals; Full Circle Health Network (FCHN); 18 Reasons; United Way Bay Area (UWBA); SAHA Homes; Lutheran Social Services of Northern California (LSS NorCal); Archstone; SteppingStone Health; Pacific Clinics; MidPen Housing; On Lok; rFoodX; Serene Health; Institute on Aging (IOA); MyMedZed; Abode Services; Lifewise CHM; Balance Pro; Manifest MedEx; Humane Prison Hospice Project; Catalight;			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Safer Together; Sutter Health; Health Plan of San Mateo (HPSM); Curry Senior Center; Wayfinder Family Services; SEIU 2015; Titanium Healthcare; Care Alliance; Bay Area Community Services (BACS); Amazon; Intake and Release Center; County Jail #1; County Jail #2; County Jail #3; Zuckerberg San Francisco General (ZSFG) / County Jail #4; San Francisco Juvenile Hall; San Francisco County Board of Supervisors			
San Joaquin	Health Plan of San Joaquin; San Joaquin County DPH; San Joaquin Public Health Services; San Joaquin Peterson Juvenile Hall; San Joaquin County Jail;	San Joaquin County-Behavioral Health	4	5

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	San Joaquin County Board of Supervisors			
San Mateo	San Mateo County Health / San Mateo; County Health Department; Anthem; Horizon Center; Titanium Healthcare; United Ways of California; Roots Community Health Center; San Mateo County Health & Human; Services (HHS); Fresh Approach; 24Hr HomeCare; Health Trust; Independent Living Systems (ILS); Access Case Management; Mom's Meals; Gardner Family Health Network (GFHN); AACI; United Way Bay Area (UWBA); LifeSTEPS; Elevance Health; North East Medical Services (NEMS); Ravenswood Family Health Center; (Ravenswood FHC);		4	4

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	rFoodX; Unite Us; Hope Services; Hospital Council of Northern and Central California; First 5 San Mateo County; Hickman Strategies; Sutter Health; Social Services Agency (SSA); Health Advocates; Healthcare in Action; CommonSpirit Health; Coastal Kids Home Care; Abode Services; Avenidas; Home Helpers Home Care; Precision Psych; Peninsula Health Care Connection (PHCC); Pacific Clinics; On Lok; Libertana Home Health; MyMedZed; Serene Health; Catalight; LeadingAge California;			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Seneca Family of Agencies; The Foundry of California; Jamboree Housing Corporation; School Health Clinics of San Mateo County; Care Alliance; Stanford University; Amazon; Silicon Valley Independent Living Center (SVILC); Wellpath; Maple Street Correctional Center; Maguire Correctional Facility; Youth Services Center; San Mateo County Board of Supervisors			
Santa Clara	Santa Clara County Public Health; Department (SCCPHD); Anthem; Horizon Center; Titanium Healthcare; United Ways of California; Roots Community Health Center; Santa Clara County Health & Human Services (HHS); Fresh Approach;		1	8

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	24Hr HomeCare; Health Trust; Independent Living Systems (ILS); Access Case Management; Mom's Meals; Gardner Family Health Network (GFHN); African American Community Initiative (AACI); United Way Bay Area (UWBA); MyMedZed; MidPen Housing; LifeSTEPS; Elevance Health; North East Medical Services (NEMS); Ravenswood Family Health Center; (Ravenswood FHC); rFoodX; Unite Us; Hope Services; Hospital Council of Northern and Central California; First 5 Santa Clara County; Hickman Strategies; Sutter Health; Social Services Agency (SSA);			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Health Advocates; Healthcare in Action; CommonSpirit Health; Coastal Kids Home Care; Abode Services; Avenidas; Home Helpers Home Care; Precision Psych; Peninsula Health Care Connection (PHCC); Pacific Clinics; On Lok; Libertana Home Health; Serene Health; Catalight; LeadingAge California; Seneca Family of Agencies; The Foundry of California; Jamboree Housing Corporation; School Health Clinics of Santa Clara County; Care Alliance; Stanford University; Amazon; Silicon Valley Independent Living Center (SVILC);			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Wellpath; Santa Clara County Juvenile Hall; Elmwood Correctional Complex; Santa Clara County Main Jail Complex; William F. James Ranch; Santa Clara County Board of Supervisors			
Santa Cruz	Vital Link Medical Alert Systems; United Ways of California; Unite Us; Tooth Fairies of California; Titanium; The Circle Family Center; Teen Kitchen Project; Tangelo; Serving Communities Health Information Organization (SCHIO); Second Harvest Food Bank Santa Cruz County; Santa Cruz Health Information Organization; Santa Cruz County Food Bank; Santa Cruz County - Public Health; Santa Cruz County - Human Services Department;	Santa Cruz County – Health Services Agency - Behavioral Health; Healthcare – Sterling; Hospitalist Medical Group Inc.; Senior Network Services; Serene Health IPA; Encompass Community Services; County Convergence Life	3	7

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Santa Cruz Community Health; Salud Para La Gente; Salinas Valley Medical Clinic; RPMCCM Professional Corporation; Roots Food Group; Reinvestment Partners; Planned Parenthood Mar Monte; Performance Kitchen; People First of Santa Cruz County; Partners in Care Foundation; Pajaro Valley Unified School District; Pajaro Valley Prevention and Student Assistance; Pair Team; National Healthcare and Housing Advisors (NHHA); Monarch Services; Mom's Meals; Modify Health; Meals on Wheels - Orange County; Mayeda Consulting Inc.; Manifest Medex; Lifewise CHM; Janus of Santa Cruz; InTouch Home Care; Innovation Horizons;			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Independent Living Systems (ILS) LLC; Humane Prison Hospice Project; Hospice of Santa Cruz County; Hope Services; Hope Cooperative; Home Safety Services; HiPaaS Inc.; Hickman Strategies LLC; Health Projects Center; Health Net LLC; Health Management Associates; Health Advocates; Full Circle Health Network; Front St Inc.; Elderday Adult Day Health Care - Community Bridges; Doctors on Duty; Depression and Bipolar Support Alliance of California; Community Driven Strategies, LLC; Community Bridges – WIC; Community Bridges – Elderday; Community Action Board of Santa Cruz; County Incorporated;			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Common Spirit Health; Coastal Kids Home Care; Central California Alliance for Health (CCAH); CenCal Health; California WIC Association; California Rural Legal Assistance Inc.; California Collaborative for Long-Term Services and Supports (CCLTSS); California Association of Licensed Midwives; Briljent; Breathe California of the Bay Area - Golden Gate and Central Coast; Bill Wilson Center; Balance; Amazon Web Services (AWS); Advocates for Human Potential Inc.; Abodes Services; 24 Hour Home Care; United Way of Santa Cruz; MidPenn Housing; Santa Cruz County Jail; Santa Cruz County Jail - Women's Facility;			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Santa Cruz County Jail Rehabilitation and Reentry Facility; Santa Cruz County Jail - Rountree Medium Facility; Santa Cruz County Juvenile Hall; Santa Cruz County Board of Supervisors			
Solano	Solano County DPH; Partnership Health Plan; CapK - Cal Fresh Healthy Living; Solano Recovery Home; The Uncuffed Project; Solano Women In Medicine/SWIM; Aliados Health; California State Prison, Solano (SOL); California Medical Facility (CMF); Claybank Detention Facility; Justice Center Detention Facility; Stanton Correctional Facility; Solano County Juvenile Detention Facility; Solano County Board of Supervisors	Restorative Community Solutions	4	3
Sonoma	Sonoma County Department of Public Health; Saint Joseph Health System; Pacifica Senior Living;	Health Action Together; Sonoma County DHS; Catholic Charities	4	5

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Sutter Health Plan; Alexander Valley Healthcare; West County Health Centers; City of Santa Rosa; Petaluma Health Center; West County Services; COTS Housing Support Services; Reach for Home; Santa Rosa Community Health; Community Support Network; Aurora Behavioral Health; Meritage Medical Network; Partnership HealthPlan; Alliance Medical Center; Petaluma People Services Center; Healthcare Foundation of Northern Sonoma County; Nation's Finest Veteran Services; YWCA; Sonoma County Domestic Violence Services; Center Point Drug Abuse Alternative Center (DAAC); Buckelew Programs; Health Begins;			

