MEMORANDUM OF UNDERSTANDING BETWEEN
DHCS AND KAISER FOUNDATION HEALTH PLAN, INC.
FOR STANDARDS AND REQUIREMENTS APPLICABLE TO
THE ALTERNATE HEALTH CARE SERVICE PLAN AS A DIRECT MEDI-CAL MANAGED CARE PLAN

Table of Contents

1. BACKGROUND AND PURPOSE

Assembly Bill ("AB") 2724 (Chapter 73; Statutes of 2022) added Welfare and Institutions ("W&I") Code section 14197.11 to define an alternate health care service plan ("AHCSP") and to authorize the Department of Health Care Services ("DHCS" or "the Department") to enter into one or more comprehensive risk contracts with an AHCSP as a primary Medi-Cal managed care plan ("MCP") in specified Geographic Areas effective January 1, 2024. W&I Code section 14197.11 requires DHCS and an AHCSP to enter into a Memorandum of Understanding ("MOU") to memorialize those standards and requirements specifically applicable to the AHCSP and its participation as a direct MCP that are different than or in addition to the standards and requirements under the comprehensive risk contract(s). In addition, AB 2724 amended W&I Code sections 14094.4, 14094.5, and 14094.6 to expand the definition of a MCP to include an AHCSP starting no sooner than January 1, 2024, thereby facilitating participation by an AHCSP in the Whole Child Model program as of this date. For the purposes of this MOU, the AHCSP is Kaiser Foundation Health Plan, Inc. referenced henceforth as "Kaiser." Pursuant to its comprehensive risk contracts with DHCS, Kaiser is and will be subject to all the same standards and requirements as other full-risk MCPs – including any plan requirements pursuant to the California Advancing and Innovating Medi-Cal ("CalAIM") initiative – except those related to beneficiary enrollment.

The purpose of this MOU between DHCS and Kaiser is to identify each party's responsibilities and obligation to each other in accordance with and based on W&I Code sections 14094.4, 14094.5, 14094.6, and 14197.11.

Pursuant to W&I code section 14197.11(c)(4)(A), this MOU will reflect any standards or requirements applicable to Kaiser that are in addition to, or different than, those imposed on other MCPs under their comprehensive risk contracts with DHCS as described in W&I code section 14197.11(c)(3).

This MOU will memorialize commitments and requirements regarding the following: (1) the default enrollment process for beneficiaries eligible to enroll in Kaiser ; (2) Kaiser's commitment to increase enrollment of members under its direct comprehensive risk, Medi-Cal managed care contract(s) with DHCS over the course of the relevant terms of those contracts and this MOU; (3) Requirements related to

Kaiser's collaboration with, and support of, applicable safety net providers, including federally qualified health centers ("FQHCs"), providing assistance related to Population Health Management ("PHM") and clinical transformation and piloting alternate models of specialty care for non-Kaiser members with the goal of focusing on highest need by specialty and geographic regions; (4) Annual reporting on the implementation status of this MOU; (5) Collaboration with Counties and Local Stakeholders; (6) Primary Care Physician Assignment for Kaiser enrollees; (7) Behavioral Health Network Adequacy and Readiness; (8) Enhanced Care Management ("ECM") and Community Supports alignment with Designated Public Hospitals; and (9) ECM and Community Supports implementation in a manner consistent with requirements outlined in the ECM and Community Supports policy guidance issued by DHCS and applicable to MCPs.

2. TERM

The initial term of this MOU is from May 30, 2023 through December 31, 2028 and upon January 1, 2024, will be coextensive with the initial term of Kaiser's Primary Operations Medi-Cal Contract with DHCS ("Primary Contract") as set forth in Exhibit E, Provision 1.13 of the Primary Contract. After the initial term, DHCS and Kaiser will meet to mutually agree on the components of the MOU to amend or extend its current provisions.

3. GEOGRAPHIC AREA(s)

The Geographic Area(s) for this MOU are the following 32 counties in which Kaiser is licensed for the full or partial county pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and to the extent contracted with DHCS as a primary MCP as of January 1, 2024: Alameda, Amador, Contra Costa, El Dorado, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo, and Yuba. The Geographic Area reflects Kaiser's currently licensed commercial footprint. DHCS reserves the right to review and approve any Medi-Cal Geographic Area expansion or contraction prior to its proposed effective

date. Any such Geographic Area changes are subject to DHCS pre-approval including, at minimum, DHCS review to (1) evaluate and verify Kaiser's readiness to serve Medi-Cal members in the case of a Geographic Area expansion, and (2) evaluate and verify Kaiser's compliance with continuity of care and member transition requirements in case of any Geographic Area contractions.

