Medi-Cal Direct Contract with Kaiser Permanente

Department of Health Care Services - 2022-23 Governor's Budget Proposal
May Revision Update

Proposal

The Department of Health Care Services (DHCS) proposes to enter into a direct contract with Kaiser Permanente (Kaiser) as a Medi-Cal managed care plan within certain geographic regions of the State, effective January 1, 2024 for a five year contract term, with potential contract extensions. Under the new contract, subject to federal approvals, Kaiser would operate as a full-risk, full-scope Medi-Cal managed care plan, consistent with other Medi-Cal managed care plans. Kaiser will no longer retain specific exceptions or alternative standards, as has been granted in the past (e.g., exemptions from the facility site review/medical record review process, timely access survey, covered benefits requirements, and alternative access standard). The only exception will be that Kaiser will not be open through the traditional Medi-Cal plan choice methods.

Due to Kaiser's distinct integrated plan and provider model that relies on brick and mortar and medical group capacity, Kaiser has historically not been subject to the traditional Medi-Cal plan choice methods, including where DHCS has a direct contract with Kaiser today (in five counties) and where Kaiser is a subcontractor under another health plan (prime plan). At the direct contract and subcontract level, Kaiser enrollment historically has only been based on continuity (i.e., persons leaving employer-sponsored Kaiser coverage and other payer-sponsored Kaiser coverage) and family linkage. In this proposal DHCS is looking to expand Kaiser's Medi-Cal enrollment from 22 counties to 32 counties and to increase the number and types of Medi-Cal beneficiaries (beyond continuity and family linkage) it is responsible for.

Kaiser has committed to growth of new Medi-Cal members of 25 percent from the start of the contract term to the end of the contract term (five years) through continuity of members who exit their other lines of business, where Kaiser has a commercial presence but not currently enrolling Medi-Cal beneficiaries; dual eligibles (those eligible for both Medicare and Medi-Cal); and open choice enrollment for foster youth. This growth would apply in the 22 counties[i] where Kaiser currently participates as Medi-Cal managed care plan and the 10 counties[ii] where Kaiser has another line of business but would open to Medi-Cal enrollment come January 1, 2024.

Furthermore, in response to stakeholder feedback received since release of this proposal in February, Kaiser has agreed to open to default enrollment for all Medi-Cal beneficiaries up to an annual cap per county based on projected capacity in order to diversify its case mix. This growth would be part of the 25 percent

growth described above. Details are forthcoming. It should be noted that Kaiser's current case mix is relatively reflective of the statewide case mix, as noted in the Table 1 below.

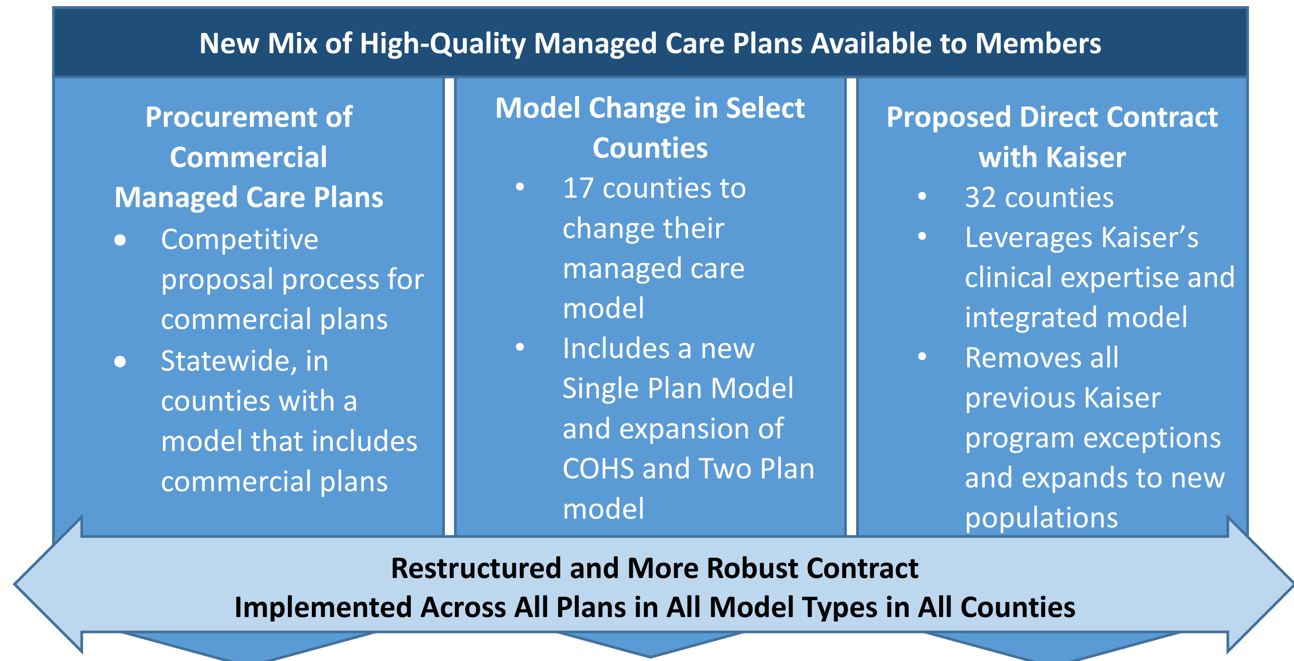
Table 1: Enrollment as of Jan 2022	**Medi-Cal Enrollment***	**Kaiser Enrollment**
ACA Expansion (including undocumented adults)	32.18%	27.84%
CHIP/Families	46.28%	59.21%
Seniors & Persons with Disabilities (SPD)	3.45%	3.76%
Duals	11%	9.03%
Other**	7.08%	0.16%
Total	100%	100%