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Main Adult Detention Facility (MADF); North County Detention Facility (NCDF); Sonoma County Probation Camp; Juvenile Hall; Sonoma County Board of Supervisors			
Stanislaus	Health Begins; Centene; Health Net; Health Plan of San Joaquin; R.E.A.C.T.; Safety Center; Unit 1 and Unit 2; Stanislaus County Board of Supervisors	United Way Stanislaus; Stanislaus County Health Services Agency	4	6
Sutter	Sutter County DPH; Partnership HealthPlan; Sutter County Jail; Tri-County Detention Center; Sutter County HHS; Sutter County Board of Supervisors	Sutter County Children and Families Commission; Sutter Yuba Behavioral Health; Sutter Yuba Homeless Consortium; Sutter County WIC	2	8
Tulare	Kaweah Health;	Tulare County HHSA	4	3

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	Community Services Employment Training; Health Net; Anthem; Mastercare Plan; Resources for Independence Central Valley; Titanium Healthcare; St. Vincent Preventative Family Care; Bob Wiley Detention Facility; Adult Pre-trial facility; Tulare County Main Jail; South County Detention Facility; Tulare County Board of Supervisors			
Ventura	Gold Country Health Plan; blue path; Communities Lifting Communities; Community Memorial Health System; Ventura County Juvenile Facilities; East County Jail Facility; Todd Road Jail; Main Jail/Pre-Trial Detention Facility; Ventura County Board of Supervisors		5	3
Yolo	Yolo County DPH; Partnership Health Plan;	Yolo Cares	7	2

County	Key Relationships	New Relationships Built	# of Executed MOUs	# of MOUs in Negotiations
	City of Davis; Monroe Detention Center; Juvenile Detention Facility; Yolo County Board of Supervisors			
Yuba	Yuba County DPH; Partnership Health Plan; Yuba County Jail; Tri-County Detention Center; Yuba County Board of Supervisors	Yuba First 5 Sutter Yuba; Behavioral Health; Sutter Yuba Homeless Consortium; Sutter County WIC	3	4

VI. IMPLEMENTATION OF ECM AND COMMUNITY SUPPORTS

Per the MOU, this section reports on implementation of ECM and Community Supports in a manner consistent with the Quarterly Implementation Monitoring Reports. In addition, this report will include progress to engage community providers (e.g., county departments, public hospitals and health systems, and community health centers county).

Kaiser delivers most Enhanced Care Management (ECM) and Community Supports (CS) services through three community-based Network Lead Entities (NLEs), which aim to coordinate the provision of care while expanding local relationships across Kaiser's 32 Medi-Cal counties. In this arrangement, Kaiser maintains health plan administrative and oversight functions, and the NLEs support community-based organizations (CBOs) with capacity building, training, and analytics to enable access to ECM and all fourteen (14) Community Supports services. To date, Kaiser has used this model to engage over 283 nonprofit CBOs. The Kaiser integrated care delivery system is available in complement to Kaiser's NLE model, providing access to clinical care and other services.

The following tables and figures provide additional details of Kaiser's implementation of ECM and Community Supports. The counts presented in the tables and figures, below, reflect DHCS methodology using raw data reported by Kaiser, consistent with the published Quarterly Implementation Monitoring Report (QIMR) for ECM and Community Supports. Under this methodology, members with an ECM benefit end date occurring within the reporting quarter are excluded from member counts, including members who received ECM services during a portion of the quarter. Kaiser reports that this exclusion materially understates ECM participation, resulting in an approximate 26% undercount of ECM members relative to Kaiser's internal utilization data.

Enhanced Care Management

Table 7: Unique Members Receiving ECM - 2025

Unique members received ECM in 2025	Unique members received ECM in Q4 2025
10,156	4,768

Sources:

DHCS ECM Quarterly Implementation Report, Table 1.6

DHCS ECM Quarterly Implementation Report, Table 1.7.2

Table 8: Number of Unique Kaiser Members Receiving ECM by County, Per Quarter in 2025

County	Q1 2025	Q2 2025	Q3 2025	Q4 2025	% Change, Q1 to Q4
Alameda	302	336	250	293	-3%
Amador	*	*	0	0	N/A
Contra Costa	270	275	201	210	-22%
El Dorado	19	26	13	16	-16%
Fresno	21	26	21	28	33%
Imperial	0	0	0	0	N/A
Kern	39	50	52	60	54%
Kings	0	0	*	*	N/A
Los Angeles	1,095	1,206	1,058	1,299	19%
Madera	*	*	*	*	N/A
Marin	52	58	39	49	-6%
Mariposa	0	0	0	0	N/A
Napa	22	27	16	20	-9%
Orange	265	295	233	288	9%
Placer	55	64	51	56	2%
Riverside	302	469	447	453	50%
Sacramento	677	632	469	522	-23%
San Bernardino	326	335	341	417	28%
San Diego	287	333	321	378	32%
San Francisco	100	84	51	63	-37%
San Joaquin	82	95	69	78	-5%
San Mateo	69	66	49	57	-17%
Santa Clara	168	183	145	173	3%
Santa Cruz	*	*	*	*	N/A

County	Q1 2025	Q2 2025	Q3 2025	Q4 2025	% Change, Q1 to Q4
Solano	171	153	135	132	-23%
Sonoma	98	104	97	87	-11%
Stanislaus	22	32	29	36	64%
Sutter	0	0	0	0	N/A
Tulare	*	0	0	0	N/A
Ventura	24	28	19	31	29%
Yolo	23	21	11	*	N/A
Yuba	*	*	*	*	N/A
Grand Total**	4,489	4,898	4,127	4,768	6%

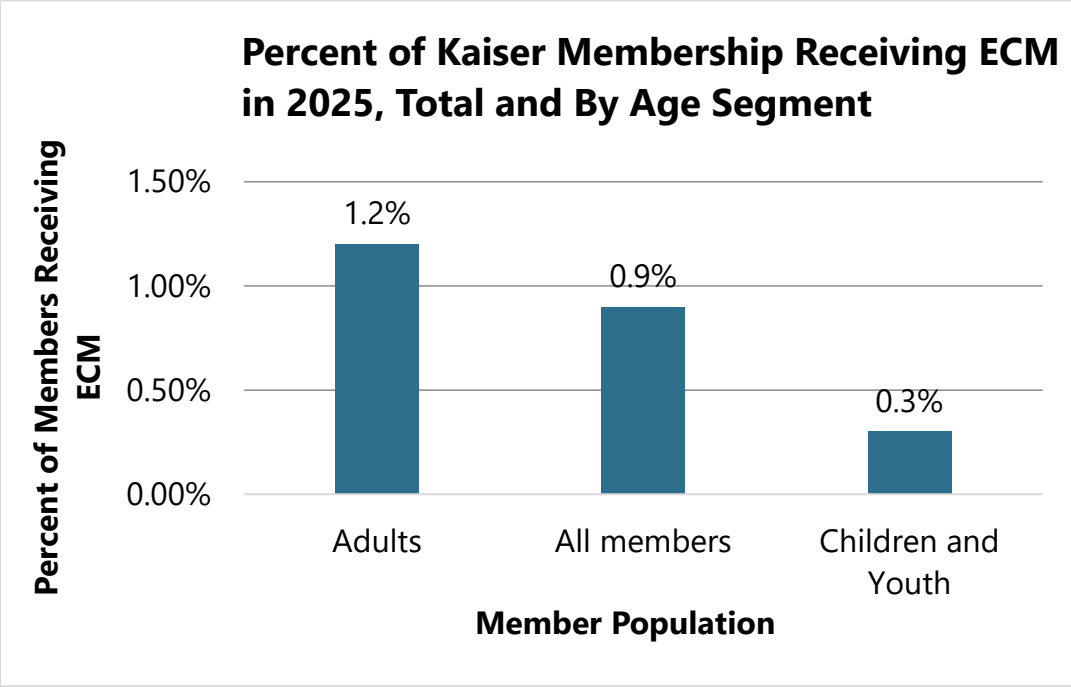
Source: DHCS ECM Quarterly Implementation Report, Table 1.7.2

** The number of members receiving ECM is lower than 11 and is suppressed to protect member privacy.*

*** The grand total number of members receiving ECM is reported as the sum of the rows with numerical values. The actual total may be slightly higher due to censorship of values lower than 11.*

The grand total number of Kaiser members receiving ECM increased in 2025. The number of members receiving ECM across the state increased 6% from Q1 to Q4 of 2025.

