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

CALENDAR YEAR 2024

DHCS

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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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) 2024. In addition, W&I Code section 14197.11(l) requires the Department to report to the health and fiscal committees of the Legislature in 2026 to provide an update on the implementation of the direct Kaiser managed care plan (MCP) contracts authorized by W&I Code section 14197.11. The report to Legislature in 2026 will be provided no sooner than July 2026.

I. ENROLLMENT OF MEDI-CAL MEMBERS

As of December 31, 2024, Kaiser Foundation Health Plan (Kaiser) has 1,156,579 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 recently adding 12,167 Adoption/Foster Care members in 2024. Parents/Caretaker Relatives & Children comprises the highest share of Kaiser's Medi- Cal membership, with 448,703 members or 39% of the total. Some aid categories include both adults and children – 260,294 members, or 58% of Parents/Caretaker Relatives & Children are under the are under the age of 18, while 12,335 or 6% of Seniors and Persons with Disabilities are under the age of 18.

KFHP Medi-Cal Membership by Aid Category, December 2024

- Seniors and Persons with Disabilities, 216,947, 19%
- ACA Expansion Adults Ages 19 to 64*, 326,599, 28%
- Adoption/Foster Care, 121,167, 1%
- Children's Health Insurance Program (CHIP), 143,969, 12%
- Long-Term Care, 2,539, 0%
- Parents/Caretaker Relatives & Children, 448,703, 39%
- Other, 5,655, 1%
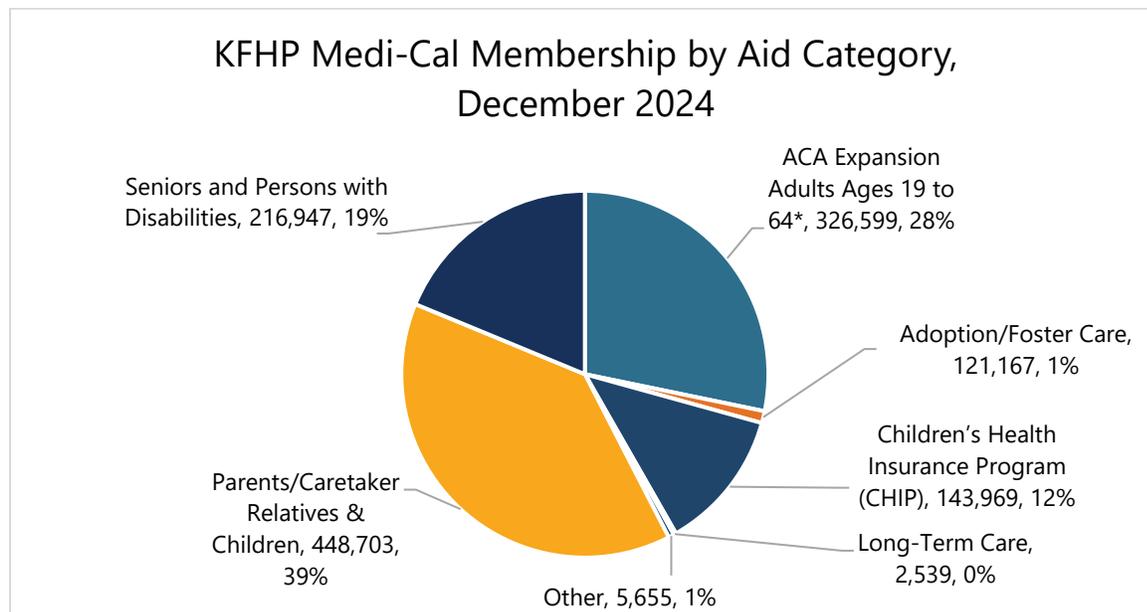
*The aid category, Parents/Caretaker Relatives and Children, provides full scope Medi-Cal coverage to citizens/lawfully present parent/caretaker relatives and their children with income at or below 109 percent of the FPL.

Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2024

Foster Care Children and Youth & Dual Eligibles

As of December 31, 2024, 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%.
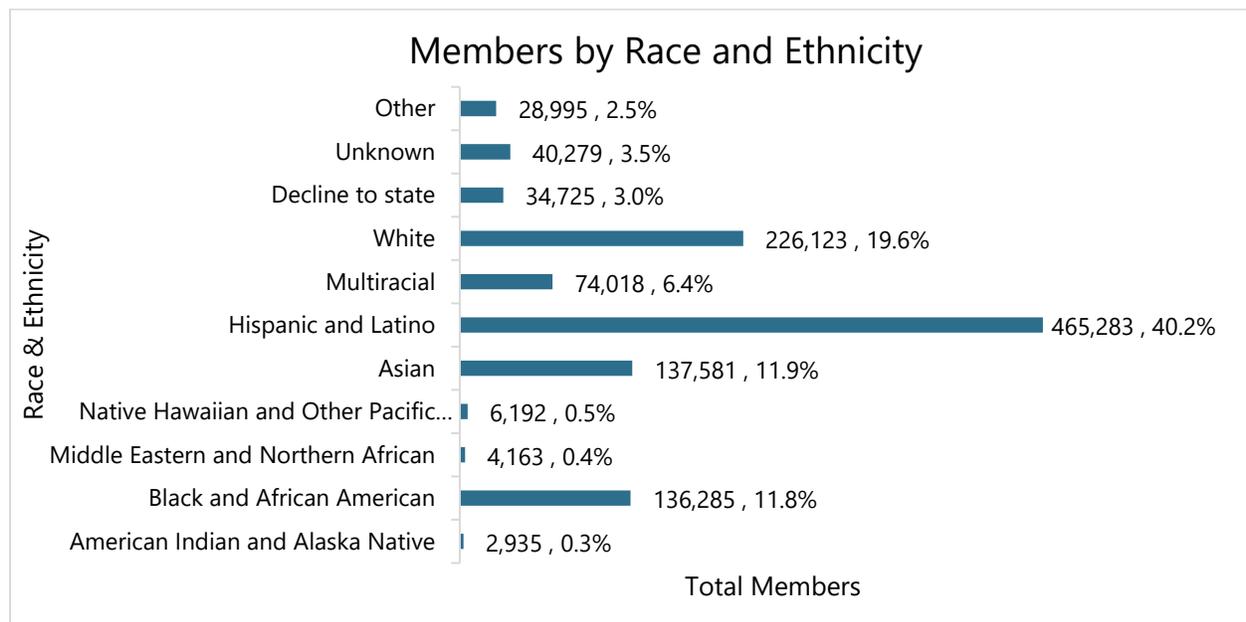
Kaiser's Medi-Cal Membership is approximately 20.6% full dual members meaning they have Medi-Cal and Medicare Part A and B. In comparison, the percentage of full dual members in other managed care plans is 20.5%.

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: 40.2% identified as Hispanic, 19.6% identified as White, 11.9% identified as Asian, 11.8% identified as Black, 6.4% identified as multiracial, 2.5% identified as Other, 0.5% identified as NHOPI, 0.4% identified as MENA, and 0.3% identified as AIAN.

Some also declined to state (DECL, 3.0%) or are unknown (3.5%).

Members by Race and Ethnicity

Race & Ethnicity	Total Members
Other	28,995 , 2.5%
Unknown	40,279 , 3.5%
Decline to state	34,725 , 3.0%
White	226,123 , 19.6%
Multiracial	74,018 , 6.4%
Hispanic and Latino	465,283 , 40.2%
Asian	137,581 , 11.9%
Native Hawaiian and Other Pacific…	6,192 , 0.5%
Middle Eastern and Northern African	4,163 , 0.4%
Black and African American	136,285 , 11.8%
American Indian and Alaska Native	2,935 , 0.3%

Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2024

Age Category

Age is categorized into three groups: (1) 0-18; (2) 19-64; and (3) 65+. Overall, 440.9K or 38.1% of members are 0-18 years of age, 562.1K or 48.6% of members are ages 18-64, and 153.5K or 13.27% of members, are 65 years or older.
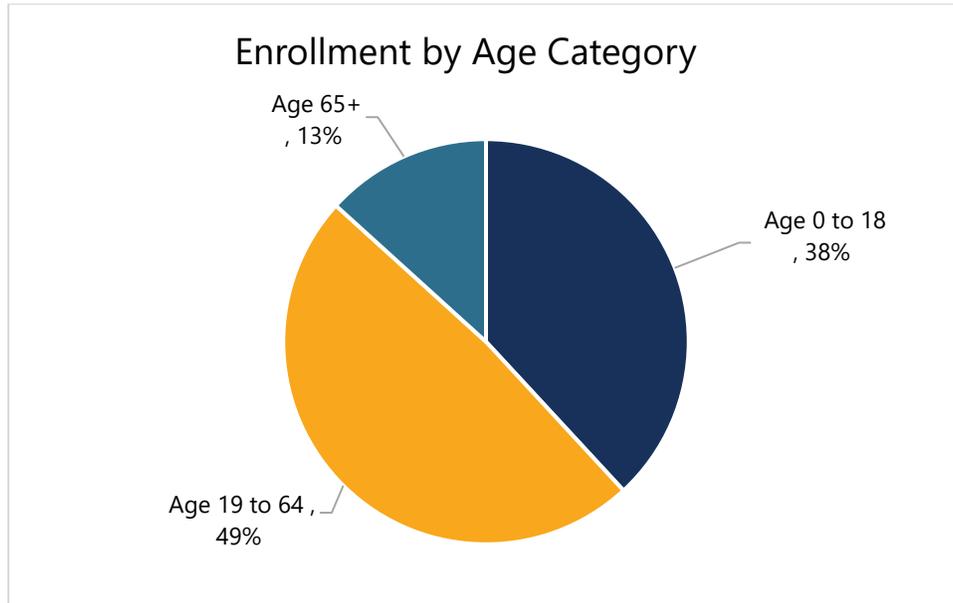
Enrollment by Age Category

Age 65+ , 13%

Age 0 to 18 , 38%

Age 19 to 64 , 49%

Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2024.