*Note – There may be a minor overlap (less than .5%) of duals in "families" aid category. Most duals are also in the SPD coverage group so they are grouped in duals vs. SPDs.
**Other for Medi-Cal Enrollment includes State Only, Presumptive Eligibility, and Restricted Scope.

Under this proposal, Kaiser would not have to bid as a commercial Medi-Cal managed care plan under the Request for Proposal (RFP) that was released on February 9. Similarly due to the unique model of local plans, i.e., County Organized Health Systems (COHS) and Local Initiative (LI) plans, do not have to bid for the RFP. DHCS released the Medi-Cal Direct Contract with Kaiser Proposal prior to the release of the Medi-Cal managed care RFP to provide transparency to potential bidders in the impacted geographic regions.

Like all Governor's Budget items, this proposal was developed confidentially until release and is now undergoing a public process. DHCS is proposing trailer bill language to clarify its statutory authority to maintain and expand direct, full-risk contracts with Kaiser, defined under current state law as an Alternate Health Care Service Plan. Subject to federal approval, the direct contracts would be available in the 32 counties in which Kaiser operates (including COHS/single plan model counties, two-plan model counties, regional model counties and Geographic Managed Care model counties, as applicable).

DHCS is Transforming Medi-Cal Managed Care Through Multiple Channels



DHCS has authority to determine which, and how many, managed care plans with which the State contracts for Medi-Cal services in counties. DHCS determination is ultimately guided by the best interests of Medi-Cal beneficiaries and State goals for the Medi-Cal managed care delivery system under CalAIM, namely to drive quality of care improvements, streamline and reduce complexity, and build on whole person care approaches.

In 2021, DHCS began the statewide procurement process for the new managed care plan contract effective January 1, 2024. Through this process, DHCS provided counties an opportunity to change the managed care plan model that operates in their county. Throughout 2021, counties intending to change their managed care plan model were required to file a number of deliverables with DHCS and ultimately pass a local County Ordinance.

The following counties submitted the necessary County Ordinance by the due date of October 10, 2021. DHCS has accepted all county ordinances and has provided a Conditional Approval to continue to move forward with their request to change the Managed Care Plan Model type that currently operates in the County. A conditional approval allows the county and Managed Care Plan to move on to the next phase in the Managed Care Plan County Model Change process which is the Plan Operational Readiness assessment that will commence in the fall of 2022. Below is a list of all conditionally approved model changes.

Single Plan Counties
Alameda County: Single Plan with Alameda Alliance
Contra Costa County: Single Plan with Contra Costa Health Plan
Imperial County: Single Plan with California Health and Wellness

COHS with Central California Alliance for Health
Mariposa County and San Benito Counties

COHS with Partnership Health Plan
Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba Counties

Two-Plan with Health Plan of San Joaquin
Alpine and El Dorado Counties

DHCS removed all conditionally approved counties from the commercial plan procurement (for a single local plan model) or reduced the number of commercial plans procured in the county (for a Two-Plan Model). This substantially increased the number of lives assigned to local plans.