Figure 8: Percent of Kaiser Membership Receiving ECM in 2025 by Age Segment



As a share of all membership, 0.9% of Kaiser members received ECM in 2025. When divided by age, 0.3% of children and youth Kaiser members received ECM in 2025, and 1.2% of adult Kaiser members received ECM in 2025. The relatively higher ECM utilization rate among adults reflects similar trends state-wide, partially due to the later launch of ECM POFs for children and youth.

When compared to other MCPs, Kaiser's ECM utilization rate is below median MCP performance in all age segments. In comparison, the median statewide ECM utilization rate in Q3 2025 was 2.1% for all members, 1.1% for children and youth members, and 2.4% for adult members.

Table 9: Kaiser Members Receiving ECM by County in Q4 2025

County	Count of Unique Members
Alameda	293
Amador	0
Contra Costa	210
El Dorado	16
Fresno	28
Imperial	0
Kern	60
Kings	*
Los Angeles	1299
Madera	*
Marin	49
Mariposa	0
Napa	20
Orange	288
Placer	56
Riverside	453
Sacramento	522
San Bernardino	417
San Diego	378
San Francisco	63
San Joaquin	78
San Mateo	57
Santa Clara	173
Santa Cruz	*
Solano	132
Sonoma	87

County	Count of Unique Members
Stanislaus	36
Sutter	0
Tulare	0
Ventura	31
Yolo	*
Yuba	*
Grand Total**	4768

Source: DHCS ECM Quarterly Implementation Report, Table 1.7.2

** The number of members receiving ECM is lower than 11, and the exact count has been suppressed to protect member privacy.*

*** The grand total number of members receiving ECM is reported as the sum of the rows with numerical values. The actual total may be slightly higher due to censorship of values lower than 11.*

Kaiser reported having members in ECM within 27 counties of operation in Q4 of 2025. Five (5) counties with a low projected volume (less than six (6)) of eligible members had no active enrollees: Amador, Imperial, Mariposa, Sutter, and Tulare. 38% of all ECM enrollments were in Los Angeles and Sacramento counties. Nine (9) counties contained 85% of Members. In order: Los Angeles, Sacramento, Riverside, San Bernardino, San Diego, Alameda, Orange, Contra Costa, and Santa Clara.

ECM Members by Population of Focus (POF) in Q4 2025

Table 10: Total Number of Kaiser Members Who Received ECM by Population of Focus in 2025 - **Adults**

Population of Focus	Q1	Q2	Q3	Q4	% Change Q1 to Q4
Individuals Experiencing Homelessness	1154	1184	860	877	-24%
Individuals At Risk for Avoidable Hospital or ED Utilization	947	1126	1200	683	-28%
Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs	2175	2036	1600	1,580	-27%
Adult Nursing Facility Residents Transitioning to Community	0	14	39	26	86%**
Adults Living in the Community and At Risk for Long-Term Care Institutionalization	174	327	364	185	51%
Individuals Transitioning from Incarceration	0	0	56	*	N/A
Birth Equity	962	875	860	688	-28%

Table 11: Total Number of Kaiser Members Who Received ECM by Population of Focus in 2025 - **Children and Youth**

Population of Focus	Q1	Q2	Q3	Q4	% Change Q1 to Q4
Individuals Experiencing Homelessness	84	114	193	125	49%
Individuals At Risk for Avoidable Hospital or ED Utilization	45	69	126	78	73%
Serious Mental Health and/or Substance Use Disorder (SUD) Needs	296	296	353	267	-10%
Enrolled in California Children's Services (CCS) with Additional Needs	315	437	432	312	-1%
Involved in Child Welfare	309	279	286	248	-20%
Individuals Transitioning from Incarceration	0	0	*	*	N/A
Birth Equity	0	0	27	13	-52%***

Source: DHCS ECM Quarterly Implementation Report, Table 1.7.3

** The number of members receiving ECM is lower than 11, and the exact count has been suppressed to protect member privacy.*

*** When Q1 2025 values were 0, the percent change from Q2 to Q4 2025 was calculated.*

****For these metrics, percent growth was calculated using the first quarter in which a non-zero value was reported. Because Q1 values were 0, either Q2 or Q3 served as the baseline, depending on when each metric first reflected a non-zero figure*

Members qualify for ECM by meeting the eligibility criteria for at least one Population of Focus (POF), and many members meet eligibility criteria for more than one POF. As such, a unique member may be included in multiple POFs in the POF table above, and a simple sum of rows should not be performed to calculate unique members served per quarter. Eligibility criteria for each ECM POF may be found in the DHCS ECM Policy Guide.

The top three (3) POF categories for Kaiser's ECM implementation in Q4 2025 were:

- Adult at Risk for Avoidable Hospital or Emergency Department Utilization
- Adults with Serious Mental Illness and/or Substance Use Disorder (SMI/SUD) Needs
- Adults experiencing Homelessness

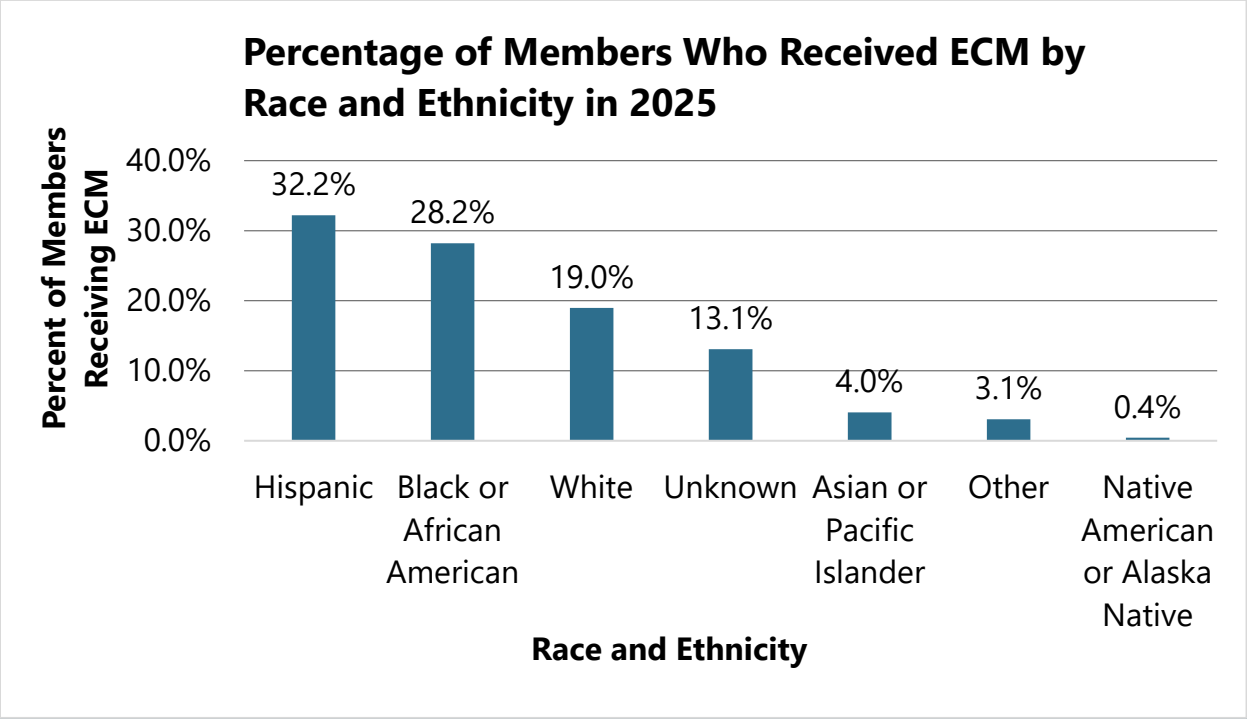
In 2025, Kaiser reported that 16% of members experiencing homelessness secured permanent housing. Among these members, 349 members were placed in permanent housing through the contribution of ECM. These results underscore ECM's potential impact in reducing homelessness.

