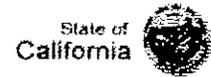


DMHC Note: Documents that were accessible by clicking on “View” are displayed after the Applicant’s certification of the Application.



Application for an Award of Advocacy and Witness Fees

Entity Name: The Western Center On Law And Poverty, Inc
Proceeding: 2002-0018 General Access/ 2005-0203 Timely Access
Date Submitted: 3/18/2010 3:42:13 PM
Submitted By: Richard Rothschild
Application version: Original App

1. For which proceeding are you seeking compensation?

2002-0018 General Access/ 2005-0203 Timely Access

2. What is the amount requested?

\$47,785.00

3. Proceeding Contribution:

Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 22, Section 1010(b)(8), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

See attachment for answers to questions 3 and 4.

Document Name	Date Uploaded	Uploaded By	
Application submitted via FedEx	3/18/2010 3:42:13 PM	Richard Rothschild	View

4. Please attach your Time and Billing Record in the "Add Attachment" box below. If you do not have your own Time and Billing Record, please use the [DMHC template](#).

I am authorized to certify this document on behalf of the applicant. By entering my name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at Los Angeles (City), CA (State), on March 18, 2010.

Enter Name: Richard A. Rothschild

WESTERN CENTER ON LAW & POVERTY

March 17, 2010

Direct Line:
213-235-2624

BY FEDERAL EXPRESS

Stephen Hansen
Department of Managed Health Care
980 - 9th Street, 5th Floor
Sacramento, CA 95814

RECEIVED
MAR 18 2010

OFFICE OF LEGAL SERVICES

Re: Consumer Participation Program
Application for an Award of Advocacy and Witness Fees

Dear Mr. Hansen:

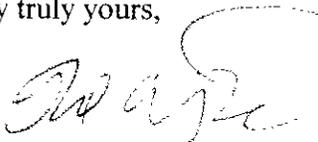
During our attempt to submit Western Center's Application for an Award of Advocacy and Witness Fees using your website, an error message regarding DMHC's server occurred several times. Since the deadline to submit Western Center's application is March 18, 2010, our Application is being submitted by Federal Express, though we will keep trying to submit the Application electronically as well.

Enclosed are the following documents:

1. The printed DMHC Application for an Award of Advocacy and Witness Fees form that Western Center attempted to file; and,
2. The Application of Western Center on Law and Poverty for Award of Advocacy Fees for Substantial Contribution to Timely Access Regulations, and attached documents in support of the Application.

Please call me at the direct phone number above if you have any questions regarding the enclosed documents.

Very truly yours,



Richard A. Rothschild
Director of Litigation
Western Center on Law and Poverty

RAR:mh
Enclosures



Organization: **The Western Center On Law And Poverty, Inc**
Elizabeth Landsberg

Report Probl

Consumer Participation Program

 Please note - If you remain inactive for 20 minutes your session will expire. If your session expires you will need to log back in. Any data that has not been saved prior to a session expiring will be lost. Please contact the DMHC with any questions or problems regarding this site.

Welcome

Manage Account Info

Application Forms

FAQ

Contact DMHC

New/Pending Forms

Submitted Forms

Back to

Application for an Award of Advocacy and Witness Fees

Please use this form to submit a Application for an Award of Advocacy and Witness Fees:

* indicates a required field

1. For which proceeding are you seeking compensation? *

- 2004-0115 Access to Language Assistance (SB853)
- 2002-0019 Prescription Drug Benefits and Co-payments (SB842)
- 2004-0100 Financial Solvency
- 2003-0298 Continuity of Care (Block Transfer)
- 2002-0018 General Access/ 2005-0203 Timely Access

2. What is the amount requested? *

\$ 47,785.00

3.

Proceeding Contribution: *

Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 22, Section 1010(b)(8), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

(7053 characters remaining)

Western Center on Law and Poverty answers Questions 3 and 4 together by submitting, in order.

1. Application of Western Center on Law and Poverty for Award of Advocacy Fees, in which Western Center explains why it should be awarded advocacy fees and why the amount of fees sought is reasonable. The remaining documents are consecutively paginated.

2. Declarations of Western Center's Participating Attorneys Elizabeth Landsberg and Jen Flory, to which time records are attached (pages DMHC 000001 - DMHC 000015).

3. Comments and Other Documents Submitted by Western Center on Law and Poverty to Department of Managed Health Care Concerning Timely Access Regulations (pages DMHC 000016 - DMHC 000085).

4. Declarations of Richard M. Pearl and Richard A. Rothschild in Support of Hourly Rates Claimed (pages DMHC 000086 - DMHC 000143).

In separate answer to Question 4, the time records are attached

Add Attachment

Accepted file formats include .pdf, .doc, .txt, .rtf, .xls, .docx, .xlsx (PDF, Microsoft Word, Excel, and text files), and maximum file size accepted is 5MB. You may attach more than one document for each question. Please close your MS Word or Excel documents first before attaching.

Document Name * DMHC-WCLP APPLICATION, ?

File *

- 4. Please attach your Time and Billing Record in the "Add Attachment" box below. If you do not have your own Time and Billing Record, please use the DMHC template. *

Add Attachment

Accepted file formats include .pdf, .doc, .txt, .rtf, .xls, .docx, .xlsx (PDF, Microsoft Word, Excel, and text files), and maximum file size accepted is 5MB. You may attach more than one document for each question. Please close your MS Word or Excel documents first before attaching.

Document Name * WCLP APPLICATION, PART 2 ?

File *

I am authorized to certify this document on behalf of the applicant. By entering my

name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at

Los Angeles (City), CA (State), on March 17, 2010 .

Enter Name: Richard A. Rothschild

Application of Western Center on Law and Poverty for Award of Advocacy Fees for Substantial Contribution to Timely Access Regulations

Western Center on Law and Poverty, over a four-year period, tenaciously and successfully advocated to improve proposed Department of Managed Health Care regulations concerning timely access to health care. Western Center now seeks an award of advocacy fees totaling \$47,785. As will be discussed, Western Center is entitled to those fees because of its substantial contribution to the final regulations; and the amount sought is reasonable.

I. Western Center Substantially Contributed to the Timely Access Regulations and is Thus Entitled to an Advocacy Fee Award

Health & Safety Code § 1348.9(a) permits DMHC to award reasonable advocacy fees when an organization representing the interests of consumers “has made a substantial contribution of behalf of consumers to the adoption of any regulation” Western Center contributed substantially to the final regulations on Timely Access to Health Care Services, and is thus entitled to a fee award.

When amendments to the timely access regulations were first proposed in 2006, Western Center attorney and legislative advocate Elizabeth Landsberg began working on this matter. On behalf of a number of legal services organizations around the state coordinated and drafted comments to the draft regulations that were issued in March of 2007. (The written comments and other documents that we submitted to the Department since 2007 are attached at pages 16 - 85.)

The comments submitted noted that the time allowed for dental care, in particular the 180-day time limit for preventative care, was too long, along with the time limits on urgent mental health care. She also offered specific suggestions regarding timely

telephone access, compliance monitoring, language access, and the alternative standards.

Another round of regulations was issued in September of 2007. One of our suggestions regarding the compliance monitoring – that is, ensuring that a statistically valid provider survey was used – was adopted in the new round of regulations. Ms. Landsberg again coordinated and drafted the comments on behalf of a number of organizations and raised a number of concerns, including concerns about the primary care standards, prohibitions on requiring providers to maintain records on compliance with telephone access standards, and necessary clarifications on enrollee education.

In December 2007, the Department radically changed course and issued a set of regulations that allowed individual health plans to determine what timely access is. Ms. Landsberg again coordinated and drafted comments on behalf of a number of organizations informing the Department that this new approach directly violated the authorizing statute. Nonetheless, the Department moved to finalize these regulations.

At this time, Western Center found the violation so substantial that we agreed to represent another organization in suing the Department for violating the law. Fortunately, the regulations were not finalized as the Office of Administrative Law found that the Department had violated procedural requirements on comment periods. Shortly thereafter, on March 27, 2008, Ms. Landsberg was called before the Senate Health Committee to testify on how the Department conducted the regulatory process and to what extent it considered consumer input.

Western Center was subsequently invited to a Timely Access Regulations Stakeholder meeting on June 30, 2008, in which Ms. Landsberg participated. At that meeting, we were asked to draft our proposals as to how various aspects of the Timely

Access regulations should work. Ms. Landsberg and Western Center attorney Jen Flory drafted one of the consumer proposals together with Ann Rubinstein of Health Rights Hotline. We were then asked to review and comment on the proposals of other organizations, which we did, informing the department where the other proposals failed to protect the consumers or comply with the law. Ms. Landsberg then attended three meetings held by the Department in September, 2008 regarding the various proposals. In late October, 2008, she met with Department officials regarding informal draft of the revised regulations.

Western Center submitted comments on the informal regulations. At this time the Department incorporated the time-elapsed standards and some of our language access considerations as requested by Western Center and other consumer groups during the proposal process. We also raised a number of concerns including the inclusion of alternative timeliness standards and the nonstandard compliance monitoring requirements. We also offered technical corrections in the regulatory language.

When new regulations were formally issued in February 2009, Western Center again provided comments on behalf of a number of organizations regarding the timeliness for urgent care, dental and specialty care, language access, and compliance monitoring. As these regulations were similar to the informal regulations we had seen in November, our comments were similar as well.

The regulations were again revised in Spring of 2009 and we submitted comments solely on the revisions that June. A final set of regulations was issued and we submitted our comments in October 2009. Again, we limited these comments to the revisions, in particular on compliance standards.

The Timely Access to Care Regulations went into effect this past January. Were it not for our participation, in coordination with other consumer groups, the regulations would have allowed individual health plans to essentially monitor themselves. Dental, vision, chiropractic, acupuncture and specialty mental health plans would have been largely exempted or had much lighter standards. Requirements on appointments with specialists would have offered longer wait times. Coordination with interpreter services at the time of appointment would not have been included. Telephone answering services after hours would not have been required to notify enrollees how to get triage services to determine whether a trip to urgent care was required. Plans could have asked for alternative timeliness standards without adequately demonstrating why such standards were appropriate. Western Center devoted considerable time in providing the Department with both legal support for our positions and an explanation of the practical effect the Department's actions would have on consumers.

In short, Western Center significantly improved the timely access regulations and therefore should be awarded advocacy fees.