While counties have a role in determining models in their individual counties, given its footprint and structure, Kaiser should be viewed outside the procurement process.

Problem Statement

On February 9, 2022, DHCS released a Request for Proposal (RFP) for select commercial Medi-Cal managed care plan contracts. Through this competitive process and resultant contracts, the state is embarking on new relationships with managed care plans to redefine how care is delivered, what leads to health equity and healthy communities, how to better hold the health care delivery system accountable for transparency, quality and results, and ultimately how the state achieves a Healthy California for All. Under this RFP, approved Medi-Cal managed care plans, in the "Two-Plan", "Regional" or "Geographic Managed Care" model counties, must take all enrollees that wish to enroll with them in their contractual service areas. The contract released through the RFP will be applicable to all Medi-Cal managed care plans statewide, regardless of whether they participate in the procurement or not.

Kaiser, which serves close to 900,000 Medi-Cal enrollees, participates as a subcontractor with 12 local Medi-Cal managed care plans (in 17 counties) and has a direct contract in five counties, inclusive of the two Geographic Managed Care (GMC) counties. In 2021, DHCS announced it would limit the number of prime plans in GMC model counties. However, due to limitations in Kaiser's integrated model, physical capacity as well as fixed geographic locations, Kaiser

is not in a position to be listed on Medi-Cal enrollment choice forms for all Medi-Cal beneficiaries.

If Kaiser is unable to participate in the RFP due to its network's physical capacity, the Medi-Cal program would lose its highest quality plan, its integrated model and clinical expertise. In addition Kaiser's enrollees in at least the GMC and direct contract counties (Sacramento, San Diego, Amador, El Dorado, and Placer) would need to change health plans. This is a unique problem that requires a unique solution.

Furthermore, the growth commitment from Kaiser in the DHCS proposal will mean that Medi-Cal growth will be at a faster rate than Kaiser's projected growth for commercial (CalPERS, Covered CA, etc.) and Medicare. While Kaiser is open to all comers on these lines of business, it is at a manageable rate that aligns with their available capacity. If Kaiser were to take all comers in Medi-Cal, the growth rate would far outpace their physical capacity, especially since DHCS' default algorithm favors quality and Kaiser far exceeds quality scores in all counties it participates in.

Advantages to the Medi-Cal Program

Under the proposal, Kaiser would be subject to ***all*** terms of the new managed care contract except it would not be open through the traditional Medi-Cal plan choice methods.

Existing Kaiser Medi-Cal members will have the option to stay with Kaiser. In addition, Kaiser will commit to growth of new Medi-Cal members of 25 percent from the start of the contract term to the end of the contract term (five years).

This growth will occur through:

- Continuity of members who exit their other lines of business in 32 counties where Kaiser has a commercial or Medicare line of business. Continuity is defined as (1) the person being enrolled in Kaiser at any time during the twelve months immediately preceding the effective date of the beneficiary's Medi-Cal eligibility or (2) the person has "family linkage" which means a situation where a beneficiary's parent, guardian, minor child or minor sibling is enrolled in or has been enrolled in Kaiser at any time during the twelve months immediately preceding the effective date of the beneficiary's Medi-Cal eligibility. Continuity enrollment applies to all Kaiser members transitioning from all lines of business and for all Medi-Cal aid codes/populations, including duals.

- Aligned enrollment, as defined in Assembly Bill 133 (2021) and the CalAIM 1115 Waiver, of dual eligibles (those eligible for both Medicare and Medi-

Cal). This would apply to the Coordinated Care Initiative (CCI) counties and counties where aligned enrollment[iii] has gone live. Prior to 2026, in non-CCI counties, DHCS will work with local plans to determine when Aligned and/or Exclusively Aligned Enrollment will go live for each county. All prime plans participating in Exclusively Aligned enrollment will go live at the same time in a given county.

- Kaiser being a choice for foster youth. Under this proposal, Kaiser would be an option along with any other Medi-Cal managed care plan available in the county. Foster youth would not be required to enroll in Medi-Cal managed care. Foster youth enrollment is not limited to continuity.

- Since the release of this proposal in February, Kaiser has agreed to open to default enrollment for all Medi-Cal beneficiaries up to an annual cap per county based on projected capacity in order to diversify its case mix. This growth would be determined in conjunction with DHCS, the local health plan, and other stakeholders.

This growth would apply in the 22 counties where Kaiser currently participates as Medi-Cal managed care plan and the 10 counties where Kaiser has another line of business.