ECM Member Characteristics

The following data on member characteristics were provided by Kaiser's internal analytics and are presented rounded to the nearest whole number or significant digit. DHCS provides state-wide data on similar measures on the publicly available ECM and Community Supports Quarterly Implementation Report, and this data may be accessed via the links below each chart.

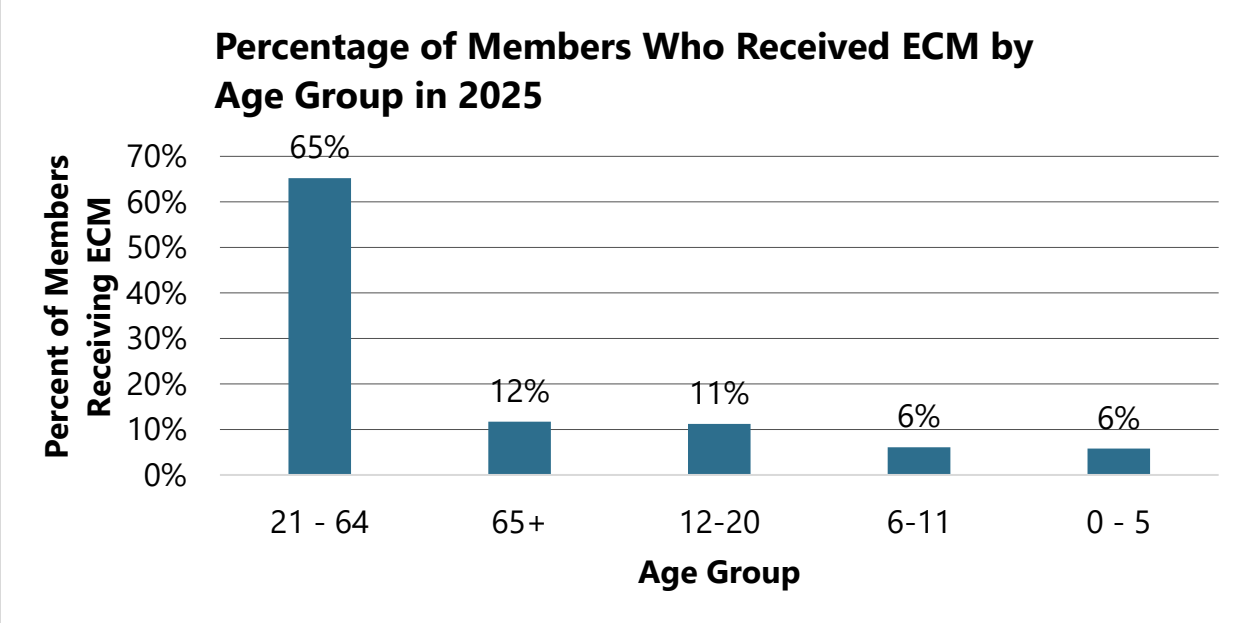
Percentages in the figures below demonstrate subgroup representation among members receiving ECM, meaning that the sum of all percentage values is 100%, or all members receiving ECM in 2025. These percentages can be compared to demographic data on Kaiser's overall Medi-Cal population earlier in the report.

Figure 9: ECM Members by Race and Ethnicity



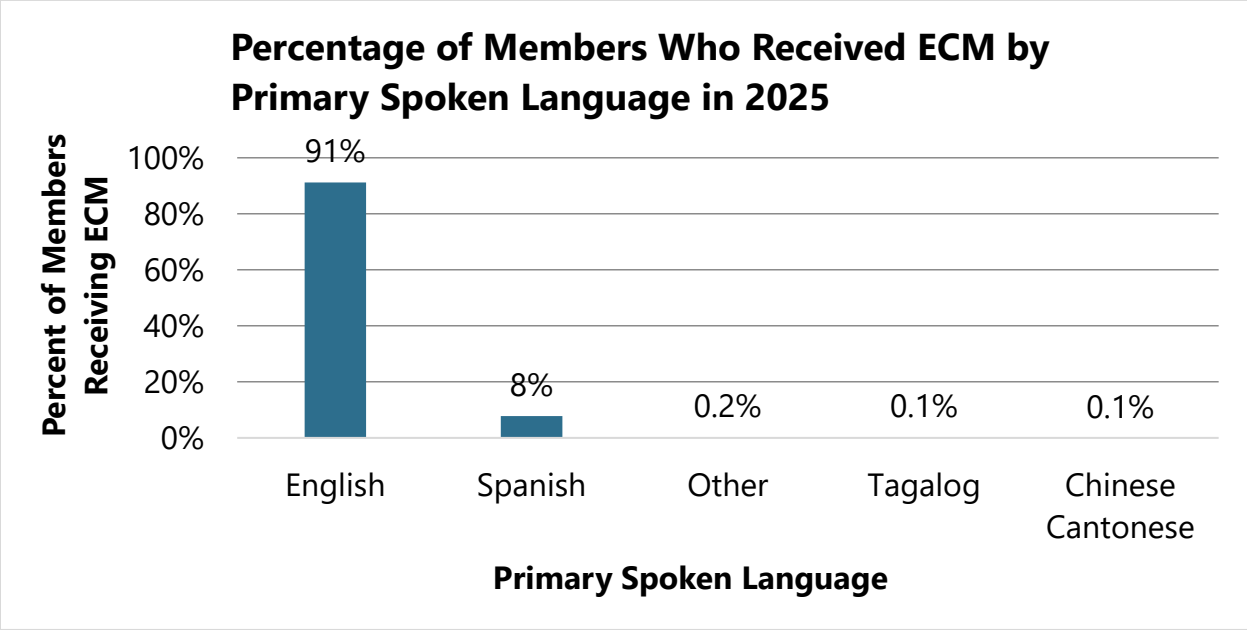
Source: Kaiser internal data and analysis. Analogous state-wide analysis available: [ECM Quarterly Implementation Report, Chart 1.4.1]

Figure 10: ECM Members by Age Group



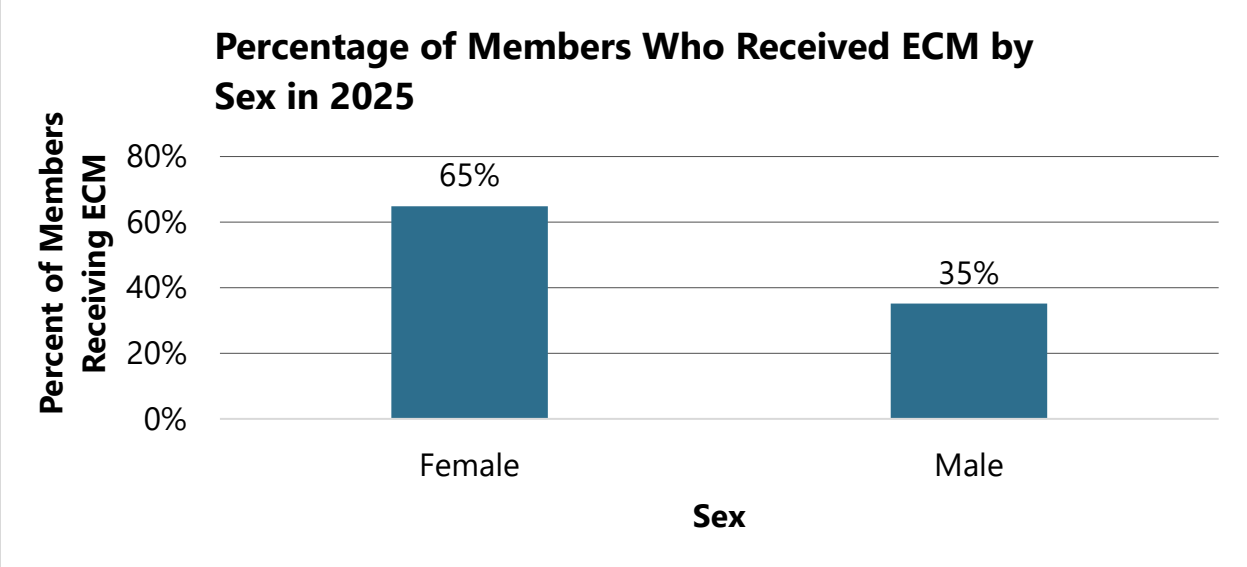
Source: Kaiser internal data and analysis. Analogous state-wide analysis available: [ECM Quarterly Implementation Report, Chart 1.4.3]

