

AMENDED IN ASSEMBLY MAY 23, 1997

AMENDED IN ASSEMBLY MAY 1, 1997

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

**ASSEMBLY BILL**

**No. 426**

**Introduced by Assembly Member Gallegos  
(Coauthor: Assembly Member Richter)**

February 20, 1997

An act to *amend Sections 14087.305 and 14089 of, and to add Sections 14087.306 and 14089.01 to, the Welfare and Institutions Code, relating to health services.*

LEGISLATIVE COUNSEL'S DIGEST

AB 426, as amended, Gallegos. Medi-Cal: managed care.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services. One of the methods for the procurement of Medi-Cal services is through contracts between managed care plans, as defined, and the department.

Existing law provides for the establishment of 2 plan systems in counties through which Medi-Cal recipients may elect to receive benefits through health care plans or other providers, and for the provision of Medi-Cal benefits in defined geographical areas in programs that allow Medi-Cal recipients to elect to receive benefits through health care plans or other providers.



Existing law requires the department to ensure the provision of information on the options and types of providers available to Medi-Cal beneficiaries in the areas in which those programs are implemented.

*Existing law requires that in any area where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority for the provision of health care services, the county shall ensure that each Medi-Cal or AFDC applicant or beneficiary be informed of the managed care options available regarding methods of receiving Medi-Cal benefits.*

*This bill would prohibit any health care contractor providing enrollment services to the department and any agent, subsidiary, employee, and subcontractor of any health care options contractor providing services under those programs from being an employee, a consultant, or a member of the board of directors of any prepaid health plan contracting to provide benefits under those programs.*

*This bill would require the department or its health care options contractor to test all enrollment information summarizing the benefits and limitations of health care plans provided to those certain Medi-Cal recipients, using statistically valid methods and the population to be served, for cultural and linguistic appropriateness, and ease of comprehension.*

*This bill would also require the department to develop an advisory committee in those counties to convene and work with representatives of the independent health care options contractor and the local subcontractor and to establish certain contract performance contractor expectations.*

*Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.*

*The people of the State of California do enact as follows:*

- 1 SECTION 1. *Section 14087.305 of the Welfare and*
- 2 *Institutions Code, as added by Section 2 of Chapter 859 of*
- 3 *the Statutes of 1995, is amended to read:*



1 14087.305. (a) In areas specified by the director for  
2 expansion of the Medi-Cal managed care program under  
3 Section 14087.3 and where the department is contracting  
4 with a prepaid health plan that is contracting with,  
5 governed, owned or operated by a county board of  
6 supervisors, a county special commission or county health  
7 authority authorized by Sections 14018.7, 14087.31,  
8 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or  
9 Aid to Families with Dependent Children (AFDC)  
10 applicant or beneficiary shall be informed of the  
11 managed care options available regarding methods of  
12 receiving Medi-Cal benefits. The county shall ensure that  
13 each beneficiary is informed of these options and  
14 informed that a health care options presentation is  
15 available.

16 (b) The managed care options information described  
17 in subdivision (a) shall include the following elements:

18 (1) Each beneficiary or eligible applicant shall be  
19 provided with the name, address, and telephone number  
20 of each primary care provider, by specialty, or clinic,  
21 participating in each prepaid health plan option. The  
22 name, address, and telephone number of each specialist  
23 participating in each prepaid health plan shall be made  
24 available by contacting the health care options contractor  
25 or the prepaid health plan.

26 (2) Each beneficiary or eligible applicant shall be  
27 informed that he or she may choose to continue an  
28 established patient-provider relationship in a managed  
29 care option, if his or her treating provider is a primary  
30 care provider contracting with any of the prepaid health  
31 plan options available and has available capacity and  
32 agrees to continue to treat that beneficiary or applicant.

33 (3) Each beneficiary or eligible applicant shall be  
34 informed that if he or she fails to make a choice, he or she  
35 shall be assigned to, and enrolled in, a prepaid health plan.