Kaiser will be required to implement Whole Child Model in the following counties: Alameda, Contra Costa, Imperial, Marin, Napa, Orange, San Mateo, Solano, Sonoma, and Yolo. Alameda, Contra Costa and Imperial counties will be required if and when authorizing legislation is enacted and effective.

Geographic Area definition is the same as Service Area definition included in the MCP contract.

Kaiser must follow the requirements of the Primary Contract. DHCS will work collaboratively with Kaiser to develop reasonable approaches for compliance with such requirements that consider Kaiser's Geographic Area, consistent with DHCS policies and requirements applicable to MCPs.

4. ELIGIBLE BENEFICIARY POPULATIONS

Beneficiary populations eligible to enroll or choose to maintain their enrollment in Kaiser are listed in W&I Code section 14197.11(b).

In accordance with this statute, the following beneficiary populations residing in affected counties will be eligible to enroll with Kaiser under these direct contracts:

- A beneficiary previously enrolled with Kaiser as their MCP at any point from January 1, 2023, to December 31, 2023, inclusive;
- A beneficiary who is an existing Kaiser member upon transition into Medi-Cal managed care ("MCMC");
- A beneficiary who was a member of Kaiser at any time during the 12 months preceding the effective date of their Medi-Cal eligibility;
- A beneficiary with "family linkage" to Kaiser when one or more of the following individuals are a current member of Kaiser upon the effective date of that beneficiary's Medi-Cal eligibility:
    - a beneficiary's spouse or domestic partner; a beneficiary's dependent child, foster child or stepchild under 26 years of age; a beneficiary's

dependent who is disabled and over 21 years of age; a parent or stepparent of a beneficiary under 26 years of age; or a grandparent, guardian, foster parent, or other relative with appropriate documentation of a familial relationship of a beneficiary under 26 years of age as determined by the Department;

- A beneficiary previously enrolled in a primary MCP other than Kaiser at any point from January 1, 2023, to December 31, 2023, inclusive, but who was assigned to, and made the responsibility of, Kaiser under a subcontract with that primary MCP;
- A beneficiary dually eligible for Medi-Cal and Medicare residing in a geographic region approved by DHCS and which is now subject to the Primary Contract between DHCS and Kaiser;
- A beneficiary who is in foster care or is a former foster care youth who elects to enroll in MCMC; and
- A beneficiary not listed above, who resides in a geographic region approved by DHCS and which is now subject to the Primary Contract between DHCS and Kaiser, and who is assigned to Kaiser according to DHCS' default enrollment process for beneficiaries that fail to select a MCP during the plan choice period, subject to an annual cap based on projected capacity as set forth in MOU Section 5.A.

5. SCOPE OF RESPONSIBILITIES

The provisions below identify the responsibilities of each party under this MOU as identified in W&I Code Section 14197.11.

A. Enrollment Processes

W&I Code section 14197.11(b)(8) authorizes Medi-Cal beneficiaries residing in Kaiser Geographic Areas that fail to elect a MCP to be assigned to Kaiser, subject to an annual default rate determined by the Department for each applicable county or geographic region based on Kaiser's projected capacity.

Kaiser Scope of Responsibilities:

a. Kaiser will provide to the DHCS by May 30, 2023 and by May 1 of each subsequent year, for the upcoming calendar year ("CY"), the maximum

number of beneficiaries, by applicable counties or geographic regions as determined by Kaiser's projected capacity, who can be enrolled in Kaiser through default enrollment. This will be referred to as the annual default enrollment ceiling and will take into account Kaiser's projected capacity and growth (i.e., growth from beneficiaries who were members of Kaiser at any time during the 12 months preceding the effective date of their Medi-Cal eligibility; beneficiaries with "family linkage" to Kaiser; beneficiaries who are dual eligible; and foster children/youth and former foster youth).

For the CY 2024, this includes a beneficiary who was previously a member of Kaiser at any point from January 1, 2023, to December 31, 2023, inclusive.

b. Once the default enrollment ceiling is reached, default enrollment into Kaiser shall halt and will not start again until the ceiling is reset the next CY.

c. As part of this submission, Kaiser will specify its approach for ensuring inclusion of foster children, youth, and families as well as dually-eligible individuals.

d. Kaiser will provide to the DHCS an annual growth report by February 15 of each year, starting in CY 2025. The report will provide actual enrollment growth in total in comparison with the baseline (described in MOU Section 5.E.a.2) and the goal of the 25% target over the initial term of the Primary Contract. The annual report will be retrospective for the prior CY and provide monthly breakdown, by county, by enrollment categories (i.e., foster children and youth, dually eligible) and other details to be specified by DHCS.

e. Kaiser cannot deny enrollment to or disenroll any individual that meets the specified enrollment or default criteria, but shall retain the ability to disenroll Medi-Cal members to the extent permitted under applicable law.