Figure 11: ECM Members by Primary Spoken Language



Source: Kaiser internal data and analysis. Data are rounded to nearest percent, except for 2025 ECM Members whose primary spoken language is Other, Tagalog or Chinese Cantonese. These percentages are rounded to one significant digit. Analogous state-wide analysis available: ECM Quarterly Implementation Report, Chart 1.4.2

Figure 12: ECM Members by Sex



Source: Kaiser internal data and analysis. Analogous state-wide analysis available: ECM Quarterly Implementation Report, Chart 1.4.4

Community Supports

Community Supports services address Kaiser Medi-Cal members' social drivers of health and help them avoid needing higher levels of care. DHCS has preapproved 14 services that MCPs are encouraged to offer as Community Supports. The Transitional Rent benefit as the 15th Community Support went live January 1, 2026 for the Behavioral Health Population of Focus. While MCPs may have chosen to launch Transitional Rent coverage for eligible members in July 2025, none opted to. Instead, all MCPs including Kaiser, were to implement Transitional Rent as a mandatory Community Support beginning January 1, 2026. Transitional Rent covers up to six months of rent for members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria. Transitional Rent is designed to provide a time-limited opportunity to help a member exit homelessness, or no longer be at risk of entering into homelessness, and establish a bridge to permanent housing. The enumerated list includes the available 14 services in 2025:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Day Habilitation Programs
7. Caregiver Respite (formerly Respite Services)
8. Assisted Living Facility Transitions (formerly Nursing Facility Transition/Diversion to Assisted Living Facilities)
9. Community or Home Transition Services (formerly Community Transition Services/Nursing Facility Transition to a Home)
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Medically-Supportive Food/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation

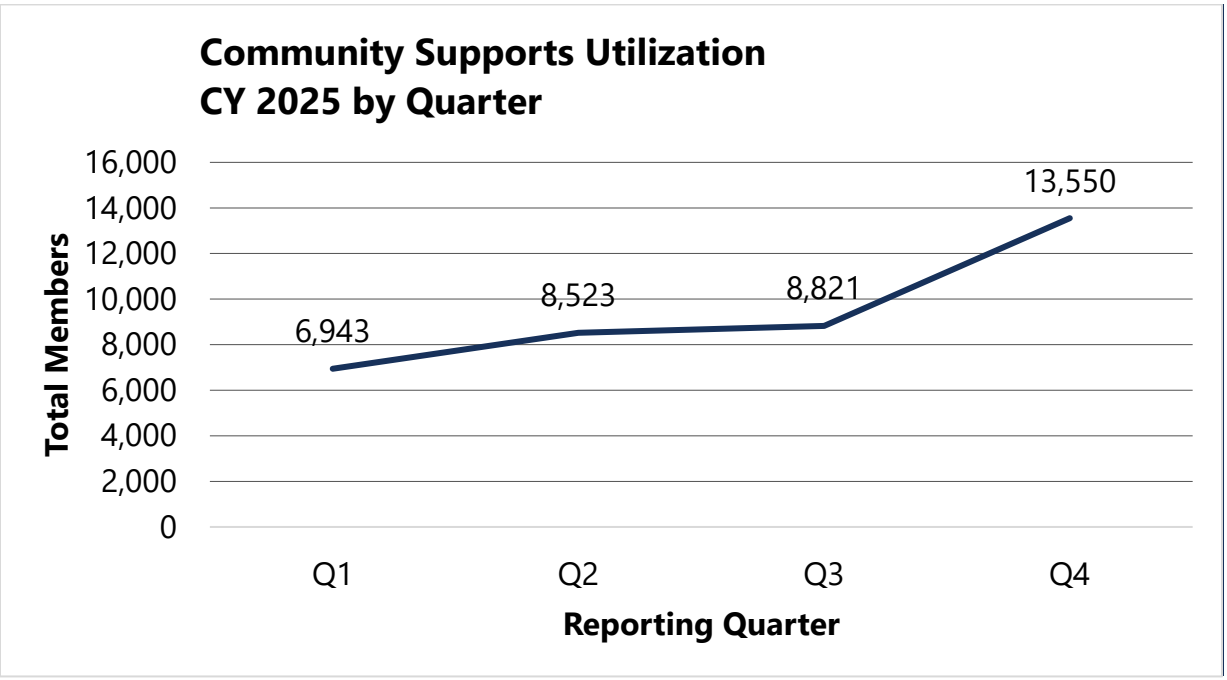
Community Supports are available in all counties where Kaiser participates in Medi-Cal. Of the 14 Community Supports that DHCS has made available to MCPs, Kaiser offers all 14 Community Supports in most counties within its Medi-Cal service area. As such, Kaiser ensures, at a minimum, that the same Community Supports offered by all MCPs in each geographic area are accessible to Kaiser's members. Since the implementation of Kaiser's contract with DHCS in 32 counties, there has been a notable increase in Kaiser's Community Support utilization, reflecting greater member engagement, awareness, and access. Kaiser reports its commitment to expanding enrollment to these essential services, ensuring that eligible members receive the support they need across all covered counties.

Table 12: Unique Members Authorized and Receiving Community Supports

Unique members authorized for Community Supports in 2025	Unique members received Community Supports in 2025	Unique members authorized for CS in Q4 2025	Unique members received CS in Q4 2025
29,120	21,092	21,241	13,550

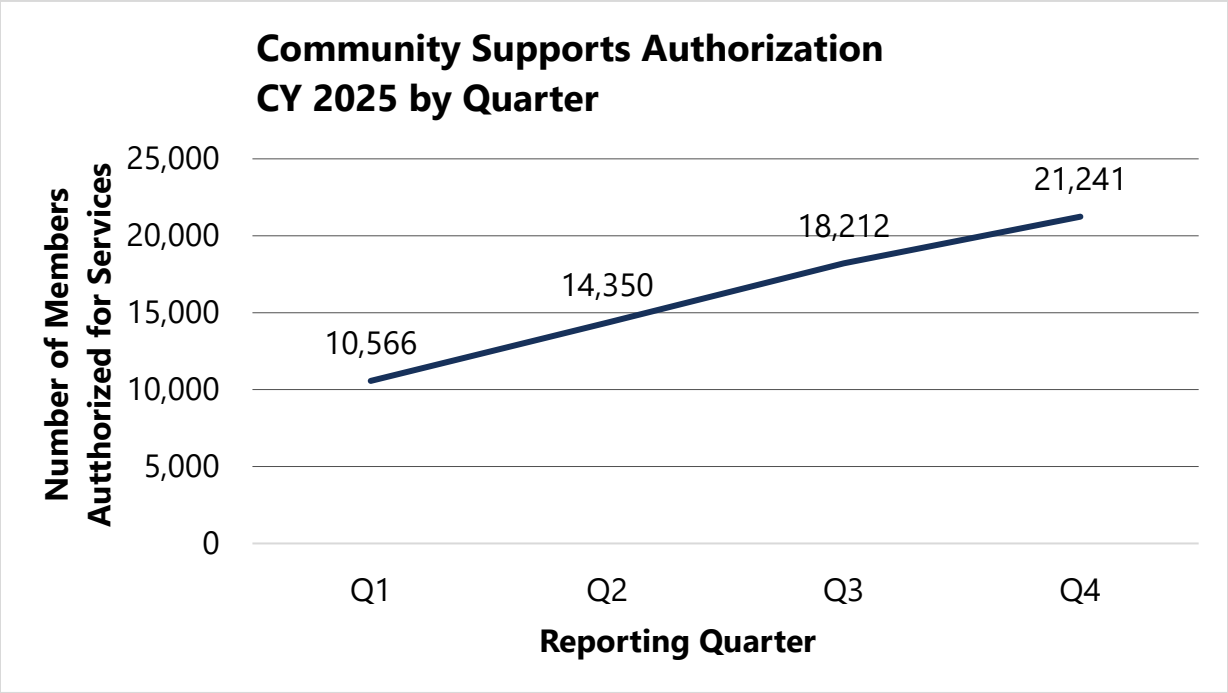
Figure 13: Community Supports Current Enrollment Volume

The chart shows that the utilization of Community Supports by members rose each quarter in 2025.