II. The Amount Sought is Reasonable

Western Center seeks \$47,785 in fees, which are summarized as follows:

Attorney	Law School Grad. Year	Hours	Hourly Rate	Total
Elizabeth Landsberg	1998	92.2	\$415	\$38,263
Jen Flory	2005	29.3	\$325	\$ 9,522.50
Total				\$47,785.5

A. The Number of Hours Claimed is Reasonable.

The number of hours claimed is reasonable. The hours are meticulously

documented based on the contemporaneous time records of Ms. Landsberg and Ms. Flory, which are attached to their declarations and separately attached at the end our submission (pages 145-48). And, as described above, they cover four years of diligent advocacy involving detailed written comments in multiple rounds of regulation proposals; testimony before the Legislature; meetings with DMHC and other stakeholders; and coordination of the advocacy community. The overall hours are modest for this substantial body of work.

B. The Hourly Rates Claimed are Reasonable.

DMHC regulations state that fees awarded shall not exceed “market rates,” which are defined as

the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas at the time of the Director's decision awarding compensation to a Participant for attorney advocates, non-attorney advocates, or experts with similar experience, skill and ability.

28 C.C.R. §1010(b)(3). Western Center seeks \$415 per hour for Ms. Landsberg, a health law expert with 12 years of experience, and \$325 per hour for Jen Flory, a five-year attorney also with considerable relevant experience. These rates are well within the range of rates charged by private attorneys in Los Angeles and the Bay Area.

1. Insurance Commission Decisions, Based on Identically Worded Regulations, Provide a Much Better Guide than PUC Decisions in Determining Market Rates.

DMHC, awarding Western Center advocacy fees in an earlier decision, based the hourly rates on rates awarded in Public Utilities Commission decisions. DMHC Decision 09-04-02, dated April 27, 2009, at 17-26. Western Center respectfully requests that DMHC reconsider this reliance.

If the rates are to be based on decisions made by different state officials, the Insurance Commissioner provides a better model than the PUC. The regulation governing hourly rates for proceedings in front of the Insurance Commissioner cases is identical to that of DMHC. 10 C.C.R. §2661.1. *Compare* Pub. Util. Code §1806 (rates in PUC matters cannot exceed rates paid by PUC or utilities for comparable services).

The rates sought here are based on Insurance Commissioner awards. In a 2009 decision, the Commissioner awarded \$425 per hour for the 2008 work of an attorney with 13 years of experience. File No. IP-2007-0006, Decision Awarding Compensation, etc., at 12, Ex. A to Dec. of Richard A. Rothschild at 138. We are seeking a slightly lower rate – \$415 – for 12-year attorney Elizabeth Landsberg. In the same decision, the Commissioner awarded \$325 per hour for a five-year attorney, Decision at 13, Ex. A to Rothschild Dec. at 139, the same as sought for Ms. Flory, a 2005 law school graduate. As will be discussed below, the Insurance Commissioner rates and the rates sought here are much closer to, though still below, the “prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas.” 28 C.C.R. §1010(b)(3).

2. The Award Should be Based on Current Rather than Historical Rates.

Preliminarily, we address the question whether the award should be based on current prevailing hourly rates or the rates prevailing at the time the work was performed. The answer lies in 28 C.C.R. § 1010(b)(3) itself, which defines market rates as “the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas *at the time of the Director's decision awarding compensation to a Participant . . .*” (Emphasis added.) This definition is consistent with case law. The courts have held that the use of current rather than historical rates is appropriate to adjust

for delay in payment. *Missouri v. Jenkins*, 491 U.S. 274, 284 (1989); *Graham v. DaimlerChrysler Corp.*, 34 Cal.4th 553, 584 (2004) (use of current rates eliminates need for a multiplier for delay in payment). *See also* Dec. of Richard M. Pearl, ¶11 at 103 (“In my experience, fee awards are almost always determined based on current rates, i.e., the attorney’s rate at the time a motion for fees is made, rather than the historical rate at the time the work was performed. This is a common and accepted practice to compensate attorneys for the delay in being paid.”). Nonetheless, as we now discuss, the rates sought here are well within the range of hourly rates charged by private firms in the years the work was done as well as currently.

3. Considerable Evidence Supports the Reasonableness of the Rates Sought Here.

The rates sought in this application are supported by considerable evidence in addition to the Insurance Commissioner precedent. This evidence includes a declaration from Richard Pearl. The Insurance Commissioner, in awarding the rates sought, relied on the Mr. Pearl’s declaration, calling him “an expert on attorneys’ fees.” Decision Awarding Compensation, etc. at 12. Ex. A to Rothschild Dec. at 138. Mr. Pearl has also submitted a declaration for this proceeding, detailing literally dozens of examples of hourly rates over the past few years in the Bay Area equal to or higher than those sought here. Pearl Dec., ¶¶8 at 90-102.

For example, \$415 per hour is sought for 12-year attorney Ms. Landsberg. The Pearl declaration includes the following examples of equal or higher rates awarded or billed over the past few years for equally or less experienced attorneys:

Firm (if available) or Case Name	Years Experience	Rate	Page in Pearl Declaration
<i>Multi-Ethnic Immigrant Workers Organizing Network v. City of L.A.</i>	8	\$425	6
<i>Jones v. City of L.A.</i>	12	\$455	6

<i>Environmental Law Foundation v. Laidlaw Transit, Inc</i>	7	\$450	7
Altshuler Berzon	8	\$475	7
Bingham McCutchen	7	\$485	8
Coughlin Stoia	11	\$510	9
Goldstein, Demchak	8	\$425	9
Morrison & Foerster	7	\$535	12
O'Melveny & Myers	8	\$565	13
Rosen, Bien & Galvan	9	\$430	13
Rudy, Exelrod & Zieff	12	\$500	15

Survey data also support the hourly rates sought. For example, Western Center seeks \$325 per hour for the work of Jen Flory, a 2005 graduate. According to a Westlaw survey of California rates, a 2005 graduate is billed at \$680 per hour by David Polk & Wardwell, and \$500 per hour at Weil, Gotshal & Manges. Hourly rates for less experienced 2006 graduates are \$470 at Gibson, Dunn & Crutcher; \$465 at Weil, Gotshal; \$400 at Munger, Tolles & Olson; \$395 at O'Melveny & Myers, which also charged much higher rates than sought here for 2007 and 2008 graduates. Westlaw Court Express, Legal Billing Report, Vol. 11, No. 1 May 2009, Ex. B to Pearl Dec. at 113-15.¹

Thus, the evidence shows that prevailing hourly rates in Los Angeles and the Bay Area are higher than those sought here and much higher than the PUC rates. *See also* Rothschild Dec., ¶7 at 125 (Los Angeles rates tend to be roughly equal to Bay Area rates). The hourly rates sought are reasonable, as is the entire fee request.

¹The earlier decision awarding Western Center fees noted that we had not submitted examples of rates awarded to Western Center in previous fee decisions. This is because all of Western Center's fee awards in recent years in Los Angeles and the Bay Area have been by stipulated order with no specification of hourly rates. The rates we seek in settlement are consistent with those sought here, and most of the settlements have been for a high percentage of the amount sought. Rothschild Dec., ¶8 at 125.

Conclusion

Western Center respectfully requests an advocacy fee award totaling \$47,785.

Dated: March 17, 2010



Richard A. Rothschild

**DECLARATIONS OF
WESTERN CENTER'S
PARTICIPATING ATTORNEYS**

**DECLARATIONS OF
WESTERN CENTER'S
PARTICIPATING ATTORNEYS**

**DECLARATION OF
JEN FLORY**

**DECLARATION OF
JEN FLORY**

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Declaration of Jen Flory

In Support of and Application for an Award of Advocacy and Witness Fees

I, Jen Flory, declare that if called as a witness, I would testify competently from first-hand knowledge as follows:

1. I am an attorney licensed to practice law in the State of California and participated in the Proceeding Nos. 2005-0203/2008-1579 on Timely Access to Non-Emergency Health Care Services on behalf of Western Center on Law & Poverty.
2. Attached to this declaration as Exhibit A is a copy of my resume.
3. I recorded the time I spent on this case either contemporaneously or at the end of each day. Attached to this declaration as Exhibit B is a summary of the work I performed on this case.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on March 4, 2009 in Los Angeles, California.


JEN FLORY

EXHIBIT A

EXHIBIT A

Jen Flory

California State Bar No. 239004

Admitted December 2005

EDUCATION

University of Southern California Gould School of Law, Juris Doctor, May 2005; GPA 3.5

Activities: Public Interest Law Foundation, President; National Lawyers Guild; Urban Leadership Forum

Honors: Miller-Johnson Equal Justice Award Recipient, Foundation of the California State Bar Public Service Scholarship, Adam Freeman Scott Memorial Grant Recipient

The Pennsylvania State University, Master of Arts, Comparative Literature, May 2000; GPA 3.97

Chapman University, Bachelor of Arts, *magna cum laude*, Spanish and English, May 1998; GPA 3.85

EXPERIENCE

Western Center on Law & Poverty, Los Angeles, CA

Staff Attorney

Oct. 2007- present

Specialize in medical debt, county indigent health programs, managed care, and immigrant access to health care. Co-counsel with other legal aid and private firms in litigation against state and county agencies on behalf of low-income Californians in areas of health and government benefits. Assist in other Western Center cases and support advocates in other legal services organizations preparing for litigation. Collaborate with state agencies in the implementation of new Medi-Cal and hospital billing regulations. Draft and provide technical assistance on legislation regarding medical debt. Draft regulation comments for federal and state government agencies. Provide technical assistance and trainings to other legal services advocates on medical debt and other health issues. Monitor the implementation of legislation mandating hospital financial assistance for uninsured and underinsured patients.

Skadden Fellow

Oct. 2005-Oct. 2007

Directed a project on health care affordability for low-income Californians. Convened a summit with nonprofit advocates, government representatives, and legislative staff members to strategize methods of minimizing medical debt and set policy priorities for the next year. Organized a medical debt workgroup to share best practices and generate solutions to common medical debt problems. Issues raised in the workgroup lead to proposed legislation to regulate dental providers' provision of medical credit cards. Drafted materials on medical debt for clients and health advocates and trained legal services advocates on defenses to medical bills. Directed a study of hospital financial assistance policies and drafted the resulting report. Preliminary results of the study were used to lobby for the passage of a law regulating maximum hospital charges for uninsured and underinsured patients. Hired and supervised law students.

Law Clerk/Project Coordinator

Summer 2003-Sept. 2005

Designed and coordinated a 2-year health advocacy project to secure and expand access to health care for survivors of politically-motivated torture. Conducted legal research and written briefing, designed and delivered trainings, and developed necessary materials to assist workers in torture treatment centers.

USC Immigration Clinic, Los Angeles, CA

Law Student Intern

Fall 2003-Spring 2004,

Spring 2005

Represented clients in asylum and other immigration cases under the guidance of a supervising attorney in hearings and asylum interviews. Translated Spanish documents submitted to the court. Coordinated expert witnesses for hearings and supplemental documentation in cases.