Gender

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

As of December 31, 2024, a majority (56.6%) of members are female, 43.4% are male, and less than 0.1% of members are unknown or declined to state.

Statewide Enrollment by Member Self-Reported Gender, December 2024
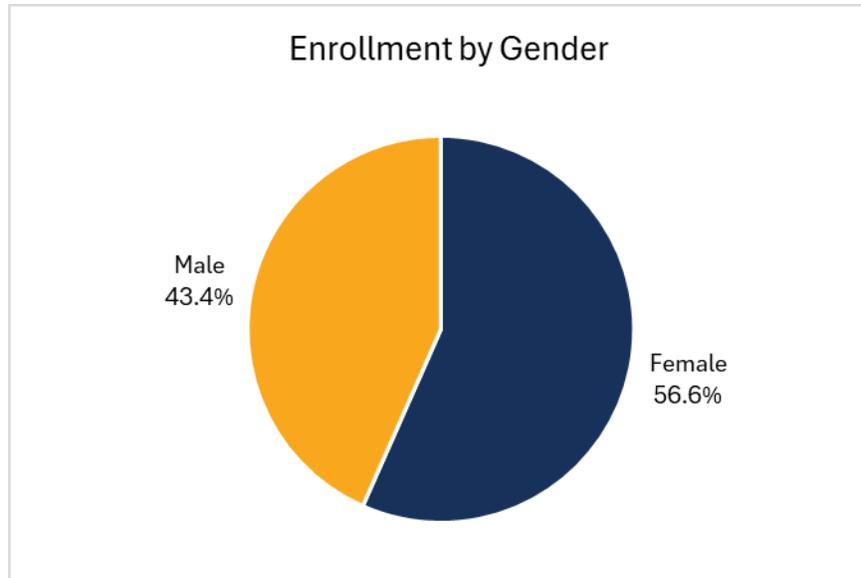
Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2024

II. ENROLLMENT GROWTH

This section summarizes enrollment growth starting with the baseline enrollment as of July 1, 2024. Per the MOU, the 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 12/31/2023 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 Foundation Health Plan, Inc. (Kaiser), Kaiser is to target growth 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, 2024, Kaiser's total Medi-Cal Membership increased from 1,019,525 to 1,156,579, equaling a growth rate of 13.44%. 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 137,054 members that joined Kaiser between July 1, 2024 and December 31, 2024, 2,085 were foster care children and youth and 13,245 were Dually Eligible members. The July 1, 2024 baseline excludes growth from January 1, 2024 through June 30, 2024 in duals, foster children/ youth, default enrollment, managed care plans exiting a county as of 12/31/2023 and new geographic areas.

Enrollment Growth Summary

Enrollment Growth Summary	Baseline (July 1, 2024) (per MOU e>E.a.ii)	Year End 2024 Membership	Growth	Growth Rate
KP Medi-Cal Membership	1,019,525	1,156,579	137,054	13.44%

Source: Kaiser Foundation Health Plan analysis of Medi-Cal statewide enrollment data, December 2024

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 the Department to measure engagement and support of Federally Qualified Health Centers (FQHCs). For example, narrative and metrics as specified by Department of Health Care Services (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

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[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.

milestones, starting with the foundational domains of empanelment, data quality and reporting, care teams and workforce, and business case. In mid-2025, CHCs began working on milestones related to their chosen population focus.

Kaiser providers 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.

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 one-on-one subject matter expertise support to implement workflows

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

- » Percentage of CHCs that have identified a panel manager (who helps manage the empanelment process): 100%

- » Percentage of CHCs that have completed empanelment of patients to a provider (ensuring provider teams' capacity limits were addressed): 100% Via a survey, CHC self-assessed their capabilities in conducting empanelment activities, and 72% of all CHCs reported year-over-year improvement (which is statistically significant).

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 & 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, the Kaiser team working with CHCs found the following:

- » As of February 2025:
  - o Percentage of CHCs who have defined and established a core patient care team: 100%
  - o Percentage of CHCs who have assured that care teams know their patient panels: 100%
  - o Percentage of CHCs who have assured that patients know their care team: 100%
- » Via a survey, CHCs self-assessed their capabilities in providing team-based care to patients. This survey showed, year over year, that 75% of CHCs improved (which is statistically significant).

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

In terms of process outcomes related to this work, the Kaiser team found the following (which are on track with expectations given work in this area is not due to be complete till the end of 2025):

  » As of February 2025, percentage of CHCs that have created an outreach protocol to reach and engage all patients assigned to the CHCs:

    o 10% completed

    o 73.3% in progress

    o 16.6% not started

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 59% of CHCs self-assessed that their abilities to address social health improvement improved year over year (which is a statistically significant increase).

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 Kaiser 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

In terms of process outcomes related to this work, the Kaiser team found the following:

» Improvements in the percentage of CHCs that could produce and submit data for key quality metrics (increasing from 69% to 91% of CHC year-over-year, which is statistically significant)

» Via a survey, CHCs self-assessed their capabilities in using technology and data. This survey showed, year over year, that 69% of CHCs improved (which is statistically significant).

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

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 1: ESA Pilot Geographical Areas, Specialty Areas, and Timeframes

Pilot Number	Geographical Area	Specialty Area	Engagement Timeframe
1	Kern County	» Endocrinology » Nephrology » Rheumatology	December 2022 – Present
2	San Joaquin and Stanislaus Counties	» Rheumatology » Endocrinology » Neurology	September 2023 – Present
3	Antelope Valley (Los Angeles County)	» Nephrology » Rheumatology » Endocrinology	April 2024 – Present

Source: Health Management Associates (HMA)

Within the ESA Pilot, implementation has focused on identifying partnering CHCs to host clinical sessions conducted by Kaiser specialists and to 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; and

» 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.

The following table summarizes each specialty area of care's launch of clinical services, the number of in-person visits as of July 2025, and the stage of development for each specialty area of care in the three geographical areas.

Geographical Regions	Specialty Areas of Care	Launch of Clinical Services	In-Person Visits as of July 2025	Stage of Development of Specialty Pilot
Kern County	Endocrinology	6/2023	718	Implementation
	Nephrology	10/2023	1115	Implementation
	Rheumatology	8/2024	521	Implementation
San Joaquin, Stanislaus Counties	Rheumatology	9/2024	62	Implementation
	Endocrinology	5/2025	20	Implementation
	Neurology	6/2025	3	Launch
Antelope Valley (Los Angeles County)	Nephrology	4/2025	19	Implementation
	Rheumatology	6/2025	3	Launch
	Endocrinology	6/2025	3	Launch

Source: Health Management Associates (HMA)

DHCS anticipates that visit volume will increase over time, especially in the pilots that have launched more recently. As demonstrated above (e.g. for neurology in San Joaquin, Stanislaus Counties and rheumatology in Antelope Valley), the number of visits completed is low during the launch of specialty areas of care. In addition, recruitment challenges in geographical areas have limited the scaling of some pilots. For example, the rheumatology pilot in San Joaquin and Stanislaus Counties started delivering clinical services in September 2024 and had completed 62 visits between that time and July 2025 (10 months), or an overall average of 6 visits per month.

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. The following figures were submitted by Kaiser to DHCS and demonstrate ESA Pilot performance in Kern County, where implementation of the pilot is sufficiently mature to demonstrate trends over time.

Figure 1: Visit Volumes in Kern County ESA Pilot, by Specialty over Time

Visit volumes by specialty in Kern County
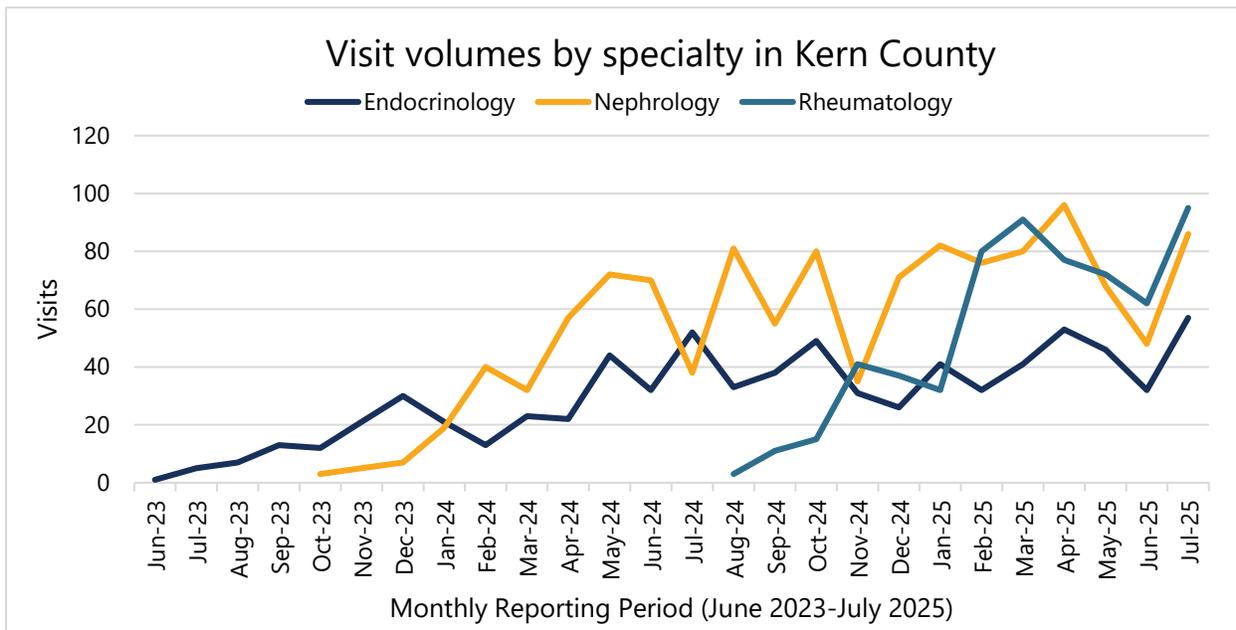
Source: Health Management Associates (HMA)