36 (c) No later than 30 days following the date a Medi-Cal  
37 or AFDC beneficiary or applicant is determined eligible  
38 for Medi-Cal, the beneficiary shall indicate his or her  
39 choice, in writing, from among the available prepaid  
40 health plans in the region and his or her choice of primary



1 care provider contracting with the selected prepaid  
2 health plan.

3 (d) At the time the beneficiary or eligible applicant  
4 selects a prepaid health plan, the department shall, when  
5 applicable, encourage the beneficiary or eligible  
6 applicant to also indicate, in writing, his or her choice of  
7 primary care provider or clinic contracting with the  
8 selected prepaid health plan.

9 (e) In areas specified by the director for expansion of  
10 the Medi-Cal managed care program under Section  
11 14087.3, and where the department is contracting with a  
12 prepaid health plan that is contracting with, governed,  
13 owned or operated by a county board of supervisors, a  
14 county special commission or county health authority  
15 authorized by Sections 14018.7, 14087.31, 14087.35,  
16 14087.36, 14087.38, and 14087.96, a Medi-Cal or AFDC  
17 beneficiary who does not make a choice of managed care  
18 plans, shall be assigned to and enrolled in an appropriate  
19 Medi-Cal prepaid health plan providing service within  
20 the area in which the beneficiary resides.

21 (f) If a beneficiary or eligible applicant does not  
22 choose a primary care provider or clinic, or does not select  
23 any primary care provider who is available, the prepaid  
24 health plan that was selected by or assigned to the  
25 beneficiary shall ensure that the beneficiary selects a  
26 primary care provider or clinic within 30 days after  
27 enrollment or is assigned to a primary care provider  
28 within 40 days after enrollment.

29 (g) Any Medi-Cal or AFDC beneficiary dissatisfied  
30 with the primary care provider or prepaid health plan  
31 shall be allowed to select or be assigned to another  
32 primary care provider within the same prepaid health  
33 plan. In addition, the beneficiary shall be allowed to select  
34 or be assigned to another prepaid health plan contracted  
35 for pursuant to this article that is in effect for the  
36 geographic area in which he or she resides, in accordance  
37 with Section 1903 (m) (2) (F) (ii) of the Social Security  
38 Act.

39 (h) The department or its contractor shall notify a  
40 prepaid health plan when it has been selected by or



1 assigned to a beneficiary. The prepaid health plan that has  
2 been selected by or assigned to a beneficiary shall notify  
3 the primary care provider that has been selected or  
4 assigned. The prepaid health plan shall also notify the  
5 beneficiary of the prepaid health plan and primary care  
6 provider selected or assigned.

7 (i) (1) The managed health care plan shall have a  
8 valid Medi-Cal contract, adequate capacity, and  
9 appropriate staffing to provide health care services to the  
10 beneficiary.

11 (2) The department shall establish standards for all of  
12 the following:

13 (A) The maximum distances a beneficiary is required  
14 to travel to obtain primary care services from the  
15 managed care plan, in which the beneficiary is enrolled.

16 (B) The conditions under which a primary care  
17 service site shall be accessible by public transportation.

18 (C) The conditions under which a managed care plan  
19 shall provide nonmedical transportation to a primary  
20 care service site.

21 (3) In developing the standards required by  
22 paragraph (2) the department shall take into account, on  
23 a geographic basis, the means of transportation used and  
24 distances typically traveled by Medi-Cal beneficiaries to  
25 obtain fee-for-service primary care services and the  
26 experience of managed care plans in delivering services  
27 to Medi-Cal enrollees. The department shall also consider  
28 the provider's ability to render culturally and  
29 linguistically appropriate services.

30 (j) To the extent possible, the arrangements for  
31 carrying out subdivision (e) shall provide for the  
32 equitable distribution of Medi-Cal beneficiaries among  
33 participating prepaid health plans, or managed care  
34 plans.