Source: Kaiser analysis of utilization of Community Supports Data, 2025.

Figure 14: Community Supports CY 2025 Authorization Volume



Source: Kaiser analysis of utilization of Community Supports Data, 2025.

Table 13: Cumulative Counts of Community Supports Received by Service per Quarter of 2025

The chart shows the total number of members receiving each Community Supports service in each Quarter of 2025.

Community Supports Service Received	Q1	Q2	Q3	Q4	% change Q1-Q4
Housing Transition/ Navigation Services	2,456	2,876	2,363	5,063	106%
Housing Deposits	365	362	149	258	-29%
Housing Tenancy and Sustaining Services	346	429	316	864	150%
Short-Term Post-Hospitalization Housing	19	21	62	52	174%
Recuperative Care	53	62	77	171	223%
Caregiver Respite	1,039	954	1,441	1,662	60%

Community Supports Service Received	Q1	Q2	Q3	Q4	% change Q1-Q4
Day Habilitation Programs	46	44	48	100	117%
ALF Transitions	241	301	590	1,143	374%
Community or Home Transition Services	39	37	145	191	390%
Personal Care and Homemaker Services	574	635	793	1,224	113%
Environmental Accessibility Adaptations	160	151	341	745	366%
Medically Tailored Meals/Medically-Supportive Food	3,052	3,634	4,183	4,621	51%
Sobering Centers	0	0	0	1	-
Asthma Remediation	93	93	63	95	2%
Grand Total	**6,943**	**8,523**	**8,821**	**13,550**	**95%**

Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs, Q1-Q4, 2025.

Table 14: Types of Community Supports Received by Members per County

The chart shows the number of types of Community Supports services received by members during Q4 2025 by county.

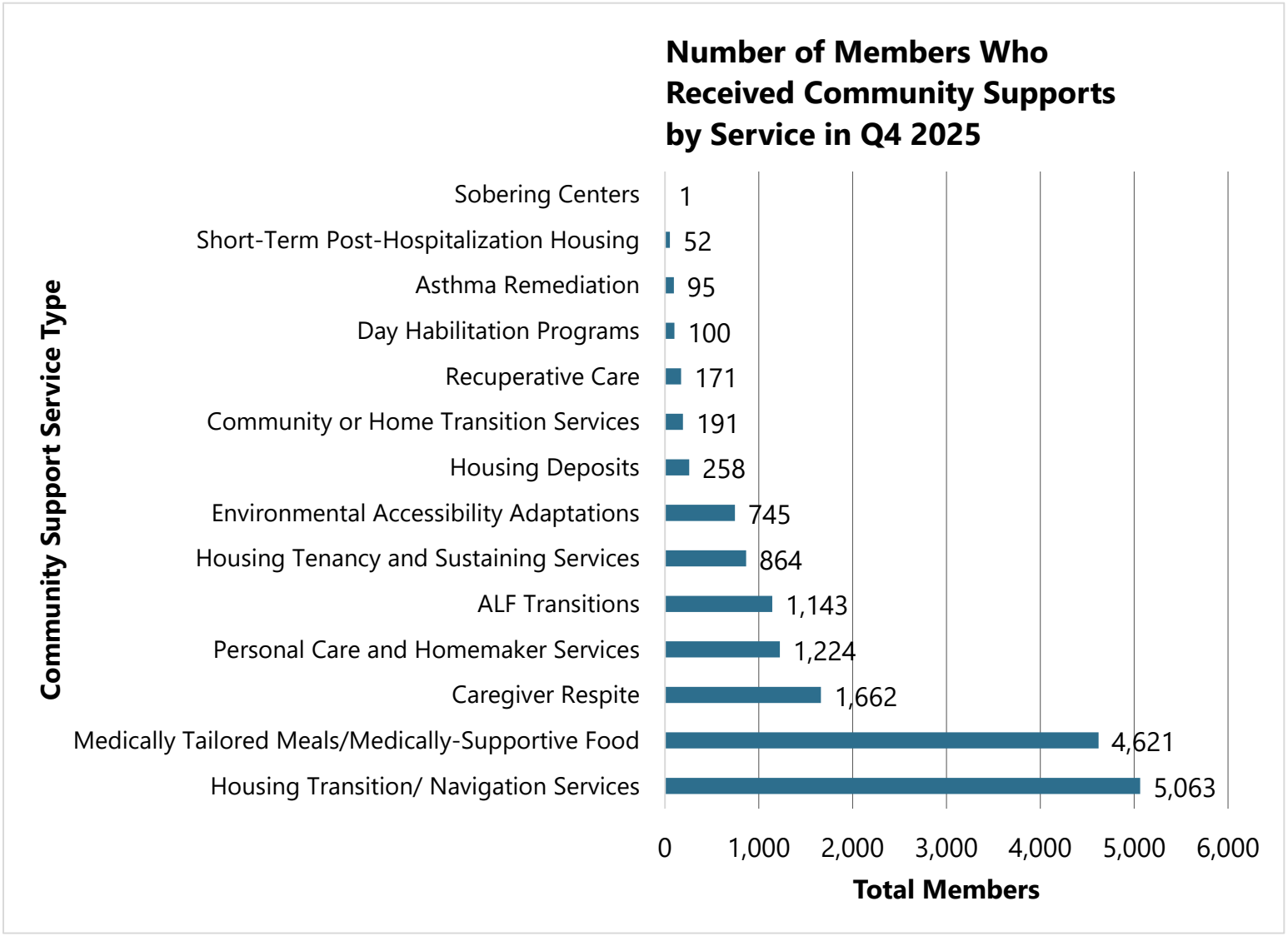
County	Types of Community Supports Received by Members in Q4
ALAMEDA	13
AMADOR	3
CONTRA COSTA	13
EL DORADO	11
FRESNO	9
IMPERIAL	0
KERN	9
KINGS	2
LOS ANGELES	13
MADERA	6
MARIN	10
MARIPOSA	0
NAPA	10
ORANGE	12
PLACER	11
RIVERSIDE	12
SACRAMENTO	14
SAN BERNARDINO	13
SAN DIEGO	13
SAN FRANCISCO	12
SAN JOAQUIN	12
SAN MATEO	13
SANTA CLARA	12
SANTA CRUZ	8

County	Types of Community Supports Received by Members in Q4
SOLANO	13
SONOMA	10
STANISLAUS	12
SUTTER	4
TULARE	0
VENTURA	6
YOLO	11
YUBA	4
GRAND TOTAL	14

Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs, Q4, 2025.

Note: 29 Counties had members receive at least one (1) of the fourteen (14) Community Supports services. 23 Counties had members receive at least eight (8) of the fourteen (14) Community Supports services.

Figure 15: Members Receiving Community Supports by Service



Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs Q4, 2025.

Housing Transition Services and Medically Tailored Meals/Medically Supportive Food are the highest volume supports provided by Kaiser. Members receiving Medically Tailored Meals/Medically Supportive Food increased by about 400 from Q3 to Q4.

In 2025, Kaiser engaged internal and external stakeholders to raise awareness of Community Supports, resulting in a rise in referrals and authorizations and subsequently growing Community Supports enrollment.

