Bold changes are in store for Medi-Cal in 2024, but will patients benefit?

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California's safety-net health program, Medi-Cal, is on the cusp of major changes that could rectify long-standing problems and improve health care for the state's low-income population.

Starting Jan. 1, Medi-Cal, California's Medicaid program, will implement new standardized contracts with its 22 managed care health plans, which collectively cover 99% of enrollees.

The new contracts tighten enforcement of quality measures, especially for women and children; require the health plans to report publicly on the performance of medical providers—and in some cases other insurers—to whom they delegate care; and mandate that plans reveal the number of enrollees who don't have access to primary care and invest more to plug the gap.

They also commit plans to better integration of physical and mental health care and greater responsiveness to the cultural and linguistic needs, sexual orientation, and gender identity of members.

To realize these promises, state regulators will have to be tougher than they have been in the past.

But that might be difficult because the changes are happening at the same time as a number of other initiatives that could compete for staff attention and confuse some enrollees.

Beginning next year, over 700,000 immigrants without permanent legal residency will become eligible for full Medi-Cal coverage. In addition, an estimated 1.2 million beneficiaries in 21 counties will need to change

health plans after the state last year rejiggered the constellation of insurers and multiple counties switched the way they deliver Medi-Cal. Some counties will have only one plan left. Where there is more than one, enrollees who are losing their plan will have to choose a new one.

Kaiser Permanente, the Oakland-based managed-care giant, will start a new direct contract with the state in 32 counties, largely an administrative shift that should not disrupt care for most enrollees. And thousands of Medi-Cal enrollees in residential care will be switched to managed care plans for the first time as the state accelerates its move away from traditional, direct-pay Medi-Cal.

All of this is happening amid the so-called unwinding, in which over 900,000 people have been shed from Medi-Cal thus far, and disenrollments are expected to continue until next summer. The unwinding follows the termination of pandemic-era protections.

"My head is spinning thinking about all of that going on at the same time," says John Baackes, CEO of L.A. Care Health Plan, the state's largest Medi-Cal plan, with nearly 2.6 million members. "Our call center is stacked to the gills."

Tony Cava, spokesperson for the Department of Health Care Services, which oversees Medi-Cal, says the new contracts, signed by all the Medi-Cal managed care plans, will provide for "quality, equitable, and comprehensive coverage," emphasizing prevention and "offering services that address long-term care needs throughout a member's life."

And in a groundbreaking move, the new contracts also require health plans for the first time to reinvest a portion of their profits — between 5% and 7.5% — in the communities where they operate.

They also provide a number of carrots and sticks, which include

withholding a small percentage of payments to health plans with a chance for them to earn it back by reaching quality and health equity benchmarks. And profitable health plans that don't meet expectations will have to reinvest an additional 7.5% of their profits in the community. This is all on top of increased fines that regulators can levy on poorly performing health plans.

The new Medi-Cal contracts also enshrine key elements of CalAIM, a $12 billion, five-year experiment, already underway, in which health plans aim to provide a range of social services for the neediest Medi-Cal members, including housing assistance and medically tailored meals, on the grounds that poverty and related social inequities are often the root of health problems. So far, however, the rollout has been slow.

Abbi Coursolle, senior attorney in the Los Angeles office of the National Health Law Program, says the requirement for health plans to report publicly on the care provided by their subcontracted medical providers should increase accountability, helping enrollees better navigate Medi-Cal.

"This is a step forward that advocates have been paying attention to for over a decade," Coursolle says. "There's so much ping-ponging people back and forth between the health plan and the provider group. That dilutes accountability so much."

Another big change for Medi-Cal is the elimination of the so-called asset limit test for a certain subset of enrollees, including people who are aged, blind, disabled, in long-term care, or on Medicare. In addition to meeting income requirements, people have had to keep the total value of their personal assets below certain thresholds to qualify for Medi-Cal. The assets that are counted include savings, certain investments, second homes, and even second cars.

Until last year, those limits were so low — $2,000 for an individual — that people had virtually no ability to accumulate savings if they wanted to be on Medi-Cal. In mid-2022, however, the limit was raised to $130,000, which meant that for the majority of people subject to the test, assets were no longer a barrier to eligibility. In 2024, the asset test will be eliminated altogether.

But given last year's change, the total elimination will likely generate only a few thousand new Medi-Cal enrollees. Still, it should save people the bureaucratic headache of having to prove they're below a certain asset threshold.

If you want to learn more about the asset limit test, the DHCS has an FAQ on the subject on its website (dhcs.ca.gov).

If you wonder whether you are among the 1.2 million Medi-Cal members who need to change health plans, and you haven't already received communication on the subject, the department has an online tool to tell you the plans that will be available in your county as of Jan. 1.

Nearly half the people who need to switch plans are Health Net members in Los Angeles County who are being transferred to Molina Health care as part of a compromise agreement the state struck last year to avoid becoming mired in lawsuits by angry health plans that lost out in a bidding competition.

If you need to change plans and you're lucky, your doctors may be in the new plan. Make sure to check. If they are not, you may be able keep them for up to a year or long enough to finish a course of treatment that is already underway. The DHCS provides a fact sheet outlining your rights to continuity.

You can also contact your current health plan for additional information

or ask your county Medi-Cal office. The Health Consumer Alliance (1-888-804-3536, or healthconsumer.org) is another source of information and assistance, as is Medi-Cal's managed care ombudsman (1-888-452-8609, or MMCDOmbudsmanOffice@dhcs.ca.gov)

Despite the state's best intentions, an acute shortage of medical professionals could be a big obstacle. "As these coverage expansions are happening, and as this innovation is happening, it is being built on a health workforce that is already strained," says Berenice Nuñez Constant, senior vice president for government relations at AltaMed Health Services, one of the state's largest community clinic groups.

Labor shortage or not, the health plans must deliver on their contractual obligations. Anthony Wright, executive director of the advocacy group Health Access California, says, "On some level, this is about holding the plans accountable for what they are promising and getting tens of billions of dollars for."