Los Angeles Center for Law & Justice

Fall 2004

Extern

Conducted client intake and research in preparation of unlawful detainer proceedings and affirmative slum litigation. Attended trials, assisted in witness preparation, and developed educational materials for clients on the unlawful detainer process.

American Civil Liberties Union of Southern California

Summer 2004

Law Clerk

Conducted research and developed strategy for litigation on behalf of the homeless. Drafted memoranda on preventing the criminalization of homelessness. Took declarations from individuals for class-action lawsuit. Drafted a federal appellate brief for *Jones v. City of Los Angeles*, a lawsuit protecting the rights of homeless individuals residing on Skid Row.

Cerritos College, Norwalk, CA
Fullerton College, Fullerton, CA

Sept. 2001-Aug. 2002

Jan. 2001-Aug. 2002

Adjunct Faculty

Taught English composition using student-centered pedagogical methods. Developed own courses to adhere to departmental course standards. Taught critical thinking, analysis, and academic writing skills through the use of cultural criticism. Received positive to outstanding evaluations from students and faculty.

The Pennsylvania State University, State College, PA

Aug. 1998 – May 2000

Teaching Fellow

Taught comparative literature and Spanish courses to undergraduates while participating in teaching seminars.

ACTIVITIES

Los Angeles County Bar Association, Los Angeles, CA

March 2009 – January 2010

Barristers Division, Pro Bono Chair

Organized a mortgage foreclosure crisis clinic involving hundreds of lawyers serving clients on Law Day, May 2, 2009. Also helped to connect volunteer attorneys with public interest agencies and served on the Barristers board.

USC Public Interest Law Foundation, Los Angeles, CA

May 2005 – January 2010

Advisory Board Member

Mentor student PILF board members on fundraising, working with law school administration, pro bono opportunities, finding jobs in the public interest community, and selecting grant recipients for summer funding and post-graduate fellowships.

Wage Justice Center, Los Angeles, CA

Fall 2007

Volunteer Attorney

Conducted legal research and drafted motion for wage claim enforcement case.

Legal Aid Foundation of Los Angeles, Los Angeles, CA

May 2006 – Nov. 2006

Volunteer Attorney

Assisted low-income consumers in determining next steps to take in dealing with bills, collection notices, or summons on a monthly basis until the closure of the Debt Crisis Clinic.

Neighborhood Legal Services, El Monte, CA

Sept. 2003-Jan. 2004

Law Student Volunteer

Assisted litigants with wage and hour claims and prepared expungement documents on a biweekly basis in the Employment Rights Self-Help Clinic.

Public Counsel, Los Angeles, CA

Oct. 2002-April 2003

Law Student Volunteer

Advocated for homeless and low-income individuals in informal negotiation with social service officers to secure available cash aid and food stamps 1-2 times per month in the Homelessness Prevention Project.

Taller San José, Santa Ana, CA

Oct. 2001-May 2002

Volunteer Teacher

Taught English GED courses to young adults who dropped out of high school due to criminal activity or pregnancy.

SPECIAL SKILLS

Proficient in written and spoken Spanish.

EXHIBIT B

EXHIBIT B

Date	Description	Hours
2/7/2008	Reviewed authorizing legislation and statutes	1
	Researched judicial deference on quasi-leg actions and the legality of the	
2/21/2008	finalized regulations	2
6/30/2008	Spoke w/ E. Landsberg re stakeholder process	0.4
7/2/2008	Reviewed docs sent by DMHC for stakeholder process	0.3
7/2/2008	Divided up issues for proposal w/ E. Landsberg & A. Rubenstein	0.3
7/21/2008	Drafted proposals for issues #5-7	3.5
7/21/2008	Went over draft proposals and problems w/ E. Landsberg & A Rubenstein	1.2
7/22/2008	Revised issues #5-7	2.2
7/23/2008	Reviewed compiled version of reg proposals	0.5
7/24/2008	Reviewed comments and finalized reg proposal	0.2
8/5/2008	Reviewed other org's proposals	1.5
8/6/2008	Began comments/positions on other proposals	1.8
8/7/2008	Finished comments to issues #5-7	1.8
11/19/2008	Drafted comments to informal revised regs re compliance and other standards	3
2/17/2009	Drafted comments to formal revised regulations	0.6
2/20/2009	Discussed changes in new version of regs w/ E Landsberg and position we should	0.2
2/23/2009	Revised comments and finalized letter	1.2
6/1/2009	Previewed portions of draft of final regs and gave E Landsberg input on changes	0.8
6/22/2009	Reviewed final text of regs for comment	0.8
6/23/2009	Reviewed DMHC response to previous comments and drafted comments to revisi	2
6/25/2009	Revised and finalized WCLP comments to DMHC second draft regs	1
10/6/2009	Reviewed 4th round of timely access revisions and drafted WCLP comments	1.5
10/8/2009	Added additional points to comments	1
10/13/2009	Finalized WCLP comments	0.5
Total		29.3

**DECLARATION OF
ELIZABETH LANDSBERG**

**DECLARATION OF
ELIZABETH LANDSBERG**

Declaration of Elizabeth Landsberg

In Support of Motion for Consumer Participation Program Fees

I, ELIZABETH LANDSBERG, declare that if called as a witness, I would testify competently from first-hand knowledge as follows:

1. I am an attorney licensed to practice law in the State of California.
2. I graduated from UC Berkeley, Boalt Hall School of Law May 1998 and was admitted to the California bar in December 1998.
3. After law school I served as the Ruth Chance Law Fellow at Equal Rights Advocates, a public interest women's law center in San Francisco, California from 1998 to 1999.
4. From 1999 to 2000 I served as a law clerk to Federal District Court Judge Martha Vázquez, in New Mexico.
5. From 2000 to 2005, I was the Supervising Attorney for the Health Rights Hotline, a project of Legal Services of Northern California (LSNC). In addition to supervising the Hotline staff who fielded individual calls from health care consumers, I analyzed data collected from the calls, identified systemic policy issues and advocated for needed change.
6. In January 2006 I joined the Western Center on Law & Poverty in 2006 as a legislative advocate specializing in health care issues. I do legislative and budget advocacy in the areas of Medi-Cal, the uninsured, medical debt, managed care, and other health issues affecting poor Californians. I am still employed at the Western Center today.
7. I recorded the time I spent on these regulations either contemporaneously or at the end of each day. Attached to this declaration as Exhibit B is a summary of the work I performed on these regulations.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on March 11, 2010 in Sacramento, California.

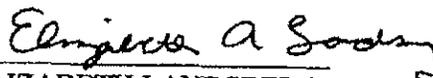

ELIZABETH LANDSBERG

EXHIBIT A
(Omitted)

EXHIBIT A
(Omitted)

EXHIBIT B

EXHIBIT B

ELIZABETH LANDSBERG

Date	Description	Hours	
1/31/06	Received CAHP's proposed changes to regs., Health Access proposed version, called HRH to join consumer pre-meeting, meeting of advocates to discuss strategy at Health Access	2.5	
2/6/06	Meeting with CAHP, CMA, CAPG, CHA	2.2	
10/17/06	Read the discussion draft and had conference call with other advocates to discuss draft regs.	1.5	
10/24/06	Coversation with Doreena Wong from NHeLP about how draft regs interact with SB 853 C & L reqs, read AB 2179, old versions of regs., old consumer letters re: regs., reread over current draft of regs., talked to Beth C. re: C and L issues, drafted notes re: concerns, attended consumer advocate meeting with Steve Hansen to discuss draft regs.	5.3	
10/25/06	Email to HCA partners to get info on HealthyFamilies and Medi-Cal contract appointment times	0.2	
10/30/06	Read Shelley Rouillard's email on Medi-Cal contract times, looked up relevant MC regs., called K. Lewis to see if she had HFks, checked MRMIB website, emailed B. Abbott, emailed Laura Rosenthal at MRMIB re: appointment time req.'s in HFks	0.4	12.1
2/5/07	Printed and read new revised regs.	0.5	
2/13/07	Wrote query request and search HCA database for delayed care cases, emailed HCA group re: regs	0.3	
2/26/07	Read through HCA delay cases	0.8	
2/28/07	Rereading regs. and drafting comments, sent comments to HCA partners	4.7	
3/2/07	Reading comments from other consumer adovates	0.3	
3/3/07	Incorporating comments, suggestions from other consumer advocates	0.8	
3/4/07	Edited written comments and worked on hearing testimony	1	
3/5/07	Went to hearing on proposed regs., coordinated with other consumer advocates after meeting, finalized written comments and sent them	4.2	
7/17/07	Coordinated among HCA partners on reg comments	0.3	
9/5/07	Read revised regs.	0.6	
9/6/07	Read revised regs.	0.5	
9/7/07	Read revised regs and starting to draft letter/comments	0.4	
9/11/07	Drafted comments	2	
9/12/07	Drafted comments; finished draft and sent out to HCA senior advocates, talked to Ann re: HRH	2.5	
9/17/07	Prepared hearing testimony, coordinated with Doreena Wang and Ann Rubinstein	1	
9/18/07	Coordinated with Doreena, prepared for testimony, attendance at hearing and testifying	6.3	
9/20/07	Coordinating final arguments, editing	1.4	
12/11/07	Printed out new proposed regs & emailed HCA parnters that I would comment & begin reading new regs	0.4	
12/12/07	Read draft regs	0.8	