35 (k) *No health care contractor providing enrollment*  
36 *services to the department pursuant to this section, and*  
37 *no agent, subsidiary, employee, and subcontractor of any*  
38 *health care options contractor shall be an employee, a*  
39 *consultant, or a member of the board of directors of any*  
40 *prepaid health plan contracting pursuant to this section.*



1 (l) This section shall be implemented in a manner  
2 consistent with any federal waiver required to be  
3 obtained by the department in order to implement this  
4 section.

5 SEC. 2. Section 14087.306 is added to the Welfare and  
6 Institutions Code, to read:

7 ~~14087.306. (a) The department or its independent~~  
8 ~~health care options contractor shall test, using statistically~~  
9 ~~valid methods and the population to be served,~~  
10 ~~enrollment information materials provided to Medi-Cal~~  
11 ~~recipients pursuant to Section 14087.305 for cultural and~~  
12 ~~linguistic appropriateness and ease of comprehension.~~

13 ~~(b) Any independent health care options contractor~~  
14 ~~providing enrollment information under Section~~  
15 ~~14087.305, shall take all reasonable steps to subcontract~~  
16 ~~with any community based nonprofit organizations that~~  
17 ~~do not have a financial interest or affiliation with a health~~  
18 ~~care plan or provider contracting to provide Medi-Cal~~  
19 ~~services.~~

20 ~~(c) The department shall ensure that the independent~~  
21 ~~contractor maintains, submits to the Legislature, and~~  
22 ~~makes available to the public on a quarterly basis county~~  
23 ~~status reports. Status reports shall include, but not be~~  
24 ~~limited to, default rates, health plan selection rates,~~  
25 ~~voluntary disenrollment rates, excluding disenrollment~~  
26 ~~due to program ineligibility, and reasons for voluntary~~  
27 ~~disenrollment, plan membership, complaints received~~  
28 ~~about the independent health care options contractor,~~  
29 ~~managed care plans or providers, general enrollment~~  
30 ~~policies, and the amount of time it takes to process~~  
31 ~~voluntary disenrollment and urgent or emergency~~  
32 ~~disenrollment requests.~~

33 *14087.306. (a) The department or its health care*  
34 *options contractor shall test enrollment information*  
35 *materials produced by the department and provided to*  
36 *Medi-Cal recipients or applicants pursuant to Section*  
37 *14087.305 for cultural and linguistic appropriateness and*  
38 *ease of comprehension. Focus groups shall be used as a*  
39 *testing method to the extent funds are available, and shall*



1 *be conducted in a manner that is sufficiently*  
2 *representative of population to be served.*

3 *(b) Any health care options contractor providing*  
4 *enrollment information under Section 14087.305 shall*  
5 *take all reasonable steps to subcontract for outreach and*  
6 *education services with one or more local*  
7 *community-based nonprofit organizations that do not*  
8 *have any financial interest in or affiliation with a prepaid*  
9 *health plan, provider, or clinic contracting to provide*  
10 *Medi-Cal services. Any entity subcontracting with the*  
11 *health care options contractor pursuant to this*  
12 *subdivision shall have the required capability and*  
13 *capacity, and meet specified selection criteria. Selection*  
14 *criteria shall be developed by a local selection committee*  
15 *comprised of representatives of the county social services*  
16 *agency, prepaid health plans, and the department or the*  
17 *health care options contractor. Staff of any*  
18 *subcontracting community-based organization shall*  
19 *undergo the same training and shall be subject to the*  
20 *same quality assurance monitoring as the health care*  
21 *options contractor staff.*

22 *(c) The department shall submit to the Legislature*  
23 *status reports regarding implementation of the Two-Plan*  
24 *Model in each county in which the Two-Plan Model is*  
25 *designated to provide Medi-Cal benefits. Status reports*  
26 *required by this subdivision shall be submitted on a*  
27 *quarterly basis for a three-year period beginning with*  
28 *submission of the first report on April 1, 1998. Each status*  
29 *report shall include, but not be limited to, all of the*  
30 *following:*