Figure 2: Third-Next Available Visit Wait Time in Kern County ESA Pilot, by Specialty over Time

Third-Next Available Visit Wait Time in Kern County
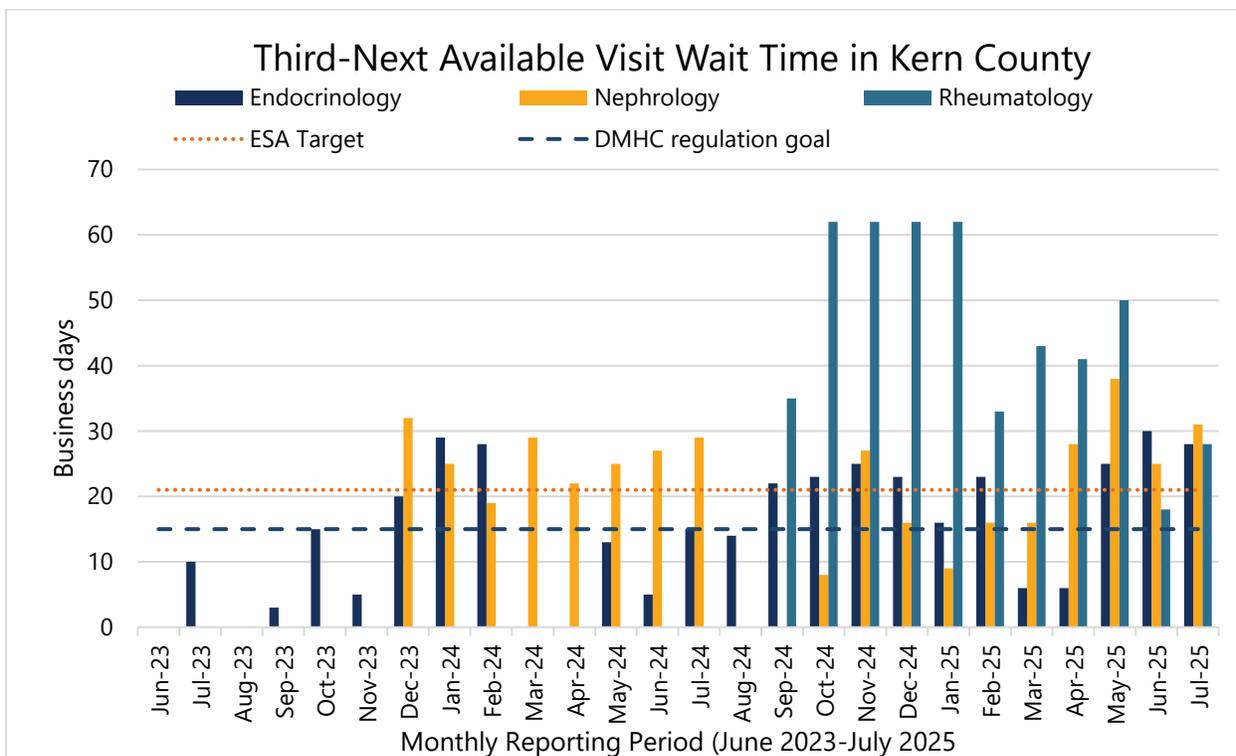
Source: Health Management Associates (HMA)

Figure 3: ESA Pilot Visits as Share of Total Medi-Cal Consultations in Kern County, by Specialty over Time
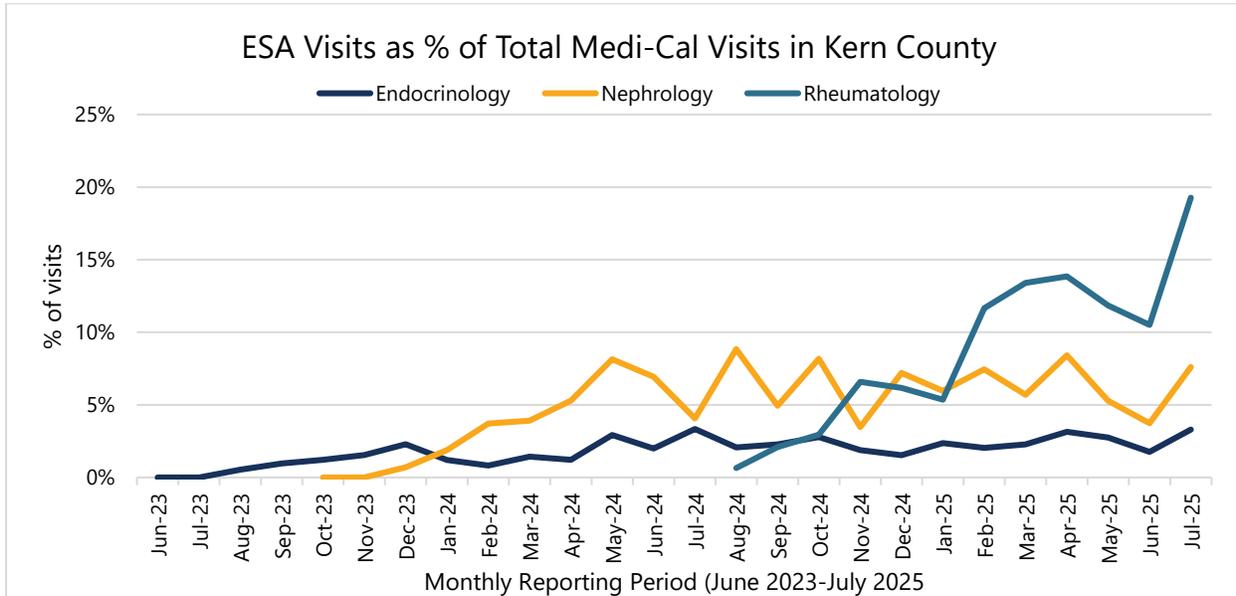

ESA Visits as % of Total Medi-Cal Visits in Kern County

Source: Kaiser Analysis of CHC and MCP Data through June 2025. In the rates above, the numerator is total 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 greater for nephrology, and 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 2024, Kaiser Foundation Health Plan (Kaiser) demonstrated its commitment to advancing Medi-Cal transformation through robust engagement with local stakeholders across all 32 counties. Kaiser provided extensive collaboration and resource development initiatives to improve access to care and foster meaningful collaborations. Examples include:

» **Community Engagement**: Kaiser conducted 1,240 external engagements and 503 trainings and presentations in 2024 to strengthen relationships with community leaders, county agencies, and community-based providers.

» **Statewide Associations**: Kaiser has developed relationships with statewide professional associations for relationship-building, issue clarification, and education. Key partners include the County Behavioral Health Directors Association, California Women Infant and Children (WIC) Association, the County Health Executives Association of California (CHEAC), and the County Welfare Directors Association (CWDA). These statewide associations have been a critical force multiplier in engaging local stakeholders and county agencies.

» **Provider Network Expansion**: Increased visibility and built collaboration to broaden access to care by working closely with Providing Access and Transforming Health Initiative (PATH) collaboratives and other MCPs.

» **Department of Health Care Services (DHCS) Listening Sessions**: Kaiser played a critical role in DHCS Listening Sessions, facilitating discussions among state and local leaders on Medi-Cal's future.

» **County engagement**: Facilitated quarterly county roadshow meetings with county health and human services, providing Kaiser an opportunity to engage with county leadership, including successes and areas for improvement. County officials provided overall positive feedback regarding these sessions and continued collaboration.

» **Resource Development for Complex Care**: Supported initiatives like the Complex Care Certificate Program to enhance provider capabilities for delivering specialized care.

» **Collective Feedback**: Participated in provider meetings to gather feedback and foster dialogue, informing improvements to improve community support offerings.

» **Continuum of Care (CoC)**: Kaiser participated in the CoC General Committee meetings and CoC Board meetings. We have provided CalAIM education/training to several CoCs, using the opportunity to identify potential Enhanced Care Management (ECM)/Community Supports contractors and link interested community partners to contracting resources. Kaiser participated in several CoC subgroups, like the Systems Performance Committee in Sacramento, the Stakeholders Meeting in Sutter/Yuba County, and the El Dorado CoC MCP Collaboration meeting. Kaiser staff served as a resource at these meetings to answer questions about CalAIM, collected any feedback for Kaiser Care Delivery and Operations about the rollout of CalAIM with housing and service providers, and listened for opportunities to collaborate.

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 specified third parties per the MCP Contract Provisions. Kaiser is also subject to the same requirements; however, Kaiser is to report on how they have developed key relationships to enable better care management for Medi-Cal members across the health care and social services continuum at the local level.