12/18/07	Coordination with other consumer groups, review of Depts. chart of comments and responses, drafting comments, sent draft comments to HCA partners	3	
12/19/07	Discussing comments with other advocates	0.5	
12/21/07	Finalized comments and submitted.	0.6	32.4
2/5/08	Pre-call with Health Access before meeting with Cindy Ehres, meeting with Ehres and other DMHC staff re: 12/07 regs.	2.5	
3/26/08	Timely access testimony prep for Senate Health Committee hearing.	2	
3/27/08	Attended hearing and testified re: timely access regs.	2	
6/27/08	Discussion with Ed Heidig re: timely access reg process.	0.2	
6/30/08	Stakeholder meeting with Dept. on reg process and principles and post meeting with consumer advocates. Email to HCA advocates on process and asking who would like to coordinate.	3.3	
7/1/08	Email to Dept. personnel re: process.	0.3	
7/11/08	talked with Ed Heidig re: process	0.2	
7/20/08	Drafting proposal for issue 1	1	
7/21/08	Drafting proposals for issues 1 & 2, call with J Flory and A Rubenstein.	3.5	
7/24/08	Finalizing timely access proposals and submitting them.	1.5	
8/13/08	Talked to Beth Abbot re: process and format for responding to proposals.	0.2	
8/18/08	Printing draft responses on issues 3 & 4, reading proposals for issue 3, editing response.	0.8	
8/19/08	Printing comments from CHA, CPEHN. Drafting response on issue 1. Starting response on issue 2.	2.8	
8/20/08	Finished draft response on issue 2, reviewed response on issues 4, 5, 6 & 7 and sent suggested edits to J Flory and A Rubenstein. Editing all responses.	3.3	
8/21/08	Finalized all 7 responses and sent them to the dept.	1.5	
9/2/08	Reviewing responsive positions.	1.5	
9/3/08	DMHC meeting on issue 1. Discussion with other consumer advocates, B Cappell, E Abbott, A Rubenstein.	3.8	
9/4/08	DMHC meeting on issue 2.	2.5	
9/10/08	Meeting on issues 3 & 4, coordination with other consumer advocates, issue 4, review of issue 5-7 proposals and responses, some materials sent by participants.	3.7	
10/30/08	Meeting with Rick Martin, Tim LeBas, Beths re: proposed informal regs.	1	
11/4/08	Call with J Flory and A Rubenstein re: proposed informal regs.	0.5	
11/19/08	Reviewing set of informal draft regs, emails/calls with Peter Schroeder, Doreena Wong, Jen Flory re: draft regs. Drafted comments on subsections (a)-(c). Reviewed J Flory's comments on (d)-(h), sent to HCA consumers for feedback and sign-on.	3.5	
12/10/08	Meeting with Ed Heidig re: timely access regs & dicount plan regs	1	

2/20/09 Reading regs, commenting on draft letter, preparing testimony.	2
6/1/09 Got email from R Martin at DMHC re: revisions to regs; sent to J Flory and discussed them; set up meeting with R Martin to discuss.	0.3
6/3/09 reviewed proposed As to regs	0.4
6/4/09 Call w/R Martin and S Crammout from DMHC and B Capell re: proposed As. Noted consumer concerns.	1
7/28/09 Reviewed 7/23/09 amendments and regs and emailed J Flory.	0.3
10/13/09 Reviewed new draft regulations and comment letter.	0.5
10/14/09 Sent in timely access 4th round reg comments	0.1
Total Hours	92.2

**COMMENTS AND OTHER DOCUMENTS
SUBMITTED BY WESTERN CENTER ON LAW
AND POVERTY TO DEPARTMENT OF
MANAGED HEALTH CARE CONCERNING
TIMELY ACCESS REGULATIONS**

**COMMENTS AND OTHER DOCUMENTS
SUBMITTED BY WESTERN CENTER ON LAW
AND POVERTY TO DEPARTMENT OF
MANAGED HEALTH CARE CONCERNING
TIMELY ACCESS REGULATIONS**

WESTERN CENTER ON LAW & POVERTY

October 13, 2009

Lucinda Ehnes, Director
Department of Managed Health Care
Office of Legal Services
Attn: Regulations Coordinator
980 9th St., Ste. 500
Sacramento, CA. 95814

Re: Timely Access to Non-Emergency Health Care Services, Control No. 2008-1579, Fourth Comment Period

Dear Ms. Ehnes,

Western Center on Law & Poverty, Health Rights Hotline, National Health Law Program, Fresno Health Consumer Center, and Neighborhood Legal Services offer these comments on proposed regulations on Timely Access to Non-Emergency Health Care Services, Control No. 2008-1579. These organizations are members of the Health Consumer Alliance, a collaborative of legal services organizations and statewide support centers providing direct health consumer assistance and policy advocacy on health care issues impacting California's low-income consumers.

Many of our initial comments to the proposed regulations were not adopted and we hope that you will again consider the comments we submitted for the first and second comment period. As we did not feel that any of the changes in the third comment period substantially affected the low-income clients we represent, we refrained from comment at that time. Similarly, in this letter, we are limiting these comments to the amended portions of the regulations that appear in the fourth set of draft regulations.

First of all, we are disappointed to see that the compliance reporting that health plans must file with the Department has been moved back a year to March 31, 2012, and the reporting period has been moved back to the year 2011. While we understand that this is due to the delay in finalizing the regulations, we remind the Department that the Legislature directed the Department to begin monitoring consumers' timely access to care back in **2002**, meaning that much of the benefit to the public has been delayed for a decade.

In subsection (c)(5)(G), we are disappointed to see that the standard allowing for an extension of the timely access standards has been downgraded from requiring that the professional determining that an extension of time be granted must now only "note" that the time will not have a detrimental impact on the enrollee's health rather than "document" this information. This is a lesser standard. As this subsection essentially waives consumers' rights, sufficient documentation of the rationale behind such waiver should be required, not just a note in the margin. Similarly, while we are pleased to see that in this same section the word "person" has been replaced with the term "health professional" in reference to who might be providing triage or screening services, only a "licensed health professional" should be allowed to determine

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when someone may be required to wait longer than the limits required by these regulations. An *unlicensed* health professional simply cannot determine when a longer waiting time will not have a detrimental impact on an enrollee's health. As such, we request that the clause "or the health professional providing triage or screening services" be deleted.

Additionally, while we have put forth our views on compliance reporting on multiple occasions, the new language in subsection (g)(2)(B) is still moving in the direction of allowing plans to self-monitor in a subjective fashion and lacks the uniformity that could help the consumer compare plans. The new language specifies that provider and enrollee reporting are sufficient to create reliable statistics. Providers have no incentive to report their failures, and enrollees, who may not know the timeliness standards they are entitled to, may underreport problems. Audits by outside entities, or at the very least, enrollee surveys based on Department-defined sampling and scripts would ensure more accurate reporting. Finally, the reference to Health & Safety Code 1367.03(f)(2) is circular in nature as that subsection of the statute requires the Department to promulgate adequate regulations that allow consumers to compare plans, which it has not done.

Sincerely,



Jen Flory
Elizabeth Landsberg
Western Center on Law & Poverty

Doreena Wong
National Health Law Program

Ann Rubinstein
Health Rights Hotline

Monica Blanco
Fresno Health Consumer Center

Barbara Siegel
Neighborhood Legal Services

WESTERN CENTER ON LAW & POVERTY

June 25, 2009

Lucinda Ehnes, Director
Department of Managed Health Care
Office of Legal Services
Attn: Regulations Coordinator
980 9th St., Ste. 500
Sacramento, CA. 95814

Re: Timely Access to Non-Emergency Health Care Services, Control No. 2008-1579, Second Comment Period

Dear Ms. Ehnes,

Western Center on Law & Poverty offers these comments on proposed regulations on Timely Access to Non-Emergency Health Care Services, Control No. 2008-1579. Western Center on Law & Poverty is a statewide legal services support center dedicated to advancing and enforcing the rights of low-income Californians in the areas of health, welfare, and housing.

We are disappointed that so few of our suggestions to the previous draft regulations were accepted, even those that were requested by multiple consumer organizations such as the shortening of the 48-hour urgent care timeliness standard. Nonetheless, we are limiting these comments to the amended portions of the regulations.

Provision of Services Out-of-Network

We are pleased to see the additional instructions to plans that they not merely refer patients to providers in neighboring services areas when there is a shortage of providers in a particular area, but that they now arrange for the provision of services with such non-network providers and that enrollees not be required to pay any more in co-pays, co-insurance, or deductibles that is provided in subsection (c)(7)(B).

Triage and Screening Requirement

The previous version of the regulations rightly set a ten-minute time limit for triage and screening services. That time limit has been raised to thirty minutes in subsection (c)(8). Thirty minutes is simply too long for a patient to wait for advice on whether they have an urgent condition. Many patients will be calling while injured or otherwise in order to avoid an unnecessary trip to the emergency room. These patients should not be punished for their efforts to avoid high cost medical care or their efforts to remain within their own health plans with a thirty-minute wait when they are sick or injured and do not know how serious their own condition is or the condition of their children. Such an increase in time to get through to someone who can advise a patient as to where they should go will only increase the number of patients heading to an emergency room for screening and triage services.

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Lucinda Ehnes, Director
Department of Managed Health Care
June 25, 2009
Page 2

Furthermore, increasingly many consumers no longer have land-based telephone lines and to the extent that some providers' screening and triage services require a patient to wait on hold, these consumers are far less likely to wait on hold for thirty minutes while calling from a cell phone. Some of these consumers have very limited minutes on their cell phone plans or are not in areas where the cell phone connection is not strong enough to stay connected the entire time. Hanging up or losing connection often moves the caller to the back of the line.

EOC Disclosure Requirement

We fail to understand why the revised regulations no longer require the evidence of coverage to describe the plan's timely access standards and instead places them in plan newsletters or other enrollee communications. While an annual disclosure of the requirements in a separate mailing may alert consumers, few consumers read everything their plan sends them, especially as many plans send out a variety of materials including random newsletters and marketing materials that are treated as junk mail. However, when consumers have questions or problems, many of them will turn to the EOC as that is the basic contract between the consumer and the health plan. While few people read the EOC from cover to cover, this is an important reference material that should have important rights within the document.

As we have communicated during this regulatory process, giving consumers benchmark expectations about how long they should expect to wait for a particular type of care is powerful indeed. Having timely access standards but not communicating them to consumers will undermine their purpose as well as the compliance monitoring process which relies in part on consumer complaints. We strongly urge that the standards themselves be included in the EOC.

PPO Network Compliance Monitoring

Subsection (d)(2)(F) has a technical error in that it should refer to the renumbered subsection (d)(2)(A) and (D) rather than the old (d)(3)(A) and (D) which no longer exists.

Finally, we urge the prompt finalization of these regulations as consumers have been waiting far too long for set standards of timely access to care. Thank you for your consideration of these comments.

Sincerely,

Jen Flory
Elizabeth Landsberg
Western Center on Law & Poverty

Testimony of Elizabeth Landsberg, Western Center on Law and Poverty

**Senate Health Committee Information Hearing:
Consumer Protection under the California Department of Managed Health Care:
Adequacy of Implementation and Enforcement
March 27, 2008**

Timely Access to Care Regulations

I have been asked to address three issues:

- 1) The extent to which the regulation process considered consumer concerns,
- 2) Whether the Department inappropriately ceded responsibility to the health plans in developing the regulations, and
- 3) The practical impact of the proposed regulations on consumers.

I think it important to give a backdrop of the importance of timely access to care. Western Center is part of the Health Consumer Alliance which includes nine local Health Consumer Centers which help low-income people in thirteen counties obtain essential health care. Consumers regularly call our Health Consumer Centers with problems accessing health services in a timely manner. We hear stories of people who cannot get an appointment for weeks or months, problems getting a timely referral for needed specialty services, and problems even getting advice and triage by phone. Sometimes a consumer was initially able to get an appointment but then had it repeatedly rescheduled. We also see delays in care due to language barriers, including patients being told to come back with their own interpreters or having their appointments re-scheduled for lack of an interpreter.

