ASSEMBLY BILL No. 1512

Introduced by Assembly Member Garrick

January 12, 2012

An act to amend Section 14016.55 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1512, as introduced, Garrick. Medi-Cal.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services under which qualified low-income individuals receive health care benefits. Under existing law, the Director of Health Care Services is required to enter into contracts with managed care plans to provide services under the Medi-Cal program. A Medi-Cal participant is given 30 days following the determination of eligibility to indicate his or her choice of health care options. Under existing law, in counties where the conversion to managed care plan enrollment has occurred, and where the default rate, as defined, is 20% or higher in 2 consecutive months occurring after the conversion, the department is required to conduct a survey of beneficiaries, as specified, and to report the results to the appropriate legislative policy and budget committees.

This bill would make technical, nonsubstantive changes to the survey and reporting provisions.

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

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

SECTION 1. Section 14016.55 of the Welfare and Institutions Code is amended to read:

14016.55. (a) It is the intent of the Legislature that Medi-Cal beneficiaries who are required to enroll in a Medi-Cal managed care health plan make an informed choice that is not the result of confusion, lack of information, or ~~understanding~~ *misunderstanding* of the choices available to them.

(b) It is the intent of the Legislature that the department strive to increase the level of choice of Medi-Cal beneficiaries required to enroll in a Medi-Cal managed care health plan and that default rates be no greater than 20 percent in any participating county.

(c) In any county in which conversion to managed care *health* plan enrollment has taken place and where the default rate, as defined in subdivision (e), is 20 percent or higher in two consecutive months occurring after conversion upon the effective date of this section, the department shall conduct a one-time survey of beneficiaries aimed at determining the reasons why beneficiaries fail to enroll into a managed care *health* plan when required to do so by the department or its health care options contractor.

(d) The department shall submit the results of the survey to the appropriate legislative policy and budget committees within six months of completion, and implement a plan of correction intended to reduce the rate of beneficiary default. The plan of correction may include, but not be limited to, culturally appropriate outreach and education activities, including the use of community based organization.

(e) For purposes of this section, "default rate" refers to the rate of Medi-Cal beneficiaries defaulting into managed care health plan enrollment by virtue of their failure to make an election, as provided for in Section 14016.5.

O