DHCS Scope of Responsibilities:

a. DHCS will establish the annual default rate for each applicable county/ Geographic Area subject to the maximum number submitted by Kaiser pursuant to MOU Section 5.A.a.

b. DHCS will process enrollments for beneficiaries described in MOU Section 4 “Eligible Beneficiary Populations”.

c. DHCS will work with Kaiser on automated solutions to streamline enrollment of beneficiaries into Kaiser.

d. DHCS will have processes in place to halt default enrollment once the default enrollment ceiling is reached.

e. DHCS will meet regularly with Kaiser leadership engaged in enrollment and operational transition planning to ensure alignment and address Kaiser specific operational issues.

B. CalAIM ECM and Community Supports Implementation

Kaiser will implement CalAIM’s ECM and Community Supports in accordance with MCP Contract requirements and policy guidance issued by DHCS.

Kaiser Scope of Responsibilities:

a. By 1/1/2024, Kaiser will implement CalAIM ECM in accordance with the MCP Contract, Exhibit A, Attachment III, Section 4.4 using community providers, which may include but are not limited to, community-based organizations and local county departments and public hospitals that participated in Whole Person Care pilots, in addition to providers that are part of Kaiser’s health system. All ECM services are expected to be community-based as outlined in the MCP Contract.

b. Kaiser must submit for DHCS pre-approval any exception to the use of community-based providers.

c. Kaiser will submit its ECM Model of Care ("MOC") to DHCS in accordance with the MCP Contract, Exhibit A, Attachment III, Section 4.4.

d. By 1/1/2024, Kaiser will implement, at minimum, the same Community Supports offered by all MCPs in the Geographic Area. Thereafter, Kaiser will report to DHCS biannually in January and July their intent to offer the DHCS-approved Community Supports election in each county where it is offered on the DHCS website. If Kaiser is unable to offer the same Community Supports offered by all Medi-Cal MCPs in the county, Kaiser must submit a justification and timeline for when the Community Support will be available within the reporting quarter.

e. Kaiser will submit its Community Supports MOC to DHCS in accordance with the MCP Contract, Exhibit A, Attachment III, Section 4.5.

f. By 1/1/2024, Kaiser will implement ECM and Community Supports in a manner consistent with requirements outlined in the ECM and Community Supports policy guidance issued by DHCS for MCPs. For example, Kaiser will engage community providers (e.g., county departments, public hospitals and health systems, and community health centers) and not solely rely upon internal resources for the provision of ECM and Community Supports.

g. Kaiser will make every effort to ensure broad uptake of Community Supports, consistent with other MCPs.

DHCS Scope of Responsibilities:

a. DHCS will timely review Kaiser's submissions in accordance with ECM policy guidance.

b. DHCS will maintain the MOC template on its website and will timely review Kaiser's MOC in accordance with ECM policy guidance.

c. DHCS will post each MCP's Community Supports elections every 6 months on the DHCS website and will timely review Kaiser's Community Supports application in accordance with Community Supports policy guidance.

d. DHCS will meet regularly with Kaiser leadership engaged in ECM and Community Supports to ensure alignment on approach for 1/1/2024.

C. FQHC Assistance with PHM and Clinical Transformation

Kaiser, with leadership and engagement from DHCS and the California Primary Care Association, will work with an initial cohort of FQHCs mutually agreed upon by DHCS and Kaiser ("Phase 1 Cohort"), at the request of the FQHC, to support PHM and clinical transformation to improve quality and health equity outcomes.

The PHM and clinical transformation solution will support Phase 1 Cohort FQHCs in their efforts to:

1. *Improve FQHC performance on most current Alternative Payment Methodology ("APM") measure set;*
2. *Improve patient engagement and experience of care;*
3. *Improve performance on access to primary care measures, through team-based care and care redesign;*
4. *Identify and improve FQHCs' ability to reduce measurable disparities in the most current APM measures; and*
5. *Improve identification and management of the population assigned to the FQHC.*

Kaiser Scope of Responsibilities:

a. Deliver a comprehensive PHM solution set that addresses the full range of PHM capabilities needed for the Phase 1 Cohort FQHCs across *people, process and technology* that will support the Phase 1 Cohort FQHCs' efforts to improve quality, capture and improve measurable disparities and support APM readiness (for those FQHCs who may choose to apply for APM participation), and align with DHCS' final PHM Strategy and Roadmap and Comprehensive Quality Strategy.