In terms of **consumer input into the regulatory process**, consumer groups primarily participated through the formal public rulemaking process. A handful of consumer groups submitted comments to the various iterations of the proposed regulations and testified at the hearings. I can tell you we were far outnumbered by plan, medical group and provider groups and while that is not an imbalance of the Department's making I cannot help but wonder if the many industry voices weren't given more weight than our fewer consumer voices.

The Department began the formal rulemaking process in 2004 without resolution and stopped the process. In the fall of 2006, the Department convened a series of stakeholder meetings to discuss the regulations and their approach moving forward. One of those meetings was with consumer advocates. Several consumer advocacy organizations attended and we both heard the Department's approach in moving forward on the regulations and had an opportunity to voice our concerns. The formal rulemaking process commenced once again in 2007 with three sets of proposed regulations. I would say that until the last iteration I felt that consumer groups were listened to on some issues. In particular the attorney working on the regulations in 2006 and at least part of 2007 incorporated some of our suggestions regarding office wait times, time-elapsd standards and compliance monitoring systems. On other issues our repeated entreaties yielded few results. And, while reasonable minds can certainly disagree on how to ensure timely access

to care, there was a particular issues where the Department misled consumer advocates. During the language access regulations, consumer advocates raised the issue of timely provision of language services and were told that issue would be handled as part of the timely access package. Western Center and two other consumer groups stated our view at one of the 2007 hearings that the two obligations had to be read together – that if a consumer should get an appointment within a certain number of days or weeks, that meant an appointment with an interpreter. Department staff at the hearing acted surprised by this suggestion and disagreed. I find this a disturbing example both of the Department’s failure to make good on its assurances and its failure to consider consumer needs. For a Spanish or Russian speaker, a timely appointment where you can’t communicate with your doctor is of little use.

And, then of course the December 2007 version of the regulations was the biggest way consumer voices were discounted. This last version was a radical departure from earlier versions and many of the components we had been working on for years.

That brings me to the **second question** and on this I would say unequivocally that the Department ceded responsibility to the health plans. AB 2179 requires the Department to “adopt regulations to ensure that enrollees have access to needed health care services in a timely manner [and] develop indicators of timeliness of access to care.” Rather than providing clear standards as required, the December 2007 version left it up to the plans to decide what is timely for a given type of care. We went, for example, from a standard of 24 hours for an urgent primary care appointment to each plan being able to set its own standard “consistent with professionally recognized standards of practice.” Our fundamental disagreement is that while recognizing there are professionally recognized standards which the plans’ standards would be measured, the Department abdicated its charge by the Legislature to determine those standards. I can’t comprehend why a consumer with Blue Cross should have a different standard of care than a consumer with Health Net.

This is critical to the final question posed to me – **the impact of the regulations on consumers**. A right is only meaningful and can only be asserted by someone who knows about it. It would be a powerful tool indeed for a consumer to know she should be able to get a preventive appointment within three weeks. The December 2007 regulations would not have allowed this as different plans could have had different standards – much more difficult to educate on. We have always been willing to have a conversation about what the given timeliness standards should be but think it critical that there be consistent standards that we can educate consumers about.

Consumer advocates will continue to push for meaningful, knowable, enforceable standards for consumers as charged by this Legislature. Thank you.

WESTERN CENTER ON LAW & POVERTY

February 23, 2009

Department of Managed Health Care
Attn: Emilie Alvarez, Regulations Coordinator
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Legislative Advocate
Mike Moynagh
Legislative Advocate

Bay Area

S. Lynn Martinez
Attorney at Law

**Re: Timely Access to Health Care Services, Control 11-12-08
Draft Text**

Dear Director Ehnes:

On behalf of National Health Law Program and the Western Center on Law and Poverty, we submit these comments in response to the Department of Managed Health Care's proposed regulations on timely access to health care services. Our organizations are the support centers that provide statewide policy advocacy for the Health Consumer Alliance (HCA) – a partnership of consumer assistance programs operated by nine local Health Consumer Centers that cover thirteen counties in California. HCA's mission is to help low-income people obtain essential health care.

Overall, the Department has fulfilled the requirements of AB 2179 (Health & Safety Code § 1367.03) by imposing time-elapsed standards for appointment times, requiring that consumers have access to triage and screening, and ensuring that Limited English Proficient (LEP) consumers have access to an interpreter within the time-elapsed standards. As you know, we have engaged in this process with the Department and other stakeholders for many years now and think this version of the regulations includes clear standards for consumers which will help us educate them and enforce their rights.

While we appreciate these critical protections for consumers in accessing timely care, we do continue to have some concerns, including exempting or applying different standards to dental and vision plans, no uniform, objective standards for compliance monitoring, and allowing plans to effectively opt out of compliance entirely by permitting them to write their own alternative standards to the time-elapsed standards.

Standards for Timely Appointments

We applaud the Department for returning to regulations with time-elapsed standards for appointments. They are the only standard which meets the statutory requirements and the only standard which are understandable and enforceable for consumers

The timeframes for non-urgent care are appropriate, but we have serious concerns that the Department has increased the timeframe for urgent care not requiring prior authorization to 48 hours in 1300.67.2.2(c)(5)(A). We had advocated that the

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timeframe urgent care appointments be 24 hours and indeed earlier draft regulations set the urgent time at 24 hours.

We understand that the Medi-Cal managed care contracts require urgent primary care appointments within 48 hours, but that should be only one consideration and is outweighed by other factors.

Most importantly, a consumer with an urgent primary, mental health, or dental need may not be able to wait more than a day before suffering serious harm to their health. Under the Department's own definition, urgent care is needed when "the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb or other major bodily function . . ." Cal. Health & Safety Code §1367.01(h)(2). Such conditions require care within 24 hours. Moreover, there are other applicable standards requiring urgent care within 24 hours. For example, Medi-Cal Specialty Mental Health Service standards for urgent care state that each plan shall make mental health services to treat a member's urgent condition available 24 hours a day, seven days per week. The Department of Mental Health contracts with mental health plans mandate that the plans "make all medically necessary covered services available in accordance with Title 9, CCR, Sections 181 0.345 and 181 0.405 with respect to: The availability of services to meet beneficiaries' urgent conditions as defined in Title 9, CCR, Section 1810.253, 24 hours a day, 7 days a week." We strongly urge the Department to return to a 24 hour standard for urgent care appointments.

We are also concerned that the timeframe for urgent care appointments for services requiring prior authorization has been extended to 96 hours in 1300.67.2.2(c)(5)(B). Previous versions had this timely access standard at 72 hours, and we do not understand why another day was added for inherently urgent health situations which again, under the Department's own definition will lead to a serious health threat if not addressed. Frankly, we are also perplexed about what type of urgent care would require prior authorization.

Similarly, in 1300.67.2.2 (c)(5)(G), the provision for extension of the applicable waiting time should be modified to include a requirement that the health care provider or triage services provider has also determined and documented that a longer waiting time will not cause additional pain to the enrollee. The determination only that a longer waiting time will not have a detrimental impact on the health of the enrollee fails to take account of additional and unnecessary pain that might be experienced as a result of the delay.

The definition of appointment waiting time rightly measures the time from the request to the earliest offered date and includes time for authorization and other requirements.

Dental and Other Specialty Care Plan Standards

These regulations would not apply the time-elapsed or compliance standards to vision, chiropractic, and acupuncture plans. We do not understand the legal rationale behind treating these specialty plans differently. The Department regulates plans that provide all types of health care so it cannot choose not to include all types of health care in the regulations. AB 2179 stated: "It is the intent of the Legislature to ensure that all enrollees of health care service plans and health

insurers have timely access to health care.” This is not limited to enrollees in non-specialty health care services plan; it extends to all enrollees, as the regulation itself should. Subsection 1367.03(a) requires that the Department consider “waiting time to speak to a qualified healthcare professional who is trained to screen or triage an enrollee who may need care” and “timeliness of care in an episode of illness, including referral time and obtaining other services, if needed” as indicators of timeliness to care. Neither of these standards is limited to a restrictive view of health care. Dental health, mental health, and all types of health conditions require care by a qualified healthcare professional. All types of health conditions can also induce an episode of illness. The Department must ensure that enrollees in all the plans it regulates have timely access to care by imposing the same standards both in appropriate wait times and in compliance monitoring to ensure that plans are abiding by the time-elapsd standards.

As to the separate time-elapsd standards for dental, we are glad to see that there are standards for dental services because of the link between dental and overall health. However, again, we urge that all urgent care be provided within 24 hours and not the 72 hours as permitted in this subsection. We are also concerned that the standard for non-urgent care is more than 7 weeks. This is a long time to wait to have a cavity filled for example, even if it has not yet caused an infection or toothache rendering it an urgent condition.

Language Access

We commend the Department for the inclusion of subsection (c)(4) which requires a interpreter at the time of the appointment – a critical and statutorily required protection for the equal treatment of LEP consumers.

Language requirements must also be incorporated into subsections (d) Quality Assurance Processes and (e) Enrollee Disclosures and Education. The language access regulations refer to quality assurance standards, but the provisions in this section provide for clearer guidance regarding accessibility, availability, and continuity of covered health care services. Moreover, any quality assurance processes should assess the timeliness of the provision of interpreter services. Subsection (e) regarding notice of the timely access standards, how to access the triage and screening service, and how to obtain assistance in a person’s language, is also important to ensuring these regulations incorporate the needs of LEP consumers. Accordingly, we suggest the following additions to incorporate the Language Access regulations with these regulations:

(d) Quality Assurance Processes. Each plan shall have ...by this Act and this section, and section 1367.04 and section 1300.67.04 of title 28.

(e) Enrollee Disclosure and Education.(1) Plans shall include in all evidences of coverage in accordance with this Act and 1367.04 and section 1300.67.04(c)(2)(F).

Triage and Screening Services

The regulations rightly require that plans provide or arrange for the provision, at all times, of triage and screening services and that the wait time for such services not exceed ten minutes. It should be clarified that if a provider uses email as a way for consumers to communicate with a

trained health care professional a provider using email must respond within 10 minutes. Further, we are perplexed by the addition of subsection 1300.67.2.2 (c)(10) which allows a provider to extend the waiting time to triage beyond ten minutes after an "initial assessment." If the provider has already assessed the health needs of a consumer, it would seem they would have sufficient information to triage them.