31 *(1) Default rates, commercial plan and local initiative*  
32 *selection rates, voluntary disenrollment rates, excluding*  
33 *disenrollment due to program ineligibility, and reasons*  
34 *for voluntary disenrollment.*

35 *(2) Grievances received by the health care options*  
36 *contractor, prepaid health plans, or providers.*

37 *(3) The amount of time it takes to process voluntary,*  
38 *urgent, and emergency disenrollment requests.*

39 *(d) The department shall develop an advisory*  
40 *committee in Two-Plan Model counties to convene and*



1 work with representatives of the ~~independent~~ contractor  
2 and the local subcontractor. The committee shall include  
3 consumers, advocates, *providers*, health plan  
4 representatives, and representatives of local  
5 government. The advisory committee shall meet  
6 monthly to develop strategies for improving the  
7 enrollment process.

8 (e) By March 1, 1998, the department shall develop  
9 contractor performance expectations including, but not  
10 limited to, ~~default~~, *acceptable default* assignment rates,  
11 the number of times the phone may ring before  
12 answering, the amount of time it takes for the contractor  
13 to send out requested materials, and the amount of time  
14 a beneficiary could be left on hold. *In any month that the*  
15 *default assignment rate in any county exceeds the*  
16 *acceptable level established pursuant to this subdivision,*  
17 *the department shall document the circumstances that*  
18 *caused the excessive default assignment rate, and include*  
19 *the information in the status report that is required*  
20 *pursuant to subdivision (c).*

21 ~~(f) A person whose enrollment forms are not~~  
22 ~~processed as the result of the independent health care~~  
23 ~~option contractor's backlog may not be defaulted into a~~  
24 ~~managed care plan.~~

25 ~~(g) Whenever the independent health care option~~  
26 ~~contractor's backlog in processing enrollments exceeds~~  
27 ~~two weeks, the department shall suspend new mandatory~~  
28 ~~enrollments and shall permit all persons in mandatory~~  
29 ~~categories to continue in fee for service if they choose to~~  
30 ~~do so.~~

31 ~~SEC. 2.—~~

32 (f) *For the purposes of this section, a “commercial*  
33 *plan” means the prepaid health plan in a designated*  
34 *region awarded a contract by the department pursuant*  
35 *to paragraph (1) of subdivision (b) of Section 53800 of*  
36 *Title 22 of the California Code of Regulations. A “local*  
37 *initiative” means the prepaid health plan organized by a*  
38 *county government or by county governments of a*  
39 *region designated by the director, or organized by*  
40 *stakeholders of the designated region, and award a*



1 *contract by the department pursuant to paragraph (2) of*  
2 *subdivision (b) of Section 53800 of Title 22 of the*  
3 *California Code of Regulations.*

4 *SEC. 3. Section 14089 of the Welfare and Institutions*  
5 *Code is amended to read:*

6 14089. (a) The purpose of this article is to provide a  
7 comprehensive program of managed health care plan  
8 services to Medi-Cal recipients residing in clearly defined  
9 geographical areas. It is, further, the purpose of this  
10 article to create maximum accessibility to health care  
11 services by permitting Medi-Cal recipients the option of  
12 choosing from among two or more managed health care  
13 plans or fee-for-service managed care arrangements,  
14 including, but not limited to, health maintenance  
15 organizations, prepaid health plans, primary care case  
16 management plans. Independent practice associations,  
17 health insurance carriers, private foundations, and  
18 university medical centers systems, not-for-profit clinics,  
19 and other primary care providers, may be offered as  
20 choices to Medi-Cal recipients under this article if they  
21 are organized and operated as managed care plans, for  
22 the provision of preventive managed health care plan  
23 services.