b. Through planning meetings that facilitate engagement from DHCS, Phase 1 Cohort FQHCs, and Kaiser, design and develop care-redesign solutions for the Phase 1 Cohort FQHCs that *address people and process* across the PHM domains of focus. Solutions aim to:

i. Improve empanelment of assigned patients to a primary care provider and improve continuity of patient care, through attribution methodology/automation, and downstream workflows, including scheduling, panel management, and other tools to improve continuity between patients and care teams;

ii. Identify and implement best practice team-based models of care, with attention to maternal, child, behavioral health and adult prevention/condition management. This includes optimal team composition and roles/responsibilities, workflows and operational care processes, and leveraging new DHCS covered benefits and services where possible, including, but not limited to, community health workers, dyadic services and doulas;

iii. Improve patient outreach and engagement, through effective outreach methods and tools, especially for assigned but unseen patients, incorporating patient experience measurement and feedback loops into FQHC care delivery and quality improvement ("QI") work;

iv. Identify and implement best practices to address social drivers of health by expanding regular and systematic social needs screening, data capture, and putting closed loop referral processes into place with attention to available local resources, including connectivity with MCP offered community supports in each geography; and

v. Provide data and analytics support to enable implementation of risk stratification consistent with CalAIM and MCP processes, establishment of registries and gaps in care reports, dashboards and analytic support to identify population outcomes, needs and efficacy of interventions, tools to support effective care management and care coordination, and tools to optimize data capture and reporting on all APM metrics.

c. Develop a PHM technology approach that enables the PHM solution and provides Phase 1 Cohort FQHCs with a technology solution option that provides for whole-person individual patient and population view(s) that enables the receipt of data sets from parties other than the FQHCs (e.g. managed care plan data including Medi-Cal enrollment and assignment data, DHCS data, local electronic health record or health information exchange data, carved out specialty mental health data, and Admit Discharge Transfer ("ADT") feeds). The technology approach aims to:

i. Enable bi-directional data exchange with MCPs, DHCS, and other key entities in the Medi-Cal delivery system;

ii. Enable digital coordination of care across transitions of care, especially regarding assigned care managers and linkage to follow-up care, as detailed in DHCS' final PHM Strategy and Roadmap; and

iii. Be flexible such that it can be used in multiple ways by FQHCs depending on their current HIT landscape, and interoperable with FQHC electronic health records as well as other PHM tools that may be in use.

If Phase 1 Cohort FQHCs opt not to adopt the PHM technology in any form, then a lower level of base support to optimize existing systems with the care redesign may be delivered.

d. Design the implementation plan for targeted roll out and support implementation of PHM technology in a subset of Phase 1 Cohort FQHCs in 2023, with opportunity to learn from early adopters, make modifications, and scale through 2025. The PHM technology approach implemented should have interoperability with DHCS's PHM Service as outlined in DHCS' final PHM Strategy and Roadmap by Q4 2023.

e. Design rollout of a comprehensive Practice Transformation Support for the Phase 1 Cohort FQHCs to improve PHM capabilities and achieve improvements in APM quality metrics and patient outcomes. Initiate Practice Transformation Support, as defined in section f. below, by the end of 2023. The Practice Transformation Support should address the key metrics of success as outlined in section a. above, along with technology implementation support for those Phase 1 Cohort FQHCs who choose to adopt the technology. The solutions and Practice Transformation Support should be FQHC-centric and address care redesign and technology for the FQHC population as a whole, not one specific payor type or line of business.

f. The methods to deliver practice transformation support should include ("Practice Transformation Support"):

i. An implementation guide that can be used directly by Phase 1 Cohort FQHCs both within the PHM initiative and may be used as a resource

for FQHCs participating in APM readiness activities with DHCS in 2023;

ii. Practice coaching support in the form of 1:1 coaching offered to each Phase 1 Cohort FQHC as defined by each Phase 1 Cohort FQHC's initial gap assessment at a minimum 20-60 hours per month to support achievement of goals and measurable improvements identified in such assessment;

iii. Consulting support and assistance to provide subject matter expertise for operational and technology needs as needed to implement and scale. This may include models of care and solutions that are focused on target metrics and populations;

iv. Web-based curriculum that is consistent with the implementation guide and is accessible to both the Phase 1 Cohort FQHCs and others participating in the APM pilots, DHCS Health Equity and Practice Transformation grants, or other transformation programs;

v. Holding, at minimum, bi-annually learning collaboratives at both the regional and statewide level that include FQHC participants and DHCS representatives; and

vi. Implementation support including workflow engineering and technical assistance for PHM platform implementation.

g. The PHM initiative Practice Transformation Support should be flexible and configured for each FQHC in the Phase 1 Cohort based on an initial gap assessment conducted in Q2 2023. Each FQHC in the Phase 1 Cohort will identify an initial 1-2 areas of focus to start based on gap assessment results and priorities. The Practice Transformation Support must account for Phase 1 Cohort FQHCs being at varying levels of PHM capabilities to start, such that each FQHC will have an action plan to make measurable improvement in their focus areas, depending on their starting point.