Kaiser began the work effort by prioritizing at the leadership level the need to build strong relationships with third parties, including Local Health Departments, County Behavioral Health Departments, Regional Centers, WIC Agencies, In-Home Supportive Services (IHSS) Agencies, and more to ensure Member care is coordinated and Members have access to community-based resources in order to support whole-person care. Kaiser also engaged a broader network of key stakeholders, such as CWDA, WIC Association, California County Offices of Education, the statewide First 5 Association, and the California Center for Children's Policy.

Collaborative efforts focused on defining shared goals, establishing communication channels, and developing joint strategies to ensure mutual understanding and alignment. Kaiser's proactive collaboration with stakeholders identified and addressed local needs early, driving community improvements. For example, child welfare liaison work enhanced foster care children and youth care coordination and increased awareness of available services. Collaborative efforts also led to process improvements, such as reviewing and updating WIC referral forms to ensure accuracy and proper use by Kaiser providers. Ongoing collaboration on processes, policies, procedures, and operating guidelines reinforced the positive impact of these collaborations on the healthcare delivery system.

Kaiser's MOU execution process enhanced local organizations' confidence by clarifying Kaiser's Medi-Cal offerings and establishing clear county-level points of contact. This improved understanding facilitated targeted training plans enabling positive community impacts.

Once the MOUs were executed, Kaiser delivered comprehensive training to stakeholders, covering MOU basics, service access pathways, and managed care responsibilities. Structured forums were established for stakeholders to co-develop MOU Operating Guidelines, which outlined processes for care coordination, data sharing, and patient referral pathways. These forums and regular meetings ensured ongoing collaboration and alignment, with meeting details made available on Kaiser's website. This structured approach ensured MOUs were fostering sustainable collaborations and achieving shared objectives.

Kaiser reported that stakeholder engagement across all thirty-two counties has driven changes in the health care delivery system. Collaborative forums established during the MOU execution process, defined steady-state operations and supported improvements in care coordination, data sharing, and bi-directional patient referral processes. Agreed-upon frameworks were operationalized and reinforced through ongoing training and quarterly meetings, ensuring alignment between stakeholders, and enhancing delivery system efficiency and effectiveness.

This structured, systematic approach strengthened collaborations and delivered measurable improvements in healthcare delivery.

COMMUNITY ADVISORY COMMITTEE (CAC)

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 began hosting quarterly CAC meetings in June 2024. Meetings were held regionally each quarter in Northern California and Southern California. Approximately 20 Medi-Cal members attended each meeting alongside Community-Based Organization (CBO) committee members. Three non-contracted, CBO partners from each region represented diverse populations, including foster children and youth, LGBTQ+ individuals, and members experiencing homelessness.

Kaiser's three CAC meetings in 2024 focused on key topics aimed at improving Medi-Cal services and member experiences. Discussion topics included Non-Specialty Mental Health Services, Food and Nutritional Supports, Population Needs Assessment (PNA), and Community Health Workers. Addressing "Accessing Health Care Information in Your Community" provided insights to shape outreach plans for Medi-Cal benefits and programs like ECM. Each topic was framed with member-related context and supported by thoughtful questions to gather CAC member recommendations. Input was focused on the cultural appropriateness of communications, collaborations, and services.

Driving Change

In 2024, engagement with the CAC drove the following changes:

» Feedback from the CAC was used to develop the Request for Proposal (RFP) for food and nutritional supports vendors for Medi-Cal that are local entities who understand the communities they serve. Kaiser made multiple operational adjustments to prioritize non-profit organizations. Kaiser's existing Network Lead Entities engaged non-profit organizations first, when engaging members for services. Kaiser also executed intentional strategy to engage nonprofit organizations in its Medically Tailored Meals (MTM)/Medically Supportive Food (MSF) expansion, guided by feedback from the CAC. The RFP process prioritized local entities with deep community ties, resulting in strong nonprofit participation through a broad screening effort and inclusive invitation strategy. Further, Kaiser is in the process of finalizing a contract with a new Network Lead Entity focused on developing a network of MTM/MSF providers, which will help further support participation from nonprofit providers, as well as ensure

culturally responsive, community-based service delivery for Medi-Cal members. As part of the new Network Lead Entity's network development strategy, the Network Lead Entity will have a specific focus on providers that are part of the California Food is Medicine Coalition.

» Feedback from the CAC was used to reach Medi-Cal members through trusted health sources for Kaiser's 2025 social media outreach campaign for ECM.

» Feedback from the CAC was used to make improvements to existing Medi-Cal materials and content as well as new content development for member-facing materials. Key takeaways include providing information on participant eligibility, program expectations and sharing stories from other members. CAC feedback is a required input in the annual review of Quality and Health Equity-related Policies and Procedures (P&Ps). Themes and recommendations raised through CACs are formally escalated to the Regional Quality Improvement and Health Equity Committees (QIHECs) at least twice annually, and more frequently as needed. The QIHECs review CAC informed insights for inclusion in Quality, Health Equity, and Member Experience initiatives. Input is routed to accountable owners for review and incorporation; proposed revisions are then vetted through QIHEC based on feedback themes such as communication, member experience, community needs, support resources, system navigation, and access to care. Additionally, CAC input is included when the QIHECs approve QI and Health Equity Program Descriptions and Workplans as well as when they approve updates to QIHETP aligned P&Ps, in compliance with DHCS and CMS standards. CACs are routinely updated during subsequent meetings on the status and impact of their recommendations, ensuring a closed and transparent feedback loop.

QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (QIHEC) & HEALTH EQUITY ACTIVITIES

Committee and Activity Results

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 were made publicly available quarterly on Kaiser's website. Successes included:

» Increased engagement focused on Health Equity in county-specific forums (e.g. Alameda kickoff for Community Health Improvement Plans (CHIP), Los Angeles Community Health Assessments (CHA)/CHIP kickoff).

» Improved reporting for member demographics by race/ethnicity at county level that is shared to external QIHEC members.

New Relationships Built

At each of the Northern California QIHEC meetings and Southern California QIHEC meetings, new participants and stakeholders were introduced at the beginning of each meeting and for the respective agenda items in the following stakeholder groups. QIHEC sessions included external voting members including CAC Committee Members, CBO representatives, External Physician Advisors/Dentists, dental directors and officers, and community-based organizations. The Medi-Cal QIHEC charter, goals, and membership were evaluated annually. To build relationships and continue engagement, the QIHEC co-chair (Kaiser Permanente Medi-Cal Medical Director) and vice chair (Kaiser Permanente Chief Health Equity Officer) of the QIHEC were active members of the Medi-Cal external engagement governance forums. Examples of relationship-building engagements included:

» 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 attended by CHEO

» CMO and CHEO attended various Population Health forums with local health jurisdictions

» Engagement with County Health Executives Association of California (annual conference, ad-hoc meetings, etc.)

Driving Change

Outcomes were shared from QIHEC forums and outcomes were posted quarterly on Kaiser's website. Successes that have emerged included:

» Reformed care practices and models that promote health equity for Black Maternal Health

- » Closed disparities in diabetes management in Hispanic/Latin members
- » Updated clinical guidelines focused on improving Health Equity
- » Changed strategies for advancing health equity and removing disparities (e.g. lead screening)

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 advanced health equity strategies statewide and focused on three priority areas: Children's Preventive Care, Behavioral Health Integration, and Maternity Care. An example of statewide engagement was that Kaiser's National Health Plan Equity, Inclusion, and Diversity (EID) team curated a collection of resources, including the Equitable Care Toolkit to provide to care teams.

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 partnered 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. 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 partner plans and make decisions on resourcing support for the LHJs; 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; and 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 partnered 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.

BOARD OF SUPERVISORS AND COURTS

Kaiser engaged with 300 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 an overview of Kaiser Medi-Cal including membership in Stanislaus County, changes with direct contract, and a highlight on ECM/Community Supports services.

» Engagement with Sonoma County elected officials included folks from board of supervisors and others.

» Kaiser met with San Diego Board of Supervisor member regarding ECM/Community Supports and PNA initiatives in her district and Kaiser's approach to implementing CalAIM.

New Relationships Built

Kaiser engaged with the Board of Supervisors across all 32 counties. Kaiser is actively engaging with all counties that are working towards Justice Involved go-live. Examples of how Kaiser reports engagement with stakeholders included:

» In October 2024, Kaiser Medi-Cal leaders and representatives from Kaiser's Medical-Legal Partnership presented to the California Commission on Aging regarding Medi-Cal Transformation.

» In December, Kaiser provided a statewide briefing for elected officials and other public officials focused on Medi-Cal Overview of Medi-Cal Transformation and preview of what is to come in Medi-Cal Policy in the upcoming year including Transitional Rent.

» Engagement with stakeholders in 2024 focused on further developing relationships with Supervisors and Courts and convening statewide officials. One example of how engagement with stakeholders drove change in the county is with Alameda County's Board of Supervisors: Kaiser initiated focused discussions with Alameda County regarding utilizing the Social Health Information Exchange. Kaiser also continues exploring use cases for behavioral health, homeless care coordination, and population health management.

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 Foundation Health Plan, Inc. (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 170 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 for all figures and tables in this section reflect DHCS methodology using raw data reported by KP, consistent with published

information on DHCS's Quarterly Implementation Report for ECM and Community Supports, unless otherwise noted. KP reports that its internal data on ECM utilization indicate higher counts.