24 (b) The negotiator may seek proposals and then shall  
25 contract based on relative costs, extent of coverage  
26 offered, quality of health services to be provided,  
27 financial stability of the health care plan or carrier,  
28 recipient access to services, cost-containment strategies,  
29 peer and community participation in quality control,  
30 emphasis on preventive and managed health care  
31 services and the ability of the health plan to meet all  
32 requirements for both of the following:

33 (1) Certification, where legally required, by the  
34 Commissioner of Corporations and the Insurance  
35 Commissioner.

36 (2) Compliance with all of the following:

37 (A) The health plan shall satisfy all applicable state and  
38 federal legal requirements for participation as a Medi-Cal  
39 managed care contractor.



1 (B) The health plan shall meet any standards  
2 established by the department for the implementation of  
3 this article.

4 (C) The health plan receives the approval of the  
5 department to participate in the pilot project under this  
6 article.

7 (c) (1) (A) The proposals shall be for the provision of  
8 preventive and managed health care services to specified  
9 eligible populations on a capitated, prepaid or  
10 postpayment basis.

11 (B) Enrollment in a Medi-Cal managed health care  
12 plan under this article shall be voluntary for beneficiaries  
13 eligible for the federal Supplemental Security Income for  
14 the Aged, Blind, and Disabled Program (Subchapter 16  
15 (commencing with Section 1381) of Chapter 7 of Title 42  
16 of the United States Code).

17 (2) The cost of each program established under this  
18 section shall not exceed the total amount which the  
19 department estimates it would pay for all services and  
20 requirements within the same geographic area under the  
21 fee-for-service Medi-Cal program.

22 (d) The department shall enter into contracts  
23 pursuant to this article, and shall be bound by the rates,  
24 terms, and conditions negotiated by the negotiator.

25 (e) (1) An eligible beneficiary shall be entitled to  
26 enroll in any health care plan contracted for pursuant to  
27 this article that is in effect for the geographic area in  
28 which he or she resides. Enrollment shall be for a  
29 minimum of six months. Contracts entered into pursuant  
30 to this article shall be for at least one but no more than  
31 three years. The director shall make available to  
32 recipients information summarizing the benefits and  
33 limitations of each health care plan available pursuant to  
34 this section in the geographic area in which the recipient  
35 resides.

36 (2) No later than 30 days following the date a Medi-Cal  
37 or AFDC recipient is informed of the health care options  
38 described in paragraph (1) of subdivision (e), the  
39 recipient shall indicate his or her choice in writing of one  
40 of the available health care plans and his or her choice of



1 primary care provider or clinic contracting with the  
2 selected health care plan.

3 (3) The health care options information described in  
4 paragraph (1) of subdivision (e) shall include the  
5 following elements:

6 (A) Each beneficiary or eligible applicant shall be  
7 provided with the name, address, and telephone number  
8 of each primary care provider, by specialty, or clinic  
9 participating in each health care plan. The name, address,  
10 and telephone number of each specialist participating in  
11 each health care plan shall be made available by  
12 contacting the health care options contractor or the  
13 health care plan.

14 (B) Each beneficiary or eligible applicant shall be  
15 informed that he or she may choose to continue an  
16 established patient-provider relationship in a managed  
17 care option, if his or her treating provider is a primary  
18 care provider contracting with any of the health plans  
19 available and has the available capacity and agrees to  
20 continue to treat that beneficiary or eligible applicant.

21 (C) Each beneficiary or eligible applicant shall be  
22 informed that if he or she fails to make a choice, he or she  
23 shall be assigned to, and enrolled in, a health care plan.

24 (4) At the time the beneficiary or eligible applicant  
25 selects a health care plan, the department shall, when  
26 applicable, encourage the beneficiary or eligible  
27 applicant to also indicate, in writing, his or her choice of  
28 primary care provider contracting with the selected  
29 health care plan.

30 (5) Commencing with the implementation of a  
31 geographic managed care project in a designated county,  
32 a Medi-Cal or AFDC beneficiary who does not make a  
33 choice of health care plans in accordance with paragraph  
34 (2), shall be assigned to and enrolled in an appropriate  
35 health care plan providing service within the area in  
36 which the beneficiary resides.