h. Undertake an evaluation design process to ensure all partners (DHCS, FQHCs, MCPs, others) are informing the key goals and design of the evaluation. The evaluation design should center on health equity and include the Medi-Cal patient voice. Kaiser will fund a third-party experienced evaluation firm mutually agreed upon by DHCS and Kaiser to conduct an outcomes-based and formative evaluation for purposes of real time learning. This is intended to avoid any conflict of interest. The

evaluation will rigorously measure impact of the initiative on the key DHCS metrics of success as well as provide robust learnings related to implementation successes and opportunities that can inform future opportunities to scale this effort.

i. The structure developed to deliver implementation support for the PHM initiative should allow for the ability of DHCS and California FQHCs to use the PHM solution set and individual elements, such as curriculum, practice coaching model, and learning collaborative models, for other care transformation work including planned DHCS Health Equity and Practice Transformation Payments program grants and APM preparation. Joint planning for the use of the PHM solution sets and elements between DHCS and Kaiser should occur.

j. Work with DHCS to obtain approvals for selection criteria for Phase 1 FQHCs, project phases and timeline.

DHCS Scope of Responsibilities

a. Meet regularly with senior Kaiser leadership engaged in this initiative to ensure alignment on strategic direction and project planning.

b. Active participation of DHCS executive leadership (Chief Quality Officer) and relevant staff in all PHM initiative governance, planning and implementation activities, including final sign off on selection criteria for FQHCs, project phases and timeline, and intervention design.

c. Will ensure alignment of quality measures, focus areas and activities outlined in the PHM initiative with broader DHCS activities, including CalAIM, the PHM Program and DHCS' Comprehensive Quality Strategy

d. Will engage in joint planning with Kaiser to ensure alignment, and where possible, partnership on key elements of the Health Equity and Practice Transformation Payment program, which will launch in 2023.In this facilitation role, DHCS will encourage appropriate sharing of data between stakeholders but will not directly provide data directly to any stakeholders.

D. Determine Highest Needs by Specialty and Geographic Area

Kaiser and DHCS shall jointly identify specific specialties and Geographic Areas of the highest access needs to outpatient specialty care. Kaiser and DHCS are seeking to improve access for Medi-Cal enrollees who are not assigned to Kaiser but are in need of specialty services. The delivery of care to these non-member Medi-Cal patients is separate and apart from contractual requirements to maintain the network composition and the Annual Network Certification requirements as outlined in All Plan Letter ("APL") 23-001. Kaiser and DHCS will take into account Kaiser's capacity when identifying specialties and geographic areas. Kaiser will include The Permanente Medical Group ("TPMG") and the Southern California Permanente Medical Group ("SCPMG") in determining how to meet the obligations of this section 5.D.

Kaiser Scope of Responsibilities:

a. By Q2 2024, implement at least one regional specialty pilot in no fewer than three different specialties, using stepped approach beginning with one specialty at one FQHC to identify best practice and learnings, and then spreading to additional FQHC and specialties. Continue to scale implementation to three regional specialty pilots (with each regional specialty pilot providing no fewer than three specialties) by the end of Q2 2025. The sum total of the Medi-Cal population across these three regions must total at least one million Medi-Cal enrollees. The specific geographic regions and specialties will be mutually agreed upon by Kaiser and DHCS based on data, patient needs, and operational feasibility.

b. Kaiser will provide in-person outpatient specialty care delivered by Kaiser providers in no fewer than three specialties in each of three distinct geographic regions. The specialty pilot process is as follows:

    i. By the end of 2023, Kaiser and DHCS shall jointly identify the highest need specialties and Geographic Areas where Kaiser will be able to provide, by TPMG and the SCPMG physicians, as appropriate, a limited number of in-person, ambulatory based, outpatient specialty care visits, and associated needs using the existing MCP network contracts, when possible and appropriate, for diagnostic testing and outpatient procedures. Kaiser, in association with DHCS and key stakeholders, will determine the best way to provide these associated

services, with development of the second and third pilots informed by the first pilot.

ii. By the end of Q2 2025, Kaiser will implement in person specialty visits by Kaiser physicians in no less than three of the identified Geographic Areas that serve a total of at least one million Medi-Cal beneficiaries.

iii. In 2026, Kaiser will assess the ability to expand to additional Geographic Areas identified by Kaiser and DHCS for the remainder of the contract term.

iv. Kaiser may supplement the above activities with virtual visits, at the request of the Medi-Cal patients when medically appropriate, but may not use these to fulfill the above commitments.