Enhanced Care Management

Unique members received ECM in 2024	Unique members received ECM in Q4 2024
7.3K	4.4K

Sources:

[DHCS ECM Quarterly Implementation Report, Table 1.6](#)

[DHCS ECM Quarterly Implementation Report, Table 1.7.2](#)

Table 2: Number of Unique Kaiser Members Receiving ECM by County, Per Quarter in 2024

County	Q1 2024	Q2 2024	Q3 2024	Q4 2024	% Change, Q1 to Q4
Alameda	228	301	322	332	46%
Amador	*	*	0	*	N/A
Contra Costa	178	236	216	255	43%
El Dorado	*	11	12	12	N/A
Fresno	*	15	29	20	N/A
Imperial	0	0	0	0	0%
Kern	16	57	74	56	250%
Kings	0	0	0	0	0%
Los Angeles	629	1,037	1,180	1,088	73%
Madera	*	*	*	*	N/A
Marin	27	43	42	44	63%
Mariposa	0	0	0	0	0%
Napa	*	11	18	20	N/A
Orange	114	218	253	230	102%
Placer	25	46	46	51	104%
Riverside	171	282	352	278	63%
Sacramento	402	591	682	688	71%
San Bernardino	170	294	349	300	76%
San Diego	143	275	291	284	99%
San Francisco	44	73	93	101	130%
San Joaquin	21	43	55	64	205%
San Mateo	23	47	50	55	139%
Santa Clara	65	132	144	163	151%
Santa Cruz	0	*	*	*	N/A
Solano	91	147	149	163	79%

| County	Q1 2024	Q2 2024	Q3 2024	Q4 2024	% Change, Q1 to Q4
Sonoma	44	64	88	100	127%
Stanislaus	*	*	19	18	N/A
Sutter	0	0	0	0	0%
Tulare	0	0	0	0	0%
Ventura	12	25	39	24	100%
Yolo	*	20	28	27	N/A
Yuba	*	*	*	*	N/A
Grand Total**	2,403	3,968	4,531	4,373	82%

Source: [DHCS ECM Quarterly Implementation Report, Table 1.7.2](#)

* The number of members receiving ECM is lower than 11 and is censored 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 total number of Kaiser members receiving ECM increased in most counties and as a total across all counties in 2024. The number of members receiving ECM across the state increased 82% from Q1 to Q4 of 2024.

Kaiser Members Receiving ECM in 2024, by Adults vs. Children and Youth
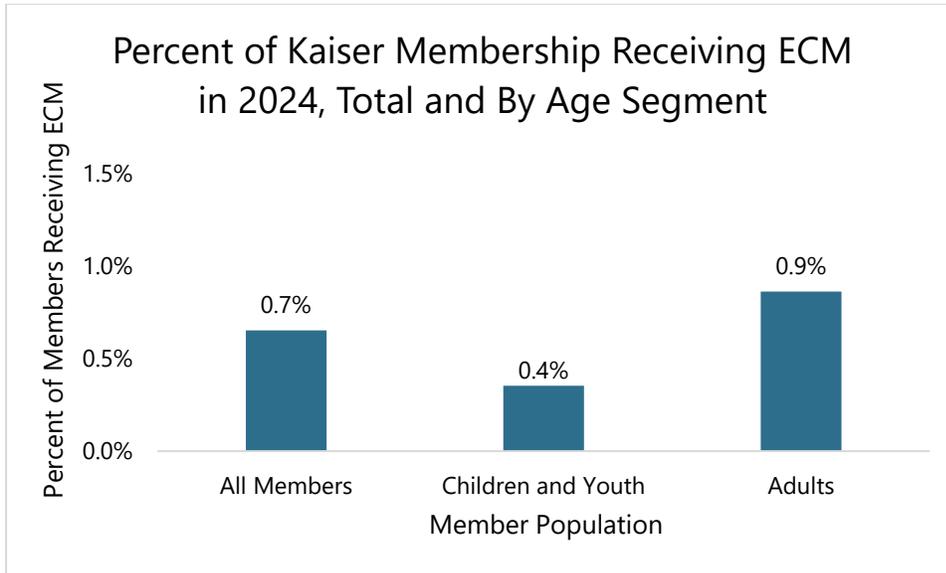
Source: DHCS ECM Quarterly Implementation Report, Table 1.6

As a share of all membership, 0.7% of Kaiser members received ECM in 2024. When divided by age, 0.4% of children and youth Kaiser members received ECM in 2024, and 0.9% of adult Kaiser members received ECM in 2024. 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. Statewide median MCP utilization rates for ECM are 1.3% for all members, 0.5% for children and youth members, and 1.5% for adult members.

Kaiser Members Receiving ECM by County in Q4 2024

County	Count of Unique Members
Alameda	332
Amador	*
Contra Costa	255
El Dorado	12
Fresno	20
Imperial	0
Kern	56
Kings	0
Los Angeles	1,088
Madera	*
Marin	44
Mariposa	0
Napa	20
Orange	230
Placer	51
Riverside	278
Sacramento	688
San Bernardino	300
San Diego	284
San Francisco	101
San Joaquin	64
San Mateo	55
Santa Clara	163
Santa Cruz	*
Solano	163
Sonoma	100

County	Count of Unique Members
Stanislaus	18
Sutter	0
Tulare	0
Ventura	24
Yolo	27
Yuba	*
Grand Total**	4,373

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 censored 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 twenty-seven (27) counties of operation in Q4 of 2024. Three counties with a low projected volume (less than ten) of eligible members had no active enrollees: Imperial, Kings, and Mariposa. Forty (40) % of all ECM enrollments were in Los Angeles and Sacramento counties. Nine (9) counties contained eighty-two (82) % of Members. In order: Los Angeles, Sacramento, Alameda, San Bernardino, Riverside, San Diego, Contra Costa, Orange, Santa Clara.

ECM Members by Population of Focus (POF) in Q4 2024

Total Number of Kaiser Members Who Received ECM by Population of Focus in 2024

Adults

Population of Focus	Q1	Q2	Q3	Q4	% Change Q1 to Q4
Individuals Experiencing Homelessness	384	698	881	975	154%
Individuals At Risk for Avoidable Hospital or ED Utilization	398	740	815	778	95%
Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs	746	1,359	1,680	1,801	141%
Adult Nursing Facility Residents Transitioning to Community	0	0	0	0	N/A
Adults Living in the Community and At Risk for Long-Term Care Institutionalization	0	41	88	144	251%**
Individuals Transitioning from Incarceration	0	0	0	0	N/A
Birth Equity	638	851	912	794	24%

Children and Youth

Population of Focus	Q1	Q2	Q3	Q4	% Change Q1 to Q4
Individuals Experiencing Homelessness	12	20	27	52	333%
Individuals At Risk for Avoidable Hospital or ED Utilization	0	0	27	31	15%
Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs	72	184	301	284	294%

Population of Focus	Q1	Q2	Q3	Q4	% Change Q1 to Q4
Enrolled in California Children's Services (CCS) with Additional Needs	0	15	36	82	447%**
Involved in Child Welfare	151	319	672	508	236%
Individuals Transitioning from Incarceration	0	0	0	0	N/A
Birth Equity	0	0	0	0	N/A

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 censored to protect member privacy.

** When Q1 2024 values were 0, the percent change from Q2 to Q4 2024 was calculated.

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 2024 are:

» Adult at Risk for Avoidable Hospital or Emergency Department Utilization

» Adults with Serious Mental Illness and/or Substance Use Disorder (SMI/SUD)Needs
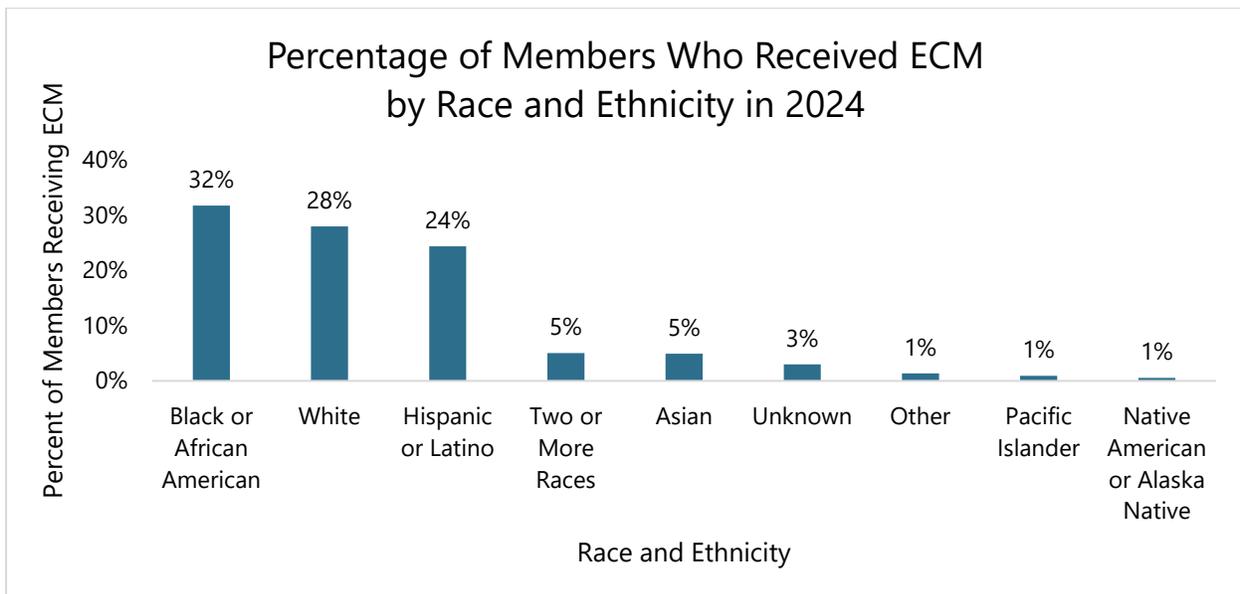
» Adults in the Birth Equity Population

In 2024, Kaiser reports that seventeen percent (17%) of members experiencing homelessness secured permanent housing. Among these members, two-hundred and thirty-eight (238) 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 these 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 2024. These percentages can be compared to demographic data on Kaiser's overall Medi-Cal population earlier in the report.