37 (6) If a beneficiary or eligible applicant does not  
38 choose a primary care provider or clinic, or does not select  
39 any primary care provider who is available, the health  
40 care plan selected by or assigned to the beneficiary shall



1 ensure that the beneficiary selects a primary care  
2 provider or clinic within 30 days after enrollment or is  
3 assigned to a primary care provider within 40 days after  
4 enrollment.

5 (7) Any Medi-Cal or AFDC beneficiary dissatisfied  
6 with the primary care provider or health care plan shall  
7 be allowed to select or be assigned to another primary  
8 care provider within the same health care plan. In  
9 addition, the beneficiary shall be allowed to select or be  
10 assigned to another health care plan contracted for  
11 pursuant to this article that is in effect for the geographic  
12 area in which he or she resides in accordance with Section  
13 1903(m)(2)(F)(ii) of the Social Security Act.

14 (8) The department or its contractor shall notify a  
15 health care plan when it has been selected by or assigned  
16 to a beneficiary. The health care plan that has been  
17 selected or assigned by a beneficiary shall notify the  
18 primary care provider that has been selected or assigned.  
19 The health care plan shall also notify the beneficiary of  
20 the health care plan and primary care provider selected  
21 or assigned.

22 (9) This section shall be implemented in a manner  
23 consistent with any federal waiver that is required to be  
24 obtained by the department to implement this section.

25 (f) A participating county may include within the plan  
26 or plans providing coverage pursuant to this section,  
27 employees of county government, and others who reside  
28 in the geographic area and who depend upon county  
29 funds for all or part of their health care costs.

30 (g) The negotiator and the department shall establish  
31 pilot projects to test the cost-effectiveness of delivering  
32 benefits as defined in subdivisions (a) through (f).

33 (h) The California Medical Assistance Commission  
34 shall evaluate the cost-effectiveness of these pilot projects  
35 after one year of implementation. Pursuant to this  
36 evaluation the commission may either terminate or  
37 retain the existing pilot projects.

38 (i) Funds may be provided to prospective contractors  
39 to assist in the design, development, and installation of



1 appropriate programs. The award of these funds shall be  
2 based on criteria established by the department.

3 (j) In implementing this article, the department may  
4 enter into contracts for the provision of essential  
5 administrative and other services. Contracts entered into  
6 under this subdivision may be on a noncompetitive bid  
7 basis and shall be exempt from Chapter 2 (commencing  
8 with Section 10290) of Part 2 of Division 2 of the Public  
9 Contract Code. These contracts shall have no force and  
10 effect unless approved by the Department of Finance.

11 (k) *No health care contractor providing enrollment*  
12 *services to the department pursuant to this section, and*  
13 *no agent, subsidiary, employee, and subcontractor of any*  
14 *health care options contractor shall be an employee, a*  
15 *consultant, or a member of the board of directors of any*  
16 *prepaid health plan contracting pursuant to this section.*

17 SEC. 4. Section 14089.01 is added to the Welfare and  
18 Institutions Code, to read:

19 ~~14089.01. (a) The department shall test all~~  
20 ~~information summarizing the benefits and limitations of~~  
21 ~~health care plans provided to Medi-Cal recipients under~~  
22 ~~Section 14089, using statistically valid methods and the~~  
23 ~~population to be served, enrollment information~~  
24 ~~materials for cultural and linguistic appropriateness, and~~  
25 ~~ease of comprehension.~~

26 ~~(b) The department or any health care options~~  
27 ~~contractor providing information under Section 14089~~  
28 ~~shall take all reasonable steps to subcontract with any~~  
29 ~~local community based nonprofit organizations that do~~  
30 ~~not have any financial interest in or affiliation with a~~  
31 ~~health care plan or provider or clinic subject to Section~~  
32 ~~14089.~~