c. The specialty pilot models will be determined in collaboration with DHCS and FQHCs who are referring providers in the region and will adhere to the principles set forth below. Development of the second and third pilots shall be informed by the implementation design, approach and stakeholder engagement process of the first pilot:

i. Designed to be patient-centered and to optimize patient experience, convenience and quality of outcomes;

ii. Improve local capacity in selected Geographic Areas for Medi-Cal managed care plans to improve access to care;

iii. Work with DHCS and local stakeholders to address specific gaps in the full scope of outpatient services related to the identified specialty, including telehealth and in-person outpatient visits. Kaiser will be involved in the overall design of how patients will receive the following services: diagnostic imaging, laboratory testing, prescription and authorization management of medications and medical equipment, referrals and authorization management for providers and other services, and procedures. Kaiser is responsible for providing training and technical assistance to both Kaiser and FQHC staff regarding clinical guidelines and referral processes for selected specialties operationalization of care delivery, care coordination, and optimizing specialist – primary care provider communications and co-

management. Kaiser specialists will appropriately and accurately code all visits to facilitate the standard billing process at the site of care;

iv. Meet a specialty/region specific gap reduction target that is agreed upon by DHCS and Kaiser, depending on network adequacy and specialty access needs. A minimum number of in person visits and/or clinical full-time equivalent ("FTE") will be negotiated between Kaiser and DHCS depending on the volume and projected need in the specific geographic region and specialties selected; and

v. Result in measurable improvements in standard metrics used to quantify specialty access for specialties and specific geographic regions identified, as defined in state and federal approaches for measuring timely access and network adequacy.

Kaiser, along with DHCS and the FQHC specialty site, will measure improvements using measures from MOU section 5.D.e.

d. The specialty pilot models tested will also include support for FQHCs in the specified region(s) in the following ways:

i. Provide didactics, learning sessions, and support for advanced practice providers to gain skills to support improvement of FQHC primary care provider management competencies for selected specialties;

ii. Collaborate on patient care between primary care providers, including advanced practice providers, and Kaiser specialists, utilizing tools including, but not limited to, eConsult;

iii. Provide technical assistance and implementation support for FQHCs in the specified region(s) for both improving competencies and their ability to co-manage care. This support includes, but is not limited to, training materials, synchronous or asynchronous learning opportunities, and technology needed to implement models such as electronic consultation tools and other methods for bidirectional transmission of care plans, test results, and other clinical communications between FQHC providers and Kaiser specialists, with the assistance and support occurring at the FQHC, as appropriate. The technical assistance should be informed by

the needs of local FQHCs and also address FQHC provider turnover; and

iv. Communicate clinical data from Kaiser to FQHCs to ensure accurate measurement of clinical quality metrics.

e. Engage a third-party evaluator mutually agreed upon by Kaiser and DHCS to evaluate the efficacy of the various specialty pilot models, including primary care provider competencies, with specific attention to impact on mutually agreed upon measures related to timeliness of specialty care, access, clinical outcomes, and patient experience.

DHCS Scope of Responsibilities:

a. Meet regularly with senior Kaiser leadership engaged in this initiative to ensure alignment on strategic direction and project planning.

b. In collaboration with Kaiser, provide and analyze data to ensure appropriate selection of specialties with access challenges as well as appropriate selection of specialty pilot regions.

c. In collaboration with Kaiser, mutually agree on specialty pilot geographic regions and specialties for implementation.

d. Active participation of DHCS executive leadership (Chief Quality Officer) and relevant staff in all specialty pilot governance, planning and implementation activities.

e. Additional stakeholders should be engaged regionally through the leadership at DHCS to set the tone and clarify intent of the initiatives. DHCS will engage other relevant partners (e.g., MCPs and public hospitals) as needed to ensure new specialty services are integrated into the local specialty care network and not displacing existing providers.

f. Ensure alignment of specialty pilots and approaches with broader DHCS activities, including CalAIM, the PHM Program and DHCS' Comprehensive Quality Strategy.

E. Reporting

W&I Code section 14197.11(c)(4)(C) requires DHCS to publish an annual report on its internet website describing implementation status for the standards and requirements imposed by this MOU. The report is to be published within six months of the end of each applicable rating period, commencing with the CY 2024 rating period.

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 contracts authorized by W&I Code section 14197.11.