ECM Members by Race and Ethnicity

Percentage of Members Who Received ECM by Race and Ethnicity in 2024

- Black or African American: 32%
- White: 28%
- Hispanic or Latino: 24%
- Two or More Races: 5%
- Asian: 5%
- Unknown: 3%
- Other: 1%
- Pacific Islander: 1%
- Native American or Alaska Native: 1%

(Y-axis: Percent of Members Receiving ECM; X-axis: Race and Ethnicity)

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

ECM Members by Age Group
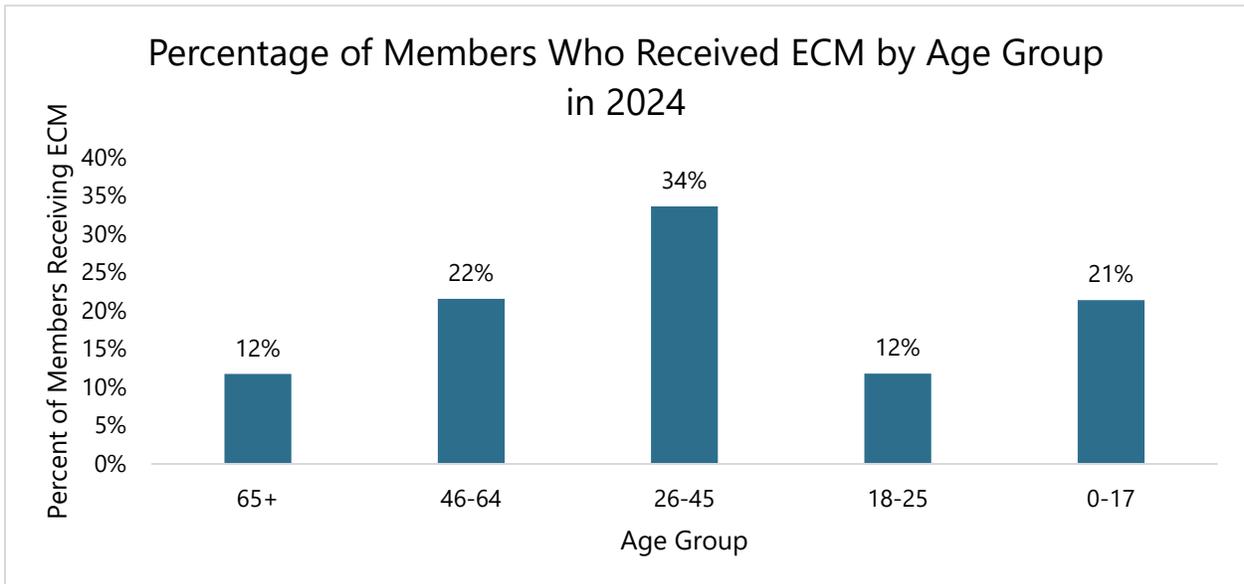
Percentage of Members Who Received ECM by Age Group in 2024

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

ECM Members by Primary Spoken Language

Percentage of Members Who Received ECM by Primary Spoken Language in 2024

Source: Kaiser internal data and analysis. Data are rounded to nearest percent, except for 2024 ECM Members whose primary spoken language is Vietnamese or Chinese Cantonese. These percentages are rounded to one significant digit. Analogous state-wide analysis available: ECM Quarterly Implementation Report, Chart 1.4.2

ECM Members by Sex
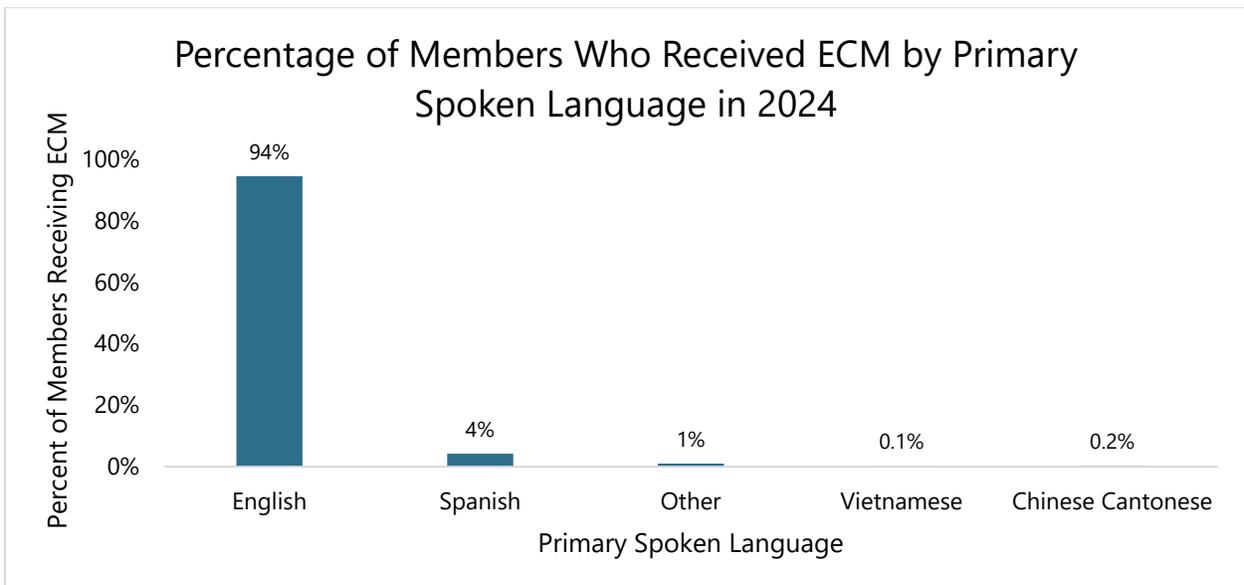
Percentage of Members Who Received ECM by Sex in 2024

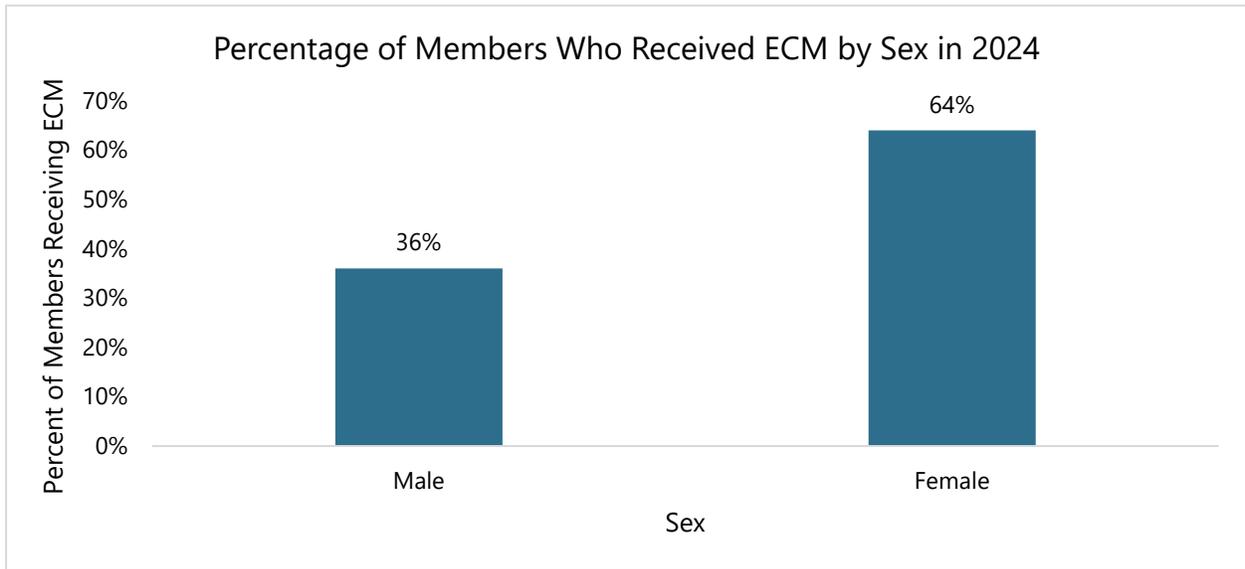*Source: Kaiser internal data and analysis. Analogous state-wide analysis available: ECM Quarterly Implementation Report, Chart 1.4.4*

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:

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. Respite Services
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. 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 every county 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 enrollments, reflecting greater member engagement and utilization. Kaiser reports its commitment to expanding enrollment to these essential services, ensuring that eligible members receive the support they need across all covered counties.

Unique members received Community Supports in 2024	Unique members received CS in Q4 2024
8.99K	5.4K

Community Supports Current Enrollment Volume

The chart shows that the utilization of Community Supports by members rose each quarter in 2024.