In addition, this proposal leverages Kaiser's expertise and augments its contribution to Medi-Cal:

- Kaiser will implement CalAIM Enhanced Care Management (ECM) and Community Supports in a manner consistent with other Medi-Cal managed care plans. Kaiser will leverage more community presence with other providers (e.g., county departments, public hospitals and health systems, and community health centers) and not solely provide all ECM and Community Supports internally. Kaiser will also commit to broad uptake of Community Supports, consistent with other Medi-Cal managed care plans and will implement at least the same number of Community Supports as other Medi-Cal managed care plans in the area.

- Kaiser will support FQHCs across the state to implement a robust portfolio of population health management and practice transformation solutions to augment clinical outcomes for patients cared for in this vital community-based system. This bolsters the strengths of two systems: The breadth of community presence and cultural and equity excellence of the FQHCs and the practice transformation and approach to quality care of Kaiser.

- DHCS and Kaiser will identify the highest need specialties and geographic areas where Kaiser will provide, by Kaiser physicians, a limited number of in-person, ambulatory based, outpatient specialty care visits, and associated needs such as diagnostic testing and outpatient procedures for non-Kaiser members. These services may be provided at locations other than Kaiser facilities (for example at FQHCs). Similar to above, this would leverage Kaiser's clinical expertise and integrated model to support underserved areas and would test out models and partnerships to deliver specialty care.

Under this proposal, the Medi-Cal program is getting more from Kaiser than under the arrangement today. Kaiser will be required to abide by the exact same rules as all other Medi-Cal managed care plans, except open enrollment. Today, Kaiser has multiple exemptions from these rules (e.g., exemptions from the facility site review/medical record review process, timely access survey, covered benefits requirements, and alternative access standard). In addition, Kaiser will contribute to the safety net through ECM and Community Support contract with counties and public hospital systems, the engagements with the FQHCs on population health management and specialty care for non-Kaiser Medi-Cal members. This requirement is not in place today.

Finally, this proposal is consistent with DHCS' overarching goals for Medi-Cal:

- **Preserves Member Continuity.** Kaiser members will have a more seamless transition to and from Covered California and employer-based coverage, as well as far better alignment for those enrolled with Kaiser for their Medicare and Medi-Cal coverage. Importantly, for these members, the payer source of coverage would not matter, they can maintain Kaiser at their option.

- **Quality Outcomes.** Kaiser consistently scores above 90% in the Aggregated Quality Factor Score (AQFS)[iv], which is a quality score that accounts for plan performance on DHCS-selected HEDIS indicators. In comparison, the weighted average of other managed care plans is 65%. Further, in 41 of 48 quality measures Kaiser (either Northern CA and/or Southern CA) exceed the weighted average for all Medi-Cal Managed Care Plans and in 37/48 measures significantly better than the weighted average. Kaiser is the highest or among the highest for Quality Scores for:

    - Follow-Up Care for Children Prescribed ADHD Medication
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics
    - Antidepressant Medication Management – Acute Phase
    - Contraceptive Care—All Women and Postpartum Women

- Timeliness of Prenatal Care
- Controlling High Blood Pressure
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood and Adolescent Immunization Status
- Well-Child Visits in the First 15 Months—Six or More Well-Child Visits
- Asthma Medication Ratio
- Emergency Department Visits (Per 1,000 Member Months) Total

This proposal grows Medi-Cal's partnership with a high quality plan and leverages Kaiser's expertise to improve care for non-Kaiser members. This proposal would additionally provide more insight into the quality of care provided by prime local plans as Kaiser's quality scores would no longer be included in the local plans' data.

- **Reduce Disparities.** Kaiser's commitment as part of this agreement to partner with FQHCs recognizes and couples the advantage of FQHCs being embedded in communities and trusted providers and Kaiser's ability to deliver effective and quality primary care and add additional specialty care access in areas traditionally underserved.

- **Removes layers of complexity, bureaucracy, and cost.** This proposal is a step forward in the path of simplification of health coverage in the state as it reduces unneeded layers of administration and bureaucracy by (1) eliminating the 12 subcontracts and corresponding administrative overhead between Kaiser and other managed care plans, majority of prime plan maintains 5 percent of the rate and some far exceed that percent, (2) eliminating consumer confusion regarding subcontracting arrangements between Kaiser and the other managed care plans, and (3) allows DHCS to have direct oversight of a plan with nearly 1 million Medi-Cal beneficiaries rather than working through another managed care plan which makes for greater accountability and more efficient processes such as data reporting and collection.