Kaiser Scope of Responsibilities:

a. Kaiser will submit at a frequency to be specified by DHCS, a report of the following information to support DHCS' reporting to the Legislature and to post on DHCS' publicly-facing website:

i. Enrollment of Medi-Cal beneficiaries by county / Geographic Area / aide code grouping specified by DHCS, by demographic (i.e., race, gender, age, SOGI, disability status).

ii. Enrollment growth with the baseline of July 1, 2024. This would be excluding any population changes from January 1, 2024 to June 30, 2024 resulting from growth in duals, foster youth, default enrollment and new Geographic Areas.

iii. Narrative and process-based metrics specified by the Department to measure engagement and support of safety net providers including FQHCs. For example, narrative and metrics as specified by DHCS describing investments, technical assistance and other support to develop capabilities among FQHCs on PHM and clinical transformation efforts.

iv. Report on the identification of highest need specialties and Geographic Areas where outpatient specialty care and services would be provided by Kaiser. Report on which areas Kaiser engaged with over which time periods and the utilization rate by specialty care sites; by county/ Geographic Area; by demographics.

v. Report on the 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".

vi. Report on implementation of ECM and Community Supports in a manner consistent with the Quarterly Monitoring Implementation 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.)

F. Collaboration with Counties and Local Stakeholders

W&I code section 14197.11(c)(5) requires Kaiser to periodically consult with counties and other affected local stakeholders in those geographic regions in which the Kaiser operates as a direct MCP, in a form and manner determined by the Department.

Kaiser Scope of Responsibilities:

a. Kaiser will periodically consult with counties and other affected local stakeholders in those geographic regions in which Kaiser operates.

b. Kaiser will submit to the Department a proposed approach for local stakeholder engagement by May 30, 2023 for the upcoming year and by May 1 for the subsequent upcoming CYs. The proposal will contain stakeholder engagement goals, specific target stakeholder groups to engage, methods of engagement, and frequency. The stakeholder engagement approach should consider interdependences, such as engagement of Community Advisory Committee(s). Once the approach has been approved, Kaiser will submit a stakeholder engagement plan by August 1 for the upcoming CY which is subject to DHCS approval.

G. Primary Care Physician Assignment

W&I code section 14197.11(d) reflects the Legislature's intent for beneficiaries enrolled in Kaiser as their primary MCP to be assigned a primary care physician who is contracted with Kaiser through its exclusive contracts with a single medical group, subject to any limitations imposed by federal law.

Kaiser Scope of Responsibilities:

a. Kaiser will ensure Medi-Cal beneficiaries enrolled in Kaiser will be assigned to a primary care provider who is contracted with Kaiser through its exclusive contracts with TPMG in Northern California and SCPMG in Southern California subject to the limitations imposed by federal law.

b. Kaiser will report to DHCS the proportion of members assigned to a TPMG or SCPMG primary care provider with a target rate of 98 percent.

c. By 1/1/2024, Kaiser will contract with at least one FQHC and one Rural Health Center ("RHC"), where available, in each county in which Kaiser operates as required by federal law.

H. Behavioral Health Network Adequacy and Readiness

W&I Code section 14197.11(f) requires the Department to conduct an assessment of Kaiser's readiness to meet behavioral health network adequacy requirements and publicly post findings and any corrective action plans imposed for noncompliance.

Kaiser Scope of Responsibilities:

a. Kaiser will meet the following network adequacy standards in accordance with Welfare and Institutions Code section 14197 and APL 23-001, Network Certification Requirements, and any superseding APL:

i. Time or distance standards for psychiatry and non-specialty mental health providers;

ii. Provider-to-member ratios for adult and pediatric non-specialty mental health providers necessary to cover the projected mental health needs for anticipated members in each county; and

iii. Timely-access compliance with appointment wait time standards for psychiatrists and non-physician mental health providers.

b. If Kaiser receives approval from DHCS on any alternative access standard ("AAS") requests, Kaiser must take the following actions as outlined in APL 23-001, and any superseding APL:

i. Post all approved AAS and use of telehealth to meet time or distance standards on its website.

ii. Assist any requesting member in obtaining an appointment with an out-of-network psychiatrist in person or via telehealth, including providing transportation costs.

c. Kaiser will annually submit documentation to DHCS to demonstrate the adequacy of their mental health networks as part of the Annual Network Certification requirements as outlined in APL 23-001.

d. Kaiser will submit additional documentation to DHCS when Kaiser's network experiences a significant change, as defined in APL 23-001, or when the network change causes Kaiser to be non-compliant with any of the Annual Network Certification requirements.

DHCS Scope of Responsibilities:

a. DHCS will annually post on its website the outcome of the Annual Network Certification, including all approved AAS and MCPs subject to a corrective action plan ("CAP") due to non-compliance with network adequacy requirements. The CAP Report will include Kaiser's response to the CAP.