The one telephone time standard that does not "ensure that enrollees have access to needed health care services in a timely manner" as required by §1367.03(a) is subsection (c)(9). It requires dental, vision, chiropractic and acupuncture plans to ensure their providers have a telephone service or machine with instructions on how to obtain urgent care "including, *when applicable*, how to contact to another provider who has agreed to be on-call to triage by phone, or if needed, deliver urgent or emergency care." Emphasis added. The use of the phrase "when applicable" suggests that not all providers would have to provide a number for a provider to provide triage and screening services. As with the time-elapsed standards, we are unclear of the statutory basis for imposing a different triage standard on certain types of specialty plans. Subsection 1367.03(a)(3) makes it clear that a key indicator of timely care is telephone triage times. Consumers are not doctors and need help to determine whether they are in need of urgent or emergency care -- including urgent or emergency dental or vision care. As with full-service health plans and mental plans, dental and vision plans should be required to ensure that their enrollees have access to a qualified professional who is trained to screen and triage.

Compliance Monitoring

Monitoring compliance with the timely access standards is required by the statute and critical to ensuring that these standards are meaningful. We strongly object to the quality assurance processes as outlined in subsection (d) as they still grant health plans far too much discretion in determining their own compliance with the timely access standards. We have asked multiple times that all plans be subject to the same uniform and objective standard, such as anonymous telephone audits of providers.

Furthermore, even assuming that all plans come up with methodology that is sufficiently valid and reliable, if each plan uses a different methodology, consumers will have no way of comparing the results against each other as is required by the mandate of Health & Safety Code § 1367.03(f)(2): "The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards." In short, consumers must be allowed to compare apples to apples, both across plans, and across time. While all of the measurements in subsection (d)(3) may be good information to gather, none of them rise to the uniform, objective standard that would truly protect and inform the consumer. In the event that enrollee surveys are conducted, however, vulnerable populations, such as LEP and communities of color, must be targeted specifically as these communities often have greater barriers to accessing care in a timely manner and are often less likely to complain when they cannot. Any surveys must be translated into the plans' threshold languages.

Also, subsection (d)(4) should have specific standards for corrective action plans in the event of non-compliance. We support the previous versions of the timely access regulations which require

health plans to respond immediately and correct deficiencies within 60 days, with an additional 60-day extension if a corrective action plan is filed which would increase timely access of enrollees. The current version has no measurable standards for corrective actions, thus does nothing to protect the consumer.

Contracts Between Plans and Provider Group

Subsection (f), which requires contracts between health plans and health care providers contain provisions that assure compliance with the timely access standards, is actually less specific than the corresponding statute section, Health & Safety Code § 1367.03 (f)(1). The statute states the same *and* requires reporting by health care providers to health care services plans. We are not aware of other regulations that are more vague than the enacting statute. If DMHC is not willing to mandate what providers should report to the plans, we see no reason for this subsection as it only undermines the mandate of the statute. We would urge DMHC to at least minimally outline what such provider reports should contain and how often they should be done.

Enrollee Disclosure and Education

We support the regulations in subsection (e) regarding enrollee disclosure and education regarding information on the plan's timely access standards, obtaining assistance when timely access standards are violated, and the provision of a telephone number for triage and screening services. Consumers need clear information about what the timeliness standards are and how to access triage services. The provision in subsection 1367.2.2 (e)(2) which allows the member card to only have the customer service number and not the triage number undermines this goal of clear consumer education. Consumers may not know about the availability of telephone triage services so will not know that if they call customer service they can get the number for triage. Only requiring the telephone triage number itself will ensure that consumers both know of the availability of these critical services and how to access them. We further ask that such information be provided to enrollees in the appropriate language as is referenced above in the section on Language Access.

Alternative Time-Elapsed Standards

We strongly oppose any alternatives for time-elapsed standards that are done on a plan by plan basis as provided for in subsection (g). Again, Health & Safety Code § 1367.03(f)(2) requires that consumers be able to compare health plans' adherence to the timely access standards. To allow some plans to opt out of these standards and set their own completely eviscerates the intent of the Legislature and the ability of consumers to compare plans. Health & Safety Code 1367.03 does not give health plans the authority to set their own standards. Subsection (c) does give the *Department* the authority to develop alternative standards but only if the *Department* demonstrates that another standard would be more appropriate than "the time elapsed between when an enrollee first seeks health care and obtains it."

Health plans and providers have been well represented in this entire regulatory process. As consumer advocates, we fail to see why DMHC would be inviting further delay or weakening of the standards in the regulations themselves by offering to the plans that they may not even need to

comply with the timely access standards if they could come up with an acceptable alternative. Indeed, if the health plans had clinical evidence that would require the modification of one of the timeliness standards, they have had ample opportunity to submit it to the Department to support changing one of the standards. Moreover, if one plan can make the case that a timeline should be changed based on clinical evidence, that should apply to all plans not just one. Subsection (g) must be deleted in its entirety.

Additionally, it was suggested at the February 23, 2009 hearing that Medi-Cal and Healthy Families plans be deemed in compliance with these regulations if they are complying with the Medi-Cal and Healthy Families standards on timeliness. We strongly oppose any suggestion granting the low-income beneficiaries of these programs fewer protections than other people who use managed care.

Network Adequacy Reporting

We are pleased to see the information regarding a plan's provider network and enrollment be included in the timely access compliance reporting as outlined in subsection (h)(2)(G). Such information will not only help in determining whether a plan is in compliance with the timely access standards but will also further enable consumers to compare networks across plans, leading to more transparency in the health care system as a whole as to what consumers can expect for their purchase.

Provider Access

Subsection (c)(7)(B) requires that, if a plan is in an area with a shortage of a type of provider, it must ensure compliance with the timeliness standards by "referring enrollees to available and accessible providers in neighboring areas." Subsection (d)(2) requires that if there is not a network provider that can meet the timeliness standards, the plan must refer to a non-contracted provider. In both cases, the obligation on the plan should be to "arrange" the care with an out-of-area or out-of-network provider rather than to merely "refer" the consumer to a provider who may or not be willing to take them. Language should be added to ensure that the enrollee is not charged more than her usual cost sharing if she is forced to go out of network because of the plan's lack of providers. Furthermore, such arrangements must be documented in writing and given to the enrollee before or at the time of treatment as care out-of-network is inherently vulnerable to billing errors or disputes.

Thank you for your consideration of these comments. We think that with changes to the urgent care standard, the standards and triage system for specialty plans, and the compliance monitoring process together with the deletion of the provision allowing alternate standards, the intent and letter of AB 2179 will be fulfilled.

Sincerely,


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November 21, 2008

Department of Managed Health Care
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Office of Legal Services
980 9th Street, Suite 500
Sacramento, CA 95814

**Re: Timely Access to Health Care Services, Control 11-12-08
Draft Text**

Dear Director Ehnes:

On behalf of Health Rights Hotline, Neighborhood Legal Services, the National Health Law Program (NHeLP), and the Western Center on Law and Poverty, we submit these comments in response to the Department of Managed Health Care's proposed regulations on timely access to health care services. Our organizations are members of the Health Consumer Alliance (HCA) – a partnership of consumer assistance programs operated by nine local Health Consumer Centers that cover thirteen counties in California. HCA's mission is to help low-income people obtain essential health care. NHeLP and Western Center provide statewide policy advocacy for these consumer centers.

Overall, the Department has fulfilled the requirements of AB 2179 (Health & Safety Code § 1367.03) by imposing time-elapsd standards for appointment times, requiring that consumers have access to triage and screening, and ensuring that Limited English Proficient (LEP) consumers have access to an interpreter within the time-elapsd standards. While we appreciate these critical protections for consumers in access timely care, we do continue to have some concerns, including exempting or applying different standards to dental and vision plans, no uniform, objective standards for compliance monitoring, and allowing plans to effectively opt out of compliance entirely by permitting them to write their own alternative standards to the time-elapsd standards.

Standards for Timely Appointments

We applaud the Department for returning to regulations with time-elapsd standards for appointments. They are the only standard which meets the statutory requirements.

The timeframes for non-urgent care are appropriate, but we have serious concerns that the Department has increased the timeframe for urgent primary care to 48 hours. We had advocated that the timeframe for both urgent mental health and urgent primary care appointments be 24 hours and indeed earlier draft regulations set the urgent primary time at 24 hours.

We understand that the Medi-Cal managed care contracts require urgent primary care appointments within 48 hours but that should be only one consideration and is outweighed by other factors. Most importantly, a consumer with an urgent primary or mental health need may not be able to wait more than a day before suffering serious harm to their health. Under the Department's own definition, urgent care is needed when "the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb or other major bodily function . . ." Cal. Health & Safety Code §1367.01(h)(2). Such conditions require care within 24 hours. Moreover, there are other applicable standards requiring urgent care within 24 hours. For example, Medi-Cal Specialty Mental Health Service standards for urgent care state that each plan shall make mental health services to treat a member's urgent condition available 24 hours a day, seven days per week. The Department of Mental Health contracts with mental health plans mandate that the plans "make all medically necessary covered services available in accordance with Title 9, CCR, Sections 181 0.345 and 181 0.405 with respect to: The availability of services to meet beneficiaries' urgent conditions as defined in Title 9, CCR, Section 1810.253, 24 hours a day, 7 days a week." We strongly urge the Department to return to a 24 hour standard for urgent primary and mental health appointments.

Similarly, in 1300.67.2.2 (c)(5)(G), the provision for extension of the applicable waiting time should be modified to include a requirement that the health care provider or triage services provider has also determined and documented that a longer waiting time will not cause additional pain to the enrollee. The determination only that a longer waiting time will not have a detrimental impact on the health of the enrollee fails to take account of additional and unnecessary pain that might be experienced as a result of the delay.

The definition of appointment waiting time rightly measures the time from the request to the earliest offered date and includes time for authorization and other requirements.

Dental and Other Specialty Care Plan Standards

These regulations would not apply the time-elapsd standard or requirement for telephone triage services to dental, vision, chiropractic, and acupuncture plans. We do not understand the legal rationale behind treating these specialty plans differently. The Department regulates plans that provide all types of health care so it cannot choose not to include all types of health care in the regulations. AB 2179 stated: "It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers have timely access to health care." This is not limited to enrollees in non-specialty health care services plan; it extends to all enrollees, as the regulation itself should. Subsection 1367.03(a) requires that the Department consider "waiting

time to speak to a qualified healthcare professional who is trained to screen or triage an enrollee who may need care” and “timeliness of care in an episode of illness, including referral time and obtaining other services, if needed” as indicators of timeliness to care. Neither of these standards is limited to a restrictive view of health care. Dental health, mental health, and all types of health conditions require care by a qualified healthcare professional. All types of health conditions can also induce an episode of illness. The Department must ensure that enrollees in all the plans it regulates have timely access to care by imposing the same standards.