Total Number of Members Who Received CS by Quarter in 2024
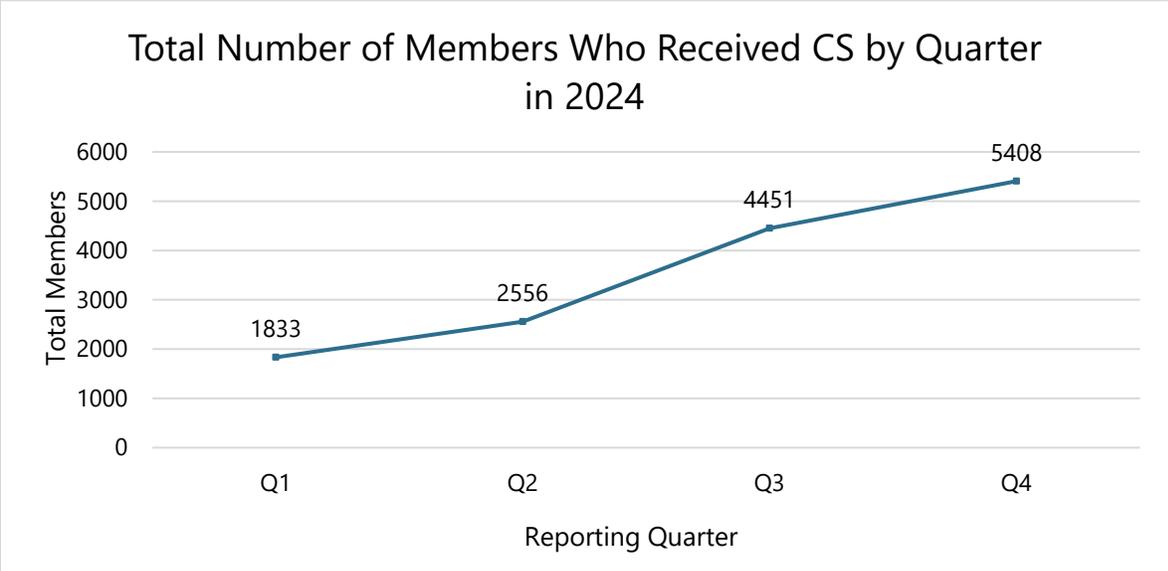
Cumulative Counts of Community Supports Received by Service per Quarter of 2024

The chart shows the total number of members receiving each Community Supports service in each Quarter of 2024.

Community Supports Service Received	Q1	Q2	Q3	Q4	% change Q1-Q4
Housing Transition/ Navigation Services	814	1,433	2,667	1,979	143%
Housing Deposits	139	172	387	352	153%
Housing Tenancy and Sustaining Services	319	136	263	265	-17%
Short-Term Post-Hospitalization Housing2	2	2	4	4	100%
Recuperative Care	8	4	36	36	350%
Respite Services	65	139	514	613	843%
Day Habilitation Programs3	4	12	21	10	+150%
NF Transition to ALF	2	4	32	46	2,200%
NF Transition to a Home	3	6	16	12	300%
Personal Care and Homemaker Services	127	198	459	403	217%
Environmental Accessibility Adaptations	10	33	60	89	790%

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[3] Q1 2024 marked the first submission including the Network Lead Entity (NLE) Model. Since then, the Plan has implemented a Quality Assurance process to identify reporting issues prior to submission to DHCS.

Community Supports Service Received	Q1	Q2	Q3	Q4	% change Q1-Q4
Medically Tailored Meals/Medically-Supportive Food[4]	474	416	598	2,568	442%
Sobering Centers	0	0	0	0	-
Asthma Remediation	0	13	21	57	338% (Q2 to Q4)
Grand Total	**2,410**	**2,568**	**5,078**	**6,434**	**167%**

Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs, Q1-Q4, 2024.

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[4] In Q4 2024, the Plan began receiving additional data from a Medically Tailored Meal (MTM) provider outside the NLE model, resulting in an increase in reported services. This data was not included in the Q1 2025 report

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 2024 by county.

County	Types of Community Supports **Received** by Members in Q4
ALAMEDA	13
AMADOR	0
CONTRA COSTA	11
EL DORADO	3
FRESNO	8
IMPERIAL	0
KERN	5
KINGS	0
LOS ANGELES	10
MADERA	5
MARIN	6
MARIPOSA	0
NAPA	7
ORANGE	9
PLACER	10
RIVERSIDE	8
SACRAMENTO	13
SAN BERNARDINO	8
SAN DIEGO	9
SAN FRANCISCO	10
SAN JOAQUIN	8
SAN MATEO	11
SANTA CLARA	9
SANTA CRUZ	5

County	Types of Community Supports Received by Members in Q4
SOLANO	11
SONOMA	8
STANISLAUS	8
SUTTER	0
TULARE	0
VENTURA	2
YOLO	6
YUBA	1
GRANT TOTAL	**204**

Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs, Q4, 2024.

Twenty-Six (26) Counties had members receive at least one (1) of the fourteen (14) Community Supports services.

Seventeen (17) Counties had members receive at least eight (8) of the fourteen (14) Community Supports services.

Members Receiving Community Supports by Service

Number of Members Who Received Community Supports by Service in Q4 2024

Community Support Service Type	Total Members
Medically-Supportive Food	2,568
Housing Transition/ Navigation Services	1,979
Respite Services	614
Personal Care and Homemaker Services	404
Housing Deposits	352
Housing Tenancy and Sustaining Services	265
Environmental Accessibility Adaptations	89
Asthma Remediation	57
NF Transition to ALF	46
Recuperative Care	36
NF Transition to a Home	12
Day Habilitation Programs	10
Short-Term Post-Hospitalization Housing	4

Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs Q4, 2024.

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 2,000 from Q3 to Q4.

In 2024, 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 launch in January 2024, Kaiser has maintained an iterative cycle of listening, learning and adapting. Over the course of 2024, Kaiser hosted multiple listening sessions with current and prospective community-based organizations to solicit insights for 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.
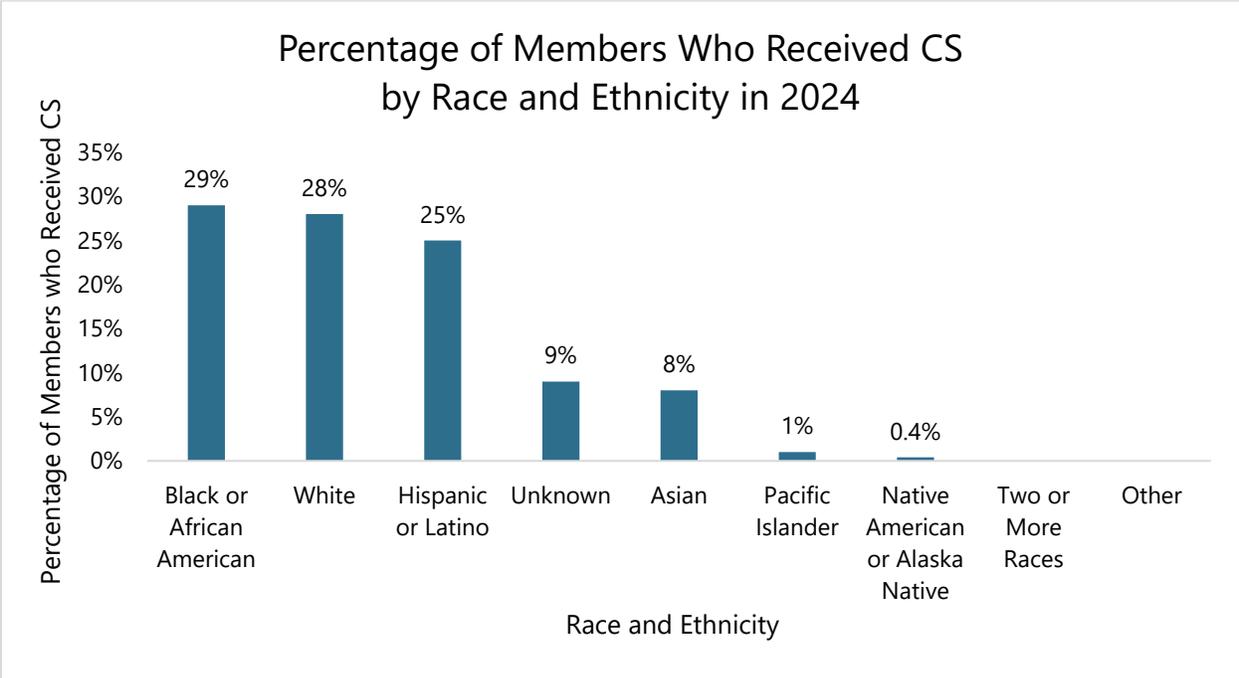
Commitment to Local Engagement and Upstream Investment

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 1,500 external engagements and over 500 Medi-Cal trainings in 2024, 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 enrolled in Community Supports during 2024, and all Kaiser Medi-Cal members as of December 2024. Kaiser is dedicated to equitable ECM services and using Community Supports to reduce health disparities.

Community Supports Members by Race and Ethnicity

Percentage of Members Who Received CS by Race and Ethnicity in 2024

A bar chart titled "Percentage of Members Who Received CS by Race and Ethnicity in 2024." The y-axis is labeled "Percentage of Members who Received CS" ranging from 0% to 35%. The x-axis is labeled "Race and Ethnicity." Values by category:
- Black or African American: 29%
- White: 28%
- Hispanic or Latino: 25%
- Unknown: 9%
- Asian: 8%
- Pacific Islander: 1%
- Native American or Alaska Native: 0.4%
- Two or More Races: (no value shown)
- Other: (no value shown)

Source: Kaiser analysis of utilization of Community Supports Data, 2024.