Impact to Local Plans - *Updated*

DHCS will develop actuarially sound rates for Kaiser as a direct contractor. This process will be informed by historical utilization and cost experience, with adjustments as needed, to produce rates that reflect reasonable, appropriate, and attainable costs under Medi-Cal and align with the projected risk/acuity of Kaiser's members. Local plans may argue that under this proposal, their rates may be impacted as a result of the removal of Kaiser members. However, local plans' rates will be appropriately adjusted for the removal of Kaiser members. DHCS collects the historical data needed to separate utilization and cost experience for

members sub-delegated to Kaiser from a local plan's overall membership. When Kaiser members are removed from the local plan's enrollment, the cost of the Kaiser members will be removed and the local plan's acuity mix will be adjusted. Consequently, rates will be adjusted to reflect the new composition and cost of members remaining enrolled in the local plan. DHCS will, again, leverage historical plan-reported supplemental and encounter data, and other data sources as appropriate, to inform and validate this adjustment through established rate-setting processes. Local plans will not need to wait two years to recognize this adjustment. DHCS remains committed to engaging plans on elements of the transition to fully regional rates (targeted to occur no sooner than CY 2024), including appropriate consideration of the impact of Kaiser's presence as a direct contractor within the regions to be established. At this time, DHCS has not performed detailed analysis of the acuity of the Kaiser members relative to the local plan's remaining membership in CY 2024; such analysis will be performed as part of CY 2024 rate setting and appropriate information shared with each plan. For reference, in Sacramento and San Diego counties, where Kaiser is a direct contractor today, Kaiser's membership is higher-risk than the county average for child and adult populations and lower-risk for seniors and persons with disabilities (partly due to a higher percentage of disabled children and youth within Kaiser's membership).

The department assessed local plan's fiscal stability and found that all local plans have a tangible net equity of over 450 percent of what is required[v]. This means that these plans have reserves well above what the Department of Managed Health Care has determined (pursuant to regulations) as necessary to demonstrate fiscal health.

Additionally, as noted above, the county model changes as a result of the procurement will likely increase the number of lives assigned to local plans. It is estimated that about 450,000 are moving to a COHS or single plan model and about 34,000 would be moving to a two plan model.

Under this proposal, DHCS and Kaiser will work with local health plans and other stakeholders to determine enrollment growth, align on implementation of CalAIM, and support the local health care delivery infrastructure.

Finally, under this proposal, the state has expanded and standardized the limited enrollment parameters for Kaiser from what they are today. Kaiser is not "picking" its members. Rather under this proposal, individuals who have picked Kaiser can maintain/obtain their coverage in Kaiser in the Medi-Cal program.

Network Adequacy - New
Kaiser is currently permitted to submit an exemption request under Welfare and Institutions Code section 14197(e)(1)(B) that allows the Plan to submit a

justification to be exempt from the time or distance standards due to their delivery system model. Kaiser must submit this request annually through the Annual Network Certification process and describe how their delivery system is capable of delivering the appropriate level of care without needing to meet time or distance standards. It is in the Department's discretion to grant the exemption under WIC § 14197(e)(1)(B) and this exemption is justifiably needed for specialty MCPs due to the special populations they serve (e.g., SCAN).

Under this proposal, DHCS will deny Kaiser's future requests for a delivery system exemption under WIC § 14197(e)(1)(B) and require that they demonstrate ability to meet time or distance standards outright or submit an AAS request under WIC § 14197(e)(1)(A) to DHCS for review and approval, which is the same process used by other MCPs. DHCS will maintain the current statutory authority in State statute to keep the alternative access exemptions under WIC § 14197(e)(1).

DHCS will assess Kaiser for network adequacy compliance in service areas where they are Knox Keene licensed consistent with the DMHC. Kaiser will continue to serve their covered service areas which include specified zip codes in counties in which they operate, similar to how Medicare and DMHC review their coverage area today.

Additionally, the San Mateo Dental Managed Care Pilot is specific only to Health Plan of San Mateo and Kaiser is not required to implement this pilot.

Summary

The chart below describes Kaiser's current participation in Medi-Cal compared to the budget trailer bill language proposal.