Continued Learning and Adaptation

Since the NLE model launched in January 2024, Kaiser has maintained an iterative cycle of listening, learning and adapting. Over the course of 2025, Kaiser hosted multiple listening sessions with current and prospective community-based organizations to solicit insights into an action plan designed to streamline processes, elevate patient and provider experiences, and deliver measurable gains in awareness, referrals, network growth and stakeholder engagement. The organization continues to actively gather feedback, demonstrating dedication to continuous improvement.

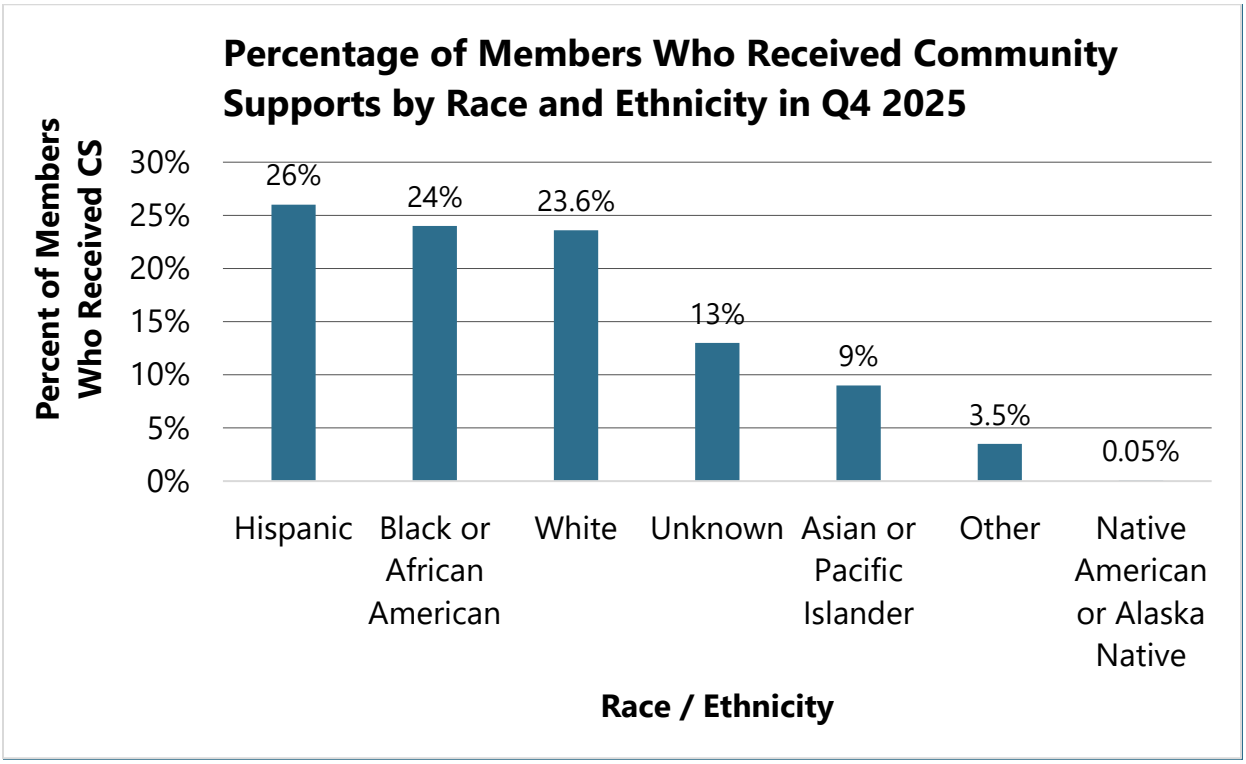
Commitment to Local Engagement and Upstream Investment

Kaiser's Medi-Cal Local Engagement team, deeply rooted in the communities it serves, fosters meaningful engagement with community providers, county agencies, Medi-Cal Managed Care Plans, and other key stakeholders within the Medi-Cal ecosystem. With over 2,450 external engagements and over 750 Medi-Cal trainings and presentations in 2025, the Kaiser team drove collaboration. Also, through the Incentive Payment Program and the Housing and Homelessness Incentive Program, Kaiser is making investments in community-based ECM and Community Supports providers as well as county agencies to build their capacity, increase member engagement in ECM/Community Supports, and strengthen the broader public health ecosystem.

Community Supports Member Characteristics

The charts below show the number of members authorized to receive one or more Community Supports services during 2025, and all Kaiser Medi-Cal members as of December 2025. Kaiser is dedicated to equitable ECM services and using Community Supports to reduce health disparities.

Figure 16: Community Supports Members by Race and Ethnicity

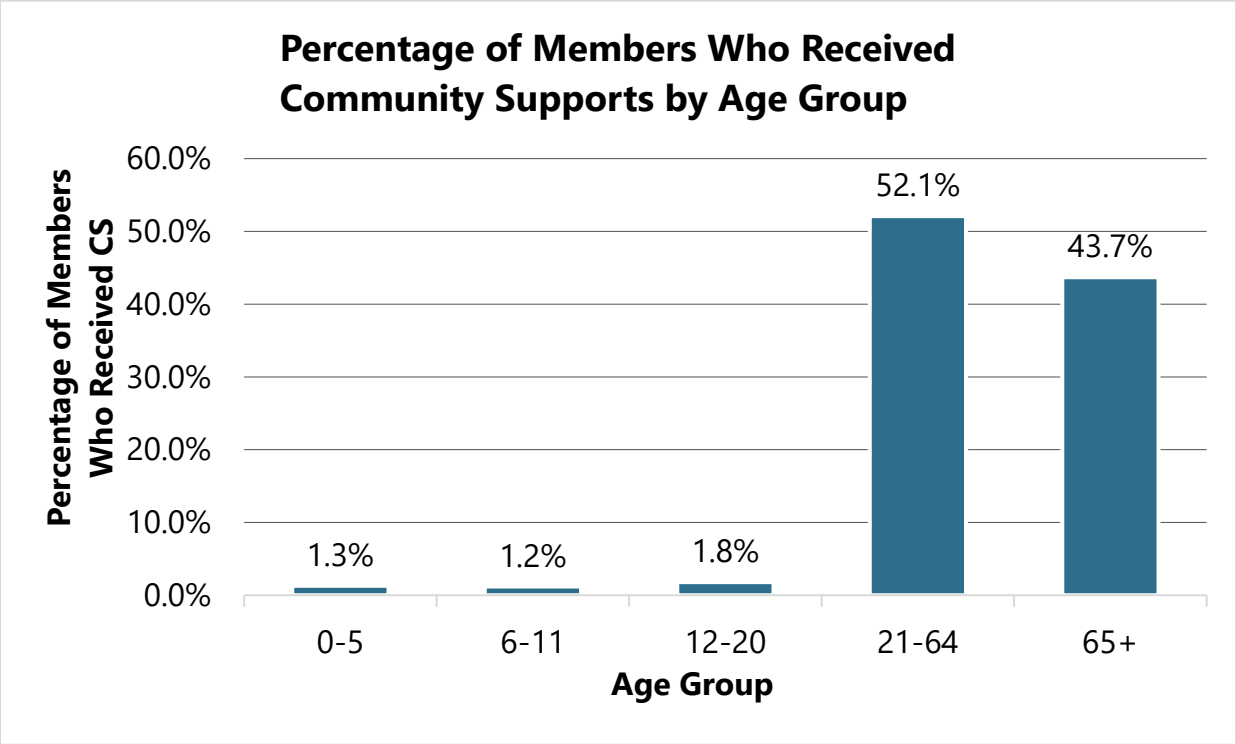


Source: Kaiser analysis of utilization of Community Supports Data, 2025.

Note: data rounded to the nearest tenth of a percent except for the Native American or Alaska Native category

Figure 17: Community Support Members by Age Group

Kaiser's Dual Medicare and Medi-Cal Program actively identifies and refers members in older populations so that they can benefit from Community Supports services delivered at home.



Source: Kaiser analysis of utilization of Community Supports Data, 2025.