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

Community Supports Members by Age
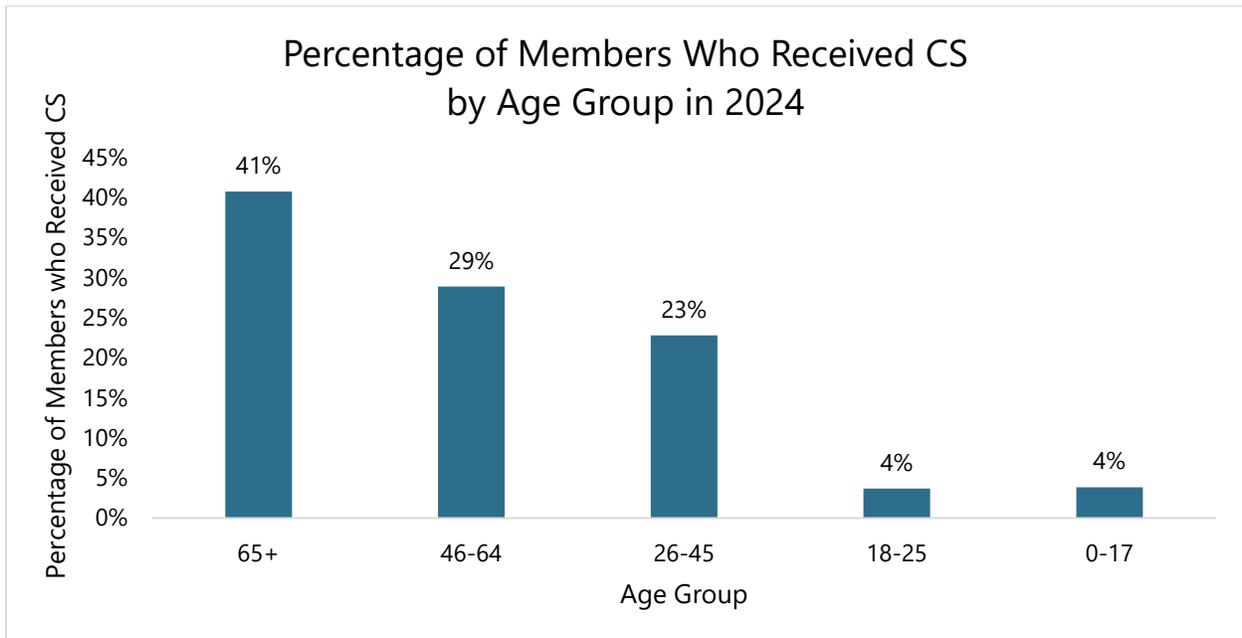
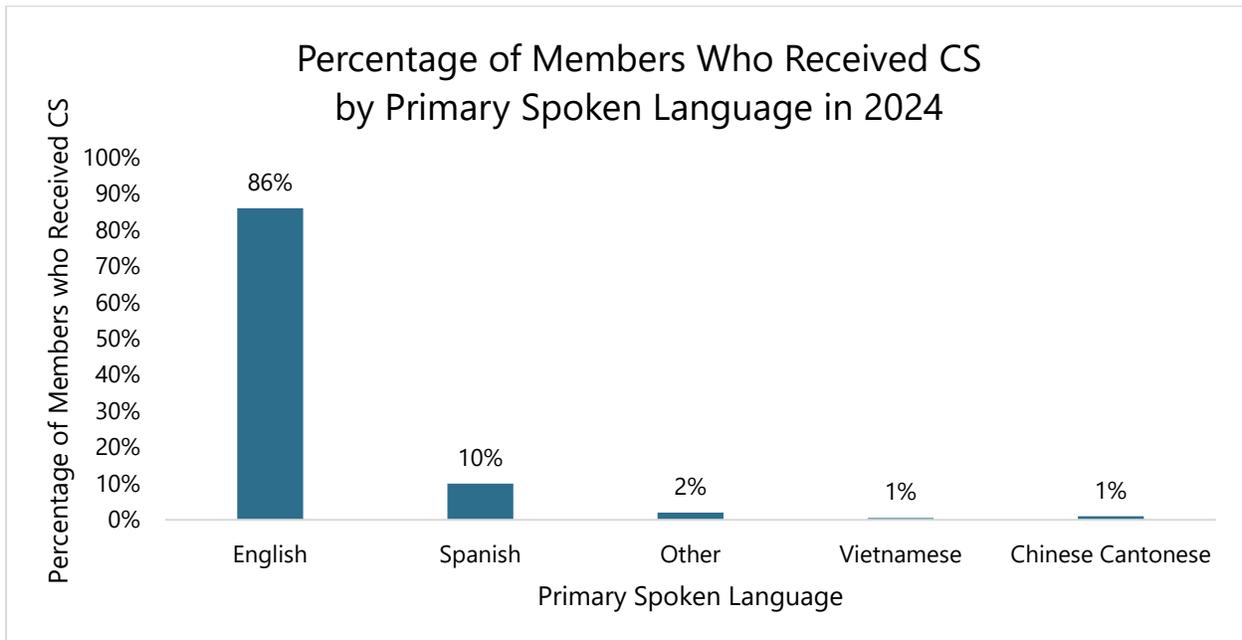## Percentage of Members Who Received CS by Age Group in 2024

Source: Kaiser analysis of utilization of Community Supports Data, 2024.

Note: data rounded to nearest percent

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.
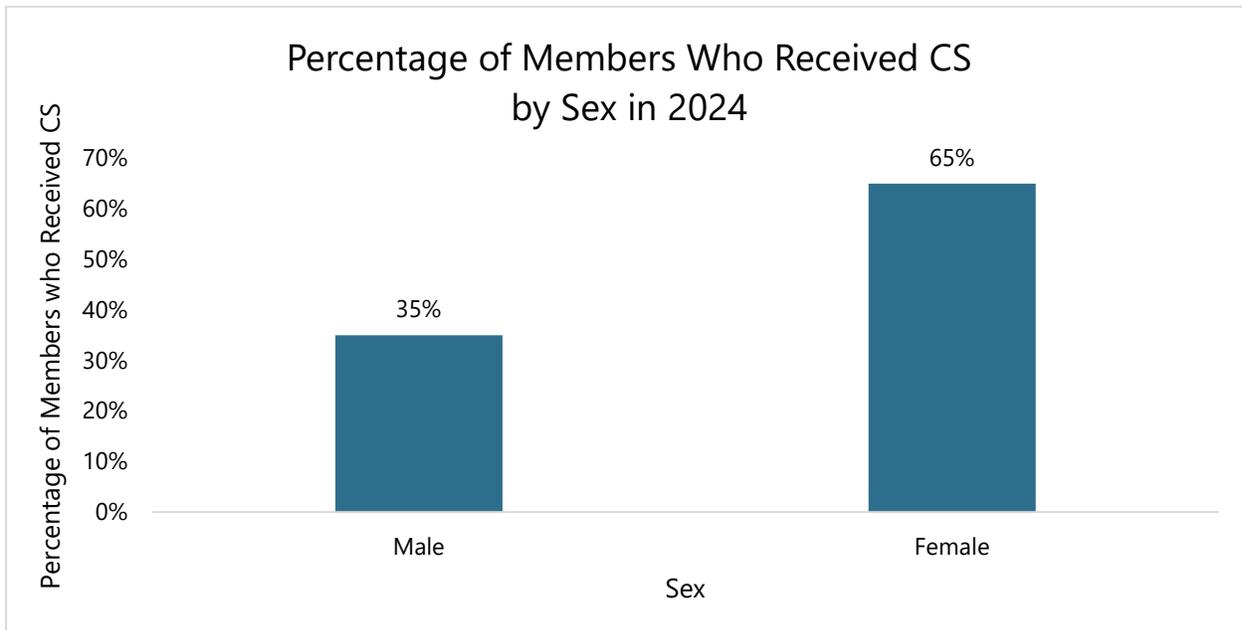
Community Supports Members by Spoken Language

Percentage of Members Who Received CS by Primary Spoken Language in 2024

Percentage of Members who Received CS

- English: 86%
- Spanish: 10%
- Other: 2%
- Vietnamese: 1%
- Chinese Cantonese: 1%

Primary Spoken Language

Source: Kaiser analysis of utilization of Community Supports Data, 2024.

Note: data rounded to the nearest percent

Community Supports Members by Sex

Percentage of Members Who Received CS by Sex in 2024

Percentage of Members who Received CS

- Male: 35%
- Female: 65%

Sex

Source: Kaiser analysis of utilization of Community Supports Data, 2024.

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 2024, the Kaiser Community Supports network included 121 Community Supports providers and 164 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 2024, 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.

Unique Provider Counts by Service Type

A total of 245 unique providers delivered ECM and Community Supports services in 2024.

Provider Types	ECM	Community Supports
Providers	164	121
% 501c3/non-Profit organizations	90%	40%
For Profit organizations	10%	60%

Source: DHCS analysis of Quarterly Monitoring Implementation Reports submitted by MCPs, October 2024.

CONCLUSION

DHCS has concluded that Kaiser Foundation Health Plan has met the current requirements of the Memorandum of Understanding (MOU) and is in good standing with Department of Health Care Services as it relates to the MOU. DHCS will continue to monitor the current growth rate to ensure that Kaiser continues to track towards the goal of a 25% target over the initial term of the Primary Contract. The PHMI has produced tools and materials to support CHCs as they further build out capabilities for population-based care. In addition, the specialty care pilots in high needs geographic areas have opportunity for further take up and utilization. DHCS will continue to engage with Kaiser and CHC partners to support specialty care use for high-needs areas. DHCS continues to meet no less than quarterly, or upon request, with Kaiser to monitor the performance related to this MOU. Lastly, DHCS anticipates ongoing compliance of the MOU deliverables as required.