6. CONFIDENTIALITY

In the performance of this MOU, Kaiser will comply with all applicable laws concerning confidentiality of information and data. To the extent applicable, confidentiality requirements for this MOU are consistent with Exhibit E, Provision

1.23 Confidentiality of Information, in Kaiser's Primary Contract with DHCS, which is incorporated herein by reference, without regard to whether the individuals to whom information and data pertains are Kaiser Members.

7. BUSINESS ASSOCIATES AGREEMENT

This MOU has been determined by DHCS to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164. The applicable terms of the Business Associate's Agreement attached as Exhibit G to the Primary Contract applies with equal force to this MOU and is incorporated herein by reference.

There is no presumption that downstream partners or participants in the work contemplated by this MOU are sub-business associates of DHCS. Kaiser will exercise its own due diligence, subject to applicable law (and the possibility of review or audit by DHCS pursuant to the BAA) to determine its appropriate relationship with downstream partners or participants.

8. FEDERAL APPROVALS

This MOU will only be operative in Service Areas where Kaiser is a party to a Primary Contract with DHCS that has been approved by the federal Centers for Medicare & Medicaid Services ("CMS"), during the term of such Primary Contract as detailed in MOU, Section 2 "Term". No federal approval of this MOU is required.

9. TRANSPARENCY

This MOU, any amendments, and any required reporting identified in this MOU will be posted to DHCS website.

10. AMENDMENTS

DHCS and Kaiser may amend this MOU at any time by written, mutual consent. Amended MOUs will be submitted to DHCS for final review and approval.

11. TERMINATION

Any termination of the Primary Contract under Exhibit E, Section 1.16 of the Primary Contract by either party will automatically terminate this MOU. Neither party may terminate this MOU apart from a termination of the Primary Contract.

12. LIAISONS

DHCS and Kaiser will designate a liaison to be the primary point of contact for this MOU. Kaiser and DHCS shall also submit the contact information for their respective liaisons to the DHCS MOU Point of Contact listed on the last page of the MOU.

13. MOU MONITORING

DHCS and Kaiser liaisons will meet no less than quarterly, or upon request, to monitor the performance of parties' responsibilities related to this MOU. Please also see the Reporting section above for specific reporting submission requirements to track MOU performance and to support Legislative and public reporting.

Should Kaiser fail to comply with any term of this MOU, DHCS will be entitled to any and all applicable remedies set forth in the Operational Readiness Contract between DHCS and Kaiser and the Primary Contract at Exhibit E, Program Terms and Conditions (which are also incorporated into the Operational Readiness Contract), including but not limited to corrective action plans, monetary and non-monetary sanctions as well as liquidated damages as set forth in Provisions 1.19 and 1.20 of Exhibit E which are incorporated herein by reference, as well as any remedies available under the law, including but not limited to the sanctions and civil penalties set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706, and 438.708, W&I Code section 14197.7, and APL 22-015.

Notwithstanding anything to the contrary, Kaiser and Kaiser Permanente reserve all rights and remedies it has under all laws, in equity, and in any agreements.

14. DISPUTE RESOLUTION

If a dispute arising in connection with the terms of this MOU cannot be resolved by the parties through meetings conducted pursuant to MOU Section 13 "MOU

Monitoring," the dispute resolution process and requirements established under Exhibit E, Provision 1.21 Contractor's Dispute Resolution Requirements, in Kaiser's Primary Contract, which is incorporated herein by reference, shall control.

15. MISCELLANEOUS PROVISIONS

a. Kaiser is an independent contractor. Neither Kaiser nor DHCS is an agent of the other party, and neither Kaiser nor DHCS will be deemed an agent of the other party for any purpose.

b. This MOU shall be governed by and construed in accordance with California law, without reference to its conflicts of law provisions.

c. Any dispute regarding this MOU shall be subject to the exclusive jurisdiction of the Superior Court of California, County of Sacramento. Each party agrees to submit to the personal and exclusive jurisdiction and venue of such court.

d. The waiver of a breach of any term or condition of this MOU by either party will not serve to waive any other breach of that term or condition, or of any other term or condition of this MOU, unless agreed by Kaiser and DHCS in writing.

16. DHCS MOU POC

The DHCS MOU POC is the Kaiser DHCS Managed Care Contract Manager.

MEMORANDUM OF UNDERSTANDING BETWEEN
DHCS AND KAISER FOUNDATION HEALTH PLAN, INC.
FOR STANDARDS AND REQUIREMENTS APPLICABLE TO
THE ALTERNATE HEALTH CARE SERVICE PLAN AS A DIRECT MEDI-CAL MANAGED CARE PLAN

17. SIGNATURES

ORIGINAL SIGNED BY

Amanda Flaum
Vice President CA & HI Medicaid
Kaiser Foundation Health Plan

Michelle Retke
Chief, Managed Care Operations Division
Department of Health Care Services