33 ~~(c) The department shall ensure that the independent~~  
34 ~~health care options contractor maintains, submits to the~~  
35 ~~Legislature, and makes available to the public on a~~  
36 ~~quarterly basis county status reports. The county status~~  
37 ~~reports shall include, but not be limited to, default rates,~~  
38 ~~health plan selection rates, voluntary disenrollment rates,~~  
39 ~~excluding disenrollment due to program ineligibility, and~~  
40 ~~reasons for voluntary disenrollment, plan membership,~~



1 ~~complaints received about the independent health care~~  
 2 ~~options contractor, managed care plans, or providers,~~  
 3 ~~general enrollment policies, and the amount of time it~~  
 4 ~~takes to process voluntary disenrollment and urgency or~~  
 5 ~~emergency disenrollment requests.~~

6 ~~(d)~~

7 *14089.01. (a) Any health care options contractor*  
 8 *providing enrollment information under Section 14089*  
 9 *shall take all reasonable steps to subcontract for education*  
 10 *and outreach services with one or more local*  
 11 *community-based nonprofit organizations that do not*  
 12 *have any financial interest in or affiliation with a prepaid*  
 13 *health plan, provider or clinic contracting to provide*  
 14 *Medi-Cal services subject to Section 14089. Any entity*  
 15 *subcontracting with the health care options contractor*  
 16 *pursuant to this subdivision shall have the required*  
 17 *capability and capacity, and meet specified selection*  
 18 *criteria. Selection criteria shall be developed by a local*  
 19 *selection committee comprised of representatives of the*  
 20 *county social services agency, prepaid health plans, and*  
 21 *the department or health care options contractor. Staff of*  
 22 *any subcontract community-based organization shall*  
 23 *undergo the same training program and shall be subject*  
 24 *to the same quality assurance monitoring as the health*  
 25 *care options contractor staff.*

26 *(b) The department shall submit to the Legislature*  
 27 *status reports regarding implementation of geographic*  
 28 *managed care. Status reports required by this subdivision*  
 29 *shall be submitted on a quarterly basis for a three-year*  
 30 *period beginning with submission of the first report on*  
 31 *April 1, 1998. Each status report shall include, but not be*  
 32 *limited to, all of the following:*

33 *(1) Default rates, prepaid health plans selection rates,*  
 34 *voluntary disenrollment rates, excluding disenrollment*  
 35 *due to program ineligibility, and reasons for voluntary*  
 36 *disenrollment.*

37 *(2) Grievances received by the health care options*  
 38 *contractor, prepaid health plans, or providers.*

39 *(3) The amount of time it takes to process voluntary,*  
 40 *urgent, and emergency disenrollment requests.*



1 (c) The department shall develop an advisory  
2 committee in geographic managed care project counties  
3 to convene and work with representatives of the  
4 ~~independent~~ health care options contractor and the local  
5 subcontractor. The committee shall include consumers,  
6 advocates, *providers*, health plan representatives, and  
7 representatives of local government. The advisory  
8 committee shall meet monthly to develop strategies for  
9 improving the enrollment process.

10 ~~(e) By March 1, 1998, the department shall develop~~  
11 ~~contractor performance expectations including, but not~~  
12 ~~limited to, default, assignment rates, the number of times~~  
13 ~~the telephone may ring before answering, the amount of~~  
14 ~~time it takes for the contractor to send out requested~~  
15 ~~materials, and the amount of time a beneficiary could be~~  
16 ~~left on hold.~~

17 ~~(f) A person whose enrollment forms are not~~  
18 ~~processed as the result of an independent health care~~  
19 ~~option contractor's backlog may not be defaulted into a~~  
20 ~~managed care plan.~~

21 ~~(g) Whenever the independent health care option~~  
22 ~~contractor's backlog in processing enrollments exceeds~~  
23 ~~two weeks, the department shall suspend new mandatory~~  
24 ~~enrollments and shall permit all persons in mandatory~~  
25 ~~categories to continue in fee-for-service if they choose to~~  
26 ~~do so.~~