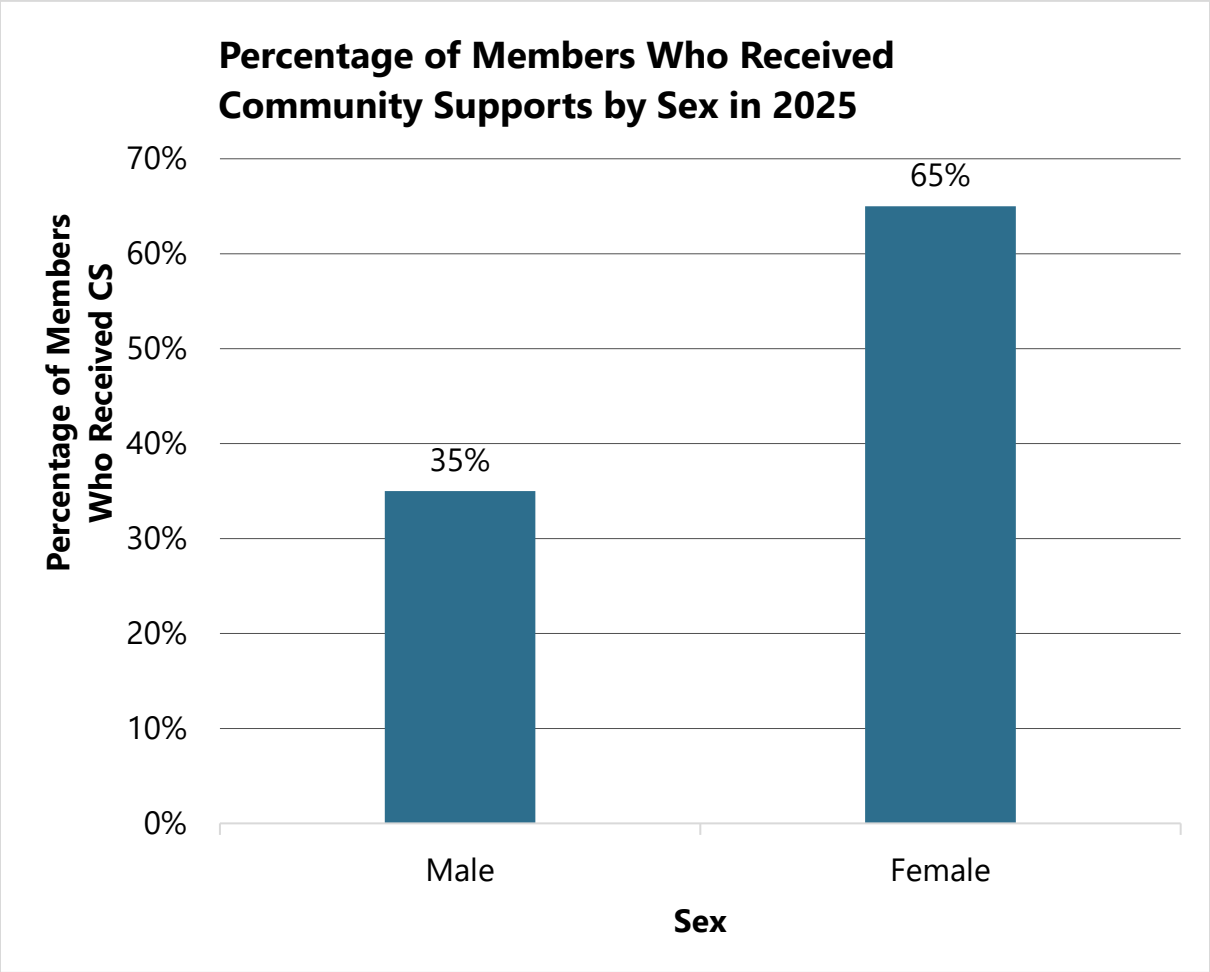
Note: data rounded to the nearest tenth of a percent

Table 15: Percentage of Members Who Received Community Supports by Primary Spoken Language in 2025

Primary Spoken Language	Percentage of Members Who Received Community Supports
ASL	0.1%
Arabic	0.2%
Armenian	0.1%
Cambodian	0.1%
Chinese	1.3%
English	81.7%
Farsi	0.3%
Hmong	0.1%
Korean	0.3%
Other	0.6%
Russian	0.1%
Spanish	13.5%
Tagalog	0.8%
Unknown	0.2%
Vietnamese	0.7%

Source: Kaiser analysis of utilization of Community Supports Data, 2025.

Figure 18: Community Supports Members by Sex Community Supports Members by Sex



Source: Kaiser analysis of utilization of Community Supports Data, 2025.

Note: data rounded to the nearest percent

Community Support and Enhanced Care Management Provider Network Engagement

Kaiser's Network Lead Entities (NLEs) contract with a diverse range of organizations and provider types to ensure broad access to Community Supports and Enhanced Care Management (ECM) services. This includes collaborations with community-based organizations (CBOs) specializing in social services, care coordination, and other critical support services for vulnerable populations. Many of these CBOs focus on serving individuals experiencing homelessness, those with behavioral health needs, and other high-risk groups who require specialized, community-driven care.

In addition, Kaiser's NLEs are actively engaged in negotiations with multiple counties to establish county contracts, further expanding the reach and accessibility of Community Supports and ECM services. Kaiser also works closely with community mental health centers and various non-profit organizations that play a vital role in delivering essential healthcare and social services to Kaiser members.

These collaborations help ensure that members receive comprehensive, localized support that addresses both medical and social determinants of health.

Kaiser continuously monitors the adequacy of its Community Supports and ECM network and the availability of services, working diligently to identify and address any gaps through targeted mitigation strategies. Throughout 2025, the Kaiser Community Supports network included 244 Community Supports providers and 307 ECM providers, the majority of which are non-profit CBOs. Kaiser's network encompasses Community Supports and ECM provided by county agencies, clinics, and other essential service providers that deliver integrated care within the communities they serve.

Furthermore, the Justice-Involved (JI) Pre-Release Initiative for Enhanced Care Management (ECM) successfully launched on October 1, 2024. Throughout 2025, Kaiser has prioritized expanding network capacity by collaborating with Managed Care Plans, County Agencies, Sheriff's Departments, Probation Offices, Behavioral Health Providers, and the California Department of Corrections & Rehabilitation (CDCR). These collaborations strengthen Kaiser's ability to provide critical support to justice-involved individuals, ensuring they have access to care coordination and essential services as they transition back into the community.

Through these ongoing efforts, Kaiser has demonstrated a commitment to ensuring a robust, community-driven provider network that enhances access to comprehensive, high-quality care for Medi-Cal members across all covered counties.

Table 16: Unique Provider Counts by Service Type

A total of 406 unique providers delivered ECM and Community Supports services in 2025. [4]

Provider Types	ECM	Community Supports
Volume of Providers	307	244
% 501c3 Non-Profit Organizations	84.2%	56.4%
% For Profit Organizations	15.8%	43.6%

Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs, October 2025.

CONCLUSION

DHCS has concluded that Kaiser Foundation Health Plan continues to meet the requirements of the MOU and remains in good standing with the Department of Health Care Services. Kaiser is advancing toward the 25% Medi-Cal growth target, reaching a 21.65% increase from the July 2024 baseline through December 2025. Kaiser enrollment indicates a slightly higher rate of enrollment of foster care children/youth as well as dually eligible members when compared with other MCPs. PHMI efforts continue to strengthen CHC capabilities, expand data driven practices, and support ongoing clinical transformation. Specialty care pilots, particularly in Kern County, show maturing implementation and increasing service capacity, with continued work underway to improve access in newer pilot regions to meet market share and TNAA goals across all specialties in all regions.

Kaiser has also deepened collaboration with counties and community stakeholders, expanded ECM and Community Supports across its service area, and increased utilization of these services in 2025. ECM utilization remains low compared to other MCPs, especially for children & youth members. DHCS will continue to meet with Kaiser at least quarterly to assess progress, and based on CY 2025 performance, anticipates ongoing compliance with all MOU deliverables.

4 Providers may deliver both ECM and Community Supports; therefore, the sum of unique ECM and Community Supports providers does not equal the total number of unique providers.