During the stakeholder process, the dental plans explained that they already have timeliness standards for dental services. Just as with other conditions, consumers with dental conditions should know what a reasonable time to wait for an appointment is and must, under the statute, be able to get necessary care timely.

Language Access

We commend the Department for the inclusion of subsection (c)(4) which requires a interpreter at the time of the appointment – a critical protection for the equal treatment of LEP consumers. To ensure that this right to an interpreter is read in conjunction with the other timeliness standards we urge that this be made explicit with the following addition:

- (4) Interpreter services required by section 1367.04 of the Act and section 1300.67.04 of title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment consistent with all the sections of (c).

Language requirements must also be incorporated into subsections (d) Quality Assurance Processes and (e) Enrollee Disclosures and Education. The language access regulations refer to quality assurance standards, but the provisions in this section provide for clearer guidance regarding accessibility, availability, and continuity of covered health care services. Moreover, any quality assurance processes should assess the timeliness of the provision of interpreter services. Subsection (e) regarding notice of the timely access standards, how to access the triage and screening service, and how to obtain assistance in a person’s language, is also important to ensuring these regulations incorporate the needs of LEP consumers. Accordingly, we suggest the following additions to incorporate the Language Access regulations with these regulations:

- (d) Quality Assurance Processes. Each plan shall have ...by this Act and this section, and section 1367.04 and section 1300.67.04 of title 28.
- (e) Enrollee Disclosure and Education.(1) Plans shall include in all evidences of coverage in accordance with this Act and 1367.04 and section 130067.04(c)(2)(F).

Triage and Screening Services

The regulations rightly require that plans provide or arrange for the provision, at all times, of triage and screening services and that the wait time for such services not exceed ten minutes. Including email as a way for consumers to communicate with a trained health care professional meets the triage requirement by mandating that as with telephone, a provider using email must respond within 10 minutes.

The one telephone time standard that does not “ensure that enrollees have access to needed health care services in a timely manner” as required by §1367.03(a) is subsection (c)(9). It requires dental, vision, chiropractic and acupuncture plans to ensure their providers have a telephone service or machine with instructions on how to obtain urgent care “including, *when applicable*, how to contact to another provider who has agreed to be on-call to triage by phone, or if needed, deliver urgent or emergency care.” Emphasis added. The use of the phrase “when applicable” suggests that not all providers would have to provide a number for a provider to provide triage and screening services. As with the time-elapsd standards, we are unclear of the statutory basis for imposing a different triage standard on certain types of specialty plans. Subsection 1367.03(a)(3) makes it clear that a key indicator of timely care is telephone triage times. Consumers are not doctors and need help to determine whether they are in need of urgent or emergency care – including urgent or emergency dental or vision care. As with full-service health plans and mental plans, dental and vision plans should be required to ensure that their enrollees have access to a qualified professional who is trained to screen and triage.

Compliance Monitoring

Monitoring compliance with the timely access standards is required by the statute and critical to ensuring that these standards are meaningful. We strongly object to the quality assurance processes as outlined in subsection (d) as they still grant health plans far too much discretion in determining their own compliance with the timely access standards. We have asked multiple times that all plans be subject to the same uniform and objective standard, such as anonymous telephone audits of providers.

Furthermore, even assuming that all plans come up with methodology that is sufficiently valid and reliable, if each plan uses a different methodology, consumers will have no way of comparing the results against each other as is required by the mandate of Health & Safety Code § 1367.03(f)(2): “The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.” In short, consumers must be allowed to compare apples to apples, both across plans, and across time. While all of the measurements in subsection (d)(3) may be good information to gather, none of them rise to the uniform, objective standard that would truly protect and inform the consumer. In the event that enrollee surveys are conducted, however, vulnerable populations, such as LEP and communities of color, must be targeted specifically as these communities often have greater barriers to accessing care in a

timely manner and are often less likely to complain when they can't. Any surveys should be translated into the plans' threshold languages.

Also, subsection (d)(4) should have specific standards for corrective action plans in the event of non-compliance. We support the previous versions of the timely access regulations which require health plans to respond immediately and correct deficiencies within 60 days, with an additional 60-day extension if a corrective action plan is filed which would increase timely access of enrollees. The current version has no measurable standards for corrective actions, thus does nothing to protect the consumer.

Contracts Between Plans and Provider Group

Subsection (f), which requires contracts between health plans and health care providers contain provisions that assure compliance with the timely access standards, is actually less specific than the corresponding statute section, Health & Safety Code § 1367.03 (f)(1). The statute states the same *and* requires reporting by health care providers to health care services plans. We are not aware of other regulations that are more vague than the enacting statute. If DMHC is not willing to mandate what providers should report to the plans, we see no reason for this subsection as it only undermines the mandate of the statute. We would urge DMHC to at least minimally outline what such provider reports should contain and how often they should be done.

Enrollee Disclosure and Education

We support the regulations in subsection (e) regarding enrollee disclosure and education regarding information on the plan's timely access standards, obtaining assistance when timely access standards are violated, and the provision of a telephone number for triage and screening services. We only ask that such information be provided to enrollees in the appropriate language as is referenced above in the section on Language Access.

Alternative Time-Elapsed Standards

We strongly oppose any alternatives for time-elapsed standards that are done on a plan by plan basis as provided for in subsection (g). Again, Health & Safety Code § 1367.03(f)(2) requires that consumers be able to compare health plans' adherence to the timely access standards. To allow some plans to opt out of these standards and set their own completely eviscerates the intent of the Legislature and the ability of consumers to compare plans. Health & Safety Code 1367.03 does not give health plans the authority to set their own standards. Subsection (c) does give the *Department* the authority to develop alternative standards, but only if the *Department* demonstrates that another standard would be more appropriate than "the time elapsed between when an enrollee first seeks health care and obtains it."

Health plans and providers have been well represented in this entire regulatory process. As consumer advocates, we fail to see why DMHC would be inviting further delay or weakening of

the standards in the regulations themselves by offering to the plans that they may not even need to comply with the timely access standards if they could come up with an acceptable alternative. Subsection (g) should be deleted in its entirety.

Network Adequacy Reporting

We are pleased to see the information regarding a plan's provider network and enrollment be included in the timely access compliance reporting as outlined in subsection (h)(2)(G). Such information will not only help in determining whether a plan is in compliance with the timely access standards, but will also further enable consumers to compare networks across plans, leading to more transparency in the health care system as a whole as to what consumers can expect for their purchase.

Provider Access

Subsection (c)(6)(B) requires that, if a plan is in an area with a shortage of a type of provider, it must ensure compliance with the timeliness standards by "referring enrollees to available and accessible providers in neighboring areas." Subsection (d)(2) requires that if there is not a network provider that can meet the timeliness standards, the plan must refer to a non-contracted provider. In both cases, the obligation on the plan should be to "arrange" the care with an out-of-area or out-of-network provider rather than to merely "refer" the consumer to a provider who may or not be willing to take them. Language should be added to ensure that the enrollee is not charged more than her usual cost sharing if she is forced to go out of network because of the plan's lack of providers. Furthermore, such arrangements must be documented in writing and given to the enrollee before or at the time of treatment as care out-of-network is inherently vulnerable to billing errors or disputes.

Thank you for your consideration of these comments. If you have any questions, I can be reached at 916-442-0753 ext. 18.

Sincerely,

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Western Center on Law and Poverty

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December 21, 2007

Department of Managed Health Care
Attn: Emilie Alvarez, Regulations Coordinator
Office of Legal Services
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Timely Access to Health Care Services, Control No. 2005-0203

Dear Director Ehnes:

On behalf of the Community Health Advocacy Project, Consumer Center for Health Education & Advocacy, Fresno Health Consumer Center, National Health Law Program (NHeLP), Neighborhood Legal Services' Health Consumer Center of Los Angeles and the Western Center on Law and Poverty we submit these comments in response to the Department of Managed Health Care's (Department) proposed regulations on timely access to health care services. Our organizations are members of the Health Consumer Alliance (HCA) – a partnership of consumer assistance programs operated by nine local Health Consumer Centers that cover thirteen counties in both urban and rural parts of California. HCA's mission is to help low-income people obtain essential health care. NHeLP and Western Center provide statewide policy advocacy for these consumer centers on health care issues impacting low-income consumers.

Timeliness Standards

As consumer advocates we are dismayed by the radical departure the latest proposed regulations take from earlier approaches. The Department has gone from thorough regulations which would have given clear guidance to consumers and providers alike regarding what timely access to care is in different arenas and required statistically significant compliance monitoring and replaced them with an approach which leaves it up to individual health plans to decide what timely means.

The current proposed regulations do not fulfill the statutory requirements of AB 2179 (Health & Safety Code § 1367.03). AB 2179 requires the Department to "adopt regulations to ensure that enrollees have access to needed health care services in a timely manner [and] develop indicators of timeliness of access to care." Rather than providing clear standards as required, these proposed regulations are a shadow of their former self and leave it up to the various health plans to decide what is timely for a given type of care. We have gone, for example, from a standard of 24 hours for an urgent primary care appointment to each plan being able to set its own standard

“consistent with professionally recognized standards of practice.” It is baffling indeed that the Department would abandon the previously proposed clear standards while still conceding that there are professionally recognized standards. We cannot see this as anything but an abdication of the Legislature’s charge to develop indicators of timely care.

We are aware that many of the health plans, medical groups and provider groups that testified on the regulations argued that the number of timeliness indicators in the last version was unduly onerous. However, the current regulations would still require a full-service plan to set standards for primary care, specialty care, mental health, and ancillary care in the categories of routine, preventive and urgent care. So, the main difference is not that the plan no longer has many standards to adhere to and track but rather that plans can diverge drastically from one another in determining what is appropriate. The result is that consumers will not have a common benchmark for knowing that they should be able to get a particular type of care within a set amount of time. This undermines the fundamental goal of the authorizing statute.

We strenuously urge the Department to return to the previous approach of laying out specific time-elapsed standards applicable to all health plans. How can it be timely for one health plan to provide urgent care within 24 hours and another within a week? If this is not possible, but rather, as we believe, it is “consistent with professionally recognized standards of practice” that all health plans offer an urgent primary care appointment within 24 hours, this suggests a consistent standard should be applied to all plans. Consumers should have a common understanding of what to expect in getting a timely appointment for a given type of care.