	Today	**Proposal**
Counties where Kaiser participates as a Medi-Cal managed care plan	Direct contract (5) • Amador, El Dorado, Placer, Sacramento, San Diego Delegation/Subcontracted plan (17) • Alameda, Contra Costa, Kern, Los Angeles, Marin, Napa, Orange, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Ventura, Yolo	Today's counties (22) as a direct contract Direct contract in counties where Kaiser has another line of business (10) • Fresno, Imperial, Kings, Madera, Mariposa, Santa Cruz, Stanislaus, Sutter, Tulare, Yuba
Medi-Cal enrollment parameters	• Continuity (i.e., persons leaving employer-sponsored Kaiser	• Continuity (i.e., persons leaving employer-sponsored Kaiser

	coverage and other payer-sponsored Kaiser coverage) • Family linkage	coverage and other payer-sponsored Kaiser coverage) • Family linkage • Duals (those eligible for both Medicare & Medi-Cal) • Foster Youth • Default enrollment for all Medi-Cal beneficiaries up to an annual cap per county based on projected capacity
	Today	**Proposal**
Managed care requirements	Exceptions or alternative standards (e.g., exemptions from the facility site review/medical record review process, timely access survey, covered benefits requirements, and alternative access standard)	No exceptions or alternative standards.
Additional terms	None	Kaiser will (1) implement CalAIM Enhanced Care Management (ECM) and Community Supports in a manner consistent with other Medi-Cal managed care plans and (2) support certain FQHCs to implement population health management and practice transformation solutions to augment clinical outcomes and (3) provide DHCS and Kaiser will identify the highest need specialties and geographic areas where Kaiser will provide, by Kaiser physicians, a limited number of in-person, ambulatory based, outpatient specialty care visits, and associated needs such as diagnostic testing and outpatient procedures for non-Kaiser members. These services may be provided at locations other than Kaiser facilities (for example at FQHCs).
State oversight	Direct oversight of Kaiser as a contracted managed care plan in 5 direct contract counties. • Amador, El Dorado, Placer, Sacramento, San Diego Indirect oversight via prime plan in 17 counties.	Direct oversight of Kaiser as a direct contracted managed care plan in 32 counties.

	• Alameda, Contra Costa, Kern, Los Angeles, Marin, Napa, Orange, verside, San Bernardino, San rancisco, San Joaquin, San ateo, Santa Clara, Solano, Sonoma, Ventura, Yolo	

<u>May Revision Updates to TBL</u>

The proposed TBL has been updated to:

- Clarify that former foster youth are included in the enrollment provisions related to foster youth.
- Add that default enrollment is part of the growth in Medi-Cal enrollment specified in this proposal.
- Specify that Kaiser cannot deny or disenroll any individual that meets the specified enrollment or default criteria.
- Specify that Kaiser is subject to all the same standards and requirements, except those related to beneficiary enrollment, as required for other Medi-Cal managed care plans, including the requirements pursuant to CalAIM.
- Require that DHCS and Kaiser enter into a Memorandum of Understanding (MOU) describing the requirements that are different than those imposed on other Medi-Cal managed care plans. The MOU shall include, but not be limited to, the commitment of Kaiser to increase its enrollment of new Medi-Cal members over the course of the contract term and requirements related to Kaiser's collaboration with safety net providers, including Federally Qualified Health Center.
- Require that DHCS post this MOU and publish a report describing the implementation of the requirements imposed by the MOU.
- Provide that Kaiser shall implement the California Children Services Whole Child Model in applicable counties.
- Ensure Kaiser maintain Knox-Keene licensure from the DMHC

[i] Kaiser currently participates as Medi-Cal managed care plan in Alameda, Amador, Contra Costa, El Dorado, Kern, Los Angeles, Marin, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Ventura, and Yolo.

[ii] Counties where Kaiser has another line of business and does not participate as a Medi-Cal managed care plan: Fresno, Imperial, Kings, Madera, Mariposa, Santa Cruz, Stanislaus, Sutter, Tulare, and Yuba.

[iii] Aligned enrollment is currently allowed in all seven CCI counties and at the prime level only in Alameda, Contra Costa, Fresno, Sacramento, San Francisco, Stanislaus and Kern. Effective 2023, exclusively aligned enrollment will begin at the prime and delegate level in all seven CCI counties.

[iv] https://www.dhcs.ca.gov/services/Documents/MMCD/Jan9-2020Release.pdf

[v]https://dmhc.ca.gov/Portals/0/Docs/DO/FSSB%20November%202021/AgendaItem6_FinancialSummaryofMediCalManagedCarePlansReport.pdf?ver=2021-11-16-101955-550