Dental, Vision, Acupuncture and Chiropractic Care

Also deeply troubling is the Department’s abandonment of standards for dental, vision, acupuncture and chiropractic care. While the previous regulations had clear timeliness standards for these types of care they are nowhere in the new regimen. Full-service plans are no longer required to set standards in these areas even if they provide these types of care and specialty plans such as dental and vision plans are no longer subject to any timeliness standards. Our work with consumers has shown us what has been well documented – the link between dental health and overall health. Take the case of “James” who was served by one of our Health Consumer Centers. When he called the Center he was suffering from gastrointestinal and heart ailments related to his inability to eat because he only had five teeth and could not eat food to get the nourishment he needed. The fact that he could not get medically necessary dental care directly impacted James’ health. We implore the Department to include timeliness standards for dental care. Similarly, the regulations should include standards for vision, acupuncture and chiropractic care.

Telephone Triage Access

The telephone waiting times are a critical component of timely access and we agree that a consumer must be able to receive telephone triage within five minutes during office hours. However, we are very concerned with the vague requirement during non-office hours. Subsection (d)(5)(D) simply requires a triage line to “provide clear recorded instructions regarding how to obtain urgent or emergency care.” It is unacceptable for a consumer not to be

able to reach a triage doctor or nurse for guidance on whether to seek urgent or emergency care. We continue to request that providers be required to advise patients how to reach a qualified professional who is trained to screen and triage.

Compliance Monitoring

Monitoring compliance with the timely access standards is required by the statute and critical to ensuring that these standards are meaningful. As with the departure from time-elapsed standards, in the area of compliance monitoring the Department has taken a troubling about-face. Until this point the Department's proposed regulations laid out progressively more effective and clear methods of compliance monitoring. The July 2007 proposed regulations set forth a carefully developed and statistically valid survey method. The latest version scraps that careful work based on academic standards. Under the current proposal plans would monitor their own set timeliness standards through:

- (A) An annual, statistically valid enrollee satisfaction survey;
- (B) An annual provider satisfaction survey of at least 5% of the contracted providers; and
- (C) Monthly review of information from enrollee complaints and grievances, monitoring of provider performance and screening and triage.

Our letters on previous versions of the regulations have pointed to problems relying on consumer surveys, non-anonymous surveys and grievances, so we will not reiterate those though we continue to have these concerns. Further, we urge the Department to return to the statistically valid survey method.

Network Providers

Subsection (c)(4) would require plans to have systems in place to ensure that if there is no available provider within the enrollee's medical group, the plan offer her a provider within the plan's network. However, it would not require similar systems to provide an appointment with an out-of-network provider. If a consumer cannot get medically necessary care covered by her health plan in a timely manner, the plan should be required to find an appointment with an out-of-plan provider.

Language Access

In previous letters we have submitted regarding these regulations and in our testimony at the hearings we have laid out in detail the need for these regulations to reference the Language Assistance Plan regulations. We are deeply disappointed that the Department did not accept our recommendation to coordinate the two sets of regulations as you lead advocates to believe you would do. The weakening of these regulations will impact all managed care enrollees and will have particular ramifications for Limited English Proficient (LEP) enrollees who will be the most likely to experience delays in care because of the vague definition of "timely access" in the Language Assistance Plan regulations and the exclusion of any application of the new timely access regulation to the LEP population. Once again, we urge the Department to follow through

on your representations and coordinate these two critical sets of regulations as we outlined in detail.

We strongly urge the Department to rethink its current approach and return to specific time-elapsd standards to effectuate the requirements of AB 2179. Thank you for your consideration of these comments.

Sincerely,

Elizabeth A. Landsberg
Western Center on Law and Poverty

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National Health Law Program

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21 September 2007

Department of Managed Health Care
Attn: Regulations Coordinator
Office of Legal Services
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Timely Access to Health Care Services, Control No. 2005-0203

Dear Director Ehnes:

On behalf of the National Health Law Program (NHeLP), Neighborhood Legal Services' Health Consumer Center of Los Angeles, Protection & Advocacy, Inc., and the Western Center on Law and Poverty, we submit these comments in response to the Department of Managed Health Care's (Department's) proposed regulations on timely access to health care services. Most of our organizations are members of the Health Consumer Alliance (HCA) – a partnership of consumer assistance programs operated by nine local Health Consumer Centers that cover thirteen counties in California. HCA's mission is to help low-income people obtain essential health care. NHeLP and Western Center provide statewide policy advocacy for the local consumer centers on health care issues impacting low-income consumers.

Our Health Consumer Centers get calls from hundreds of consumers each year who are not able to get the care they need in a timely manner. We hear stories of consumers who cannot get an appointment for weeks or months, callers who repeatedly have their appointment rescheduled, problems getting a timely referral for specialty services, and problems getting advice by phone after their doctor's office is closed. We also see delays in care due to language barriers, including patients being told to come back with their own interpreters or having their appointments re-scheduled for lack of an interpreter. We see the real impact these problems have on consumers' health outcomes.

We appreciate the progress the Department has made in this version of the proposed regulations to ensure timely access to care as required by AB 2179 (Health & Safety Code § 1367.03). In particular the Department has clearly taken considerable effort in developing a statistically valid provider survey process. We still have concerns about these regulations including a number of the time-elapsd standards, the compliance monitoring methods, how these regulations intersect with the language access regulations, and consumer education.

We urge the Department to move expeditiously to finalize these critical standards. We strenuously disagree that the Department should "take a step back" and appoint a commission of

stakeholders to rethink the approach as suggested by numerous speakers at the hearing. All stakeholders have had ample time to come forward with alternative approaches. We support the Department's approach of putting in place specific time-elapsd standards for various types of care and are at a loss as to how an I-know-it-when-I-see-it standard as proposed by some stakeholders is in any way measurable or enforceable.

Standards for Timely Appointments

With some notable exceptions we believe that most of the timeframes set forth in the regulations comply with the requirements of AB 2179.

Primary Care Standards

We continue to support the primary care times and think it critical that a consumer be able to get an urgent primary care appointment within 24 hours. This version of the proposed regulations allows a primary care appointment to be made with an urgent care center. While urgent care centers are an important component in the health care system, they cannot and should not replace the need for consumers to have a medical home with a primary care provider. In most cases, an urgent care center will not have a consumer's medical records and will not have an established relationship with the consumer. Accordingly, we think it important that such centers only be used for urgent care appointments. If the Department decides over our objection to allow non-urgent, primary care to be provided through an urgent care center, the regulations must specify that in such cases, the consumer will not incur more cost sharing than if she was seen by her primary care provider. Subsection 1300.67.2.2 (c)(2)(A) already includes a description of a medical home. We suggest this language be designated as the definition of medical home and then that the primary care appointment standard state that an urgent care appointment can be made at an urgent care center only if there is no appointment time available with the consumer's medical home. Our suggested language is as follows:

A new term should be added to the definition list:

§ 1300.67.2.2 (b)(4) Medical home means the primary location or provider group to which the enrollee is assigned or has selected or where the enrollee regularly receives care.

The following changes should be made to the primary care standards:

§ 1300.67.2.2 (c)(2)(A) **Primary Care Accessibility.** An appointment shall be offered with a primary care physician or, if appropriate for the enrollee's health care needs consistent with good professional practice, with a physician assistant, nurse, practitioner, or certified nurse midwife, acting within his or her scope of practice, at the ~~primary care location or provider group to which the enrollee is assigned or has selected or where the enrollee regularly receives care~~ or at an urgent care center. enrollee's medical home. Urgent primary care appointments may be provided at an urgent care center if a provider from the enrollee's medical home is not available. If an enrollee receives care from an

urgent care center the enrollee's financial responsibility shall be limited to applicable copayments, coinsurance and/or deductibles that would apply had the enrollee seen a provider in the enrollee's medical home.

Full-service plans shall monitor for provider compliance with the following appointment waiting time standards for primary care, in-person or via electronic communications or telemedicine, consistent with the standard of care appropriate for the enrollee's needs

Dental Care Standards

The time standards set forth for dental care appointments continue to be too long and we are dismayed that the Department has not corrected these lengthy times in this version of the proposed regulations. As with urgent primary care, the time for urgent dental care should be changed from 48 to 24 hours. A consumer in intense pain from an infected tooth should not be expected to wait two days for an appointment; they should be seen within one day. Dental health is inextricably intertwined with one's health and should not be treated differently. Good oral health can prevent other conditions. Millions of Americans who treat or manage a range of diseases with medications may experience side effects that negatively effect oral health, e.g. xerostomia, known commonly as dry mouth, is a listed side effect on more than 400 medications. Without timely and adequate oral care, bacteria and plaque can accumulate in the mouth and make a person more vulnerable to gum disease and tooth decay.

The other dental care appointment times are also much too long. The Department proposes that an appointment for routine dental care may be given within 36 business days and for preventive dental care within 180 calendar days. As previously stated, these standards are notably "out of whack" with all the other standards and are hardly timely. They are also significantly longer than the standards current dental plans have on file with the Department. It does not make sense that while primary, specialty, ancillary, acupuncture, and chiropractic preventive care must each be provided in 22 business days, preventive dental care need not be scheduled for 180 days – a time period more than six times as long. While we recognize that the practice is that dental check-ups and cleanings are often scheduled every six months from one cleaning appointment to the next, an enrollee should not as a matter of course have to wait six months for a dental cleaning or other preventive dental care. Similarly, while most types of routine care would have to be provided within eight to twelve business days, the timeframe proposed for routine dental care is 36 business days (seven weeks) – three to four times as long. We propose that the timeframes for routine and preventive dental care be set at 12 business days and 60 calendar days respectively.

Mental Health Care Standards

Again, we are disappointed that the Department did not heed advocates' strenuous objection to the proposed 48-hour standard for urgent mental health care. Someone with extreme anxiety or depression or who is in crisis should not have to wait 48 hours for intervention. We reiterate that urgent mental health appointments should be given within 24 hours. Conforming the standard for urgent mental health with the standard for urgent physical health needs is in keeping with California's mental health parity law. It would also better align these timely access standards

with the Department of Mental Health's standards for mental health plans which require that services for urgent conditions be available 24 hours a day, seven days a week. 9 CCR §§ 1810.345 and 1810.405. Similarly, the Medi-Cal Specialty Mental Health Service standards require that plans make mental health services to treat a member's urgent condition available 24 hours a day, seven days per week. Individuals covered by a managed care plan who are in crisis should not have to wait longer than 24 hours to receive the mental health care that they need. We strongly encourage the Department to modify the standard for urgent mental health care to 24 hours at the longest. We also concur with the comments made at the hearing that all health plans should be required to have a mental health professional available 24 hours a day, seven days a week to speak to members in crisis.

Timely Telephone Access

The telephone waiting times are a critical component of timely access but this latest version of the regulations weakens this important area – demoting them from standards to guidelines. Consumers all too often wait for more than fifteen minutes on the telephone with their plan or provider during business hours. This may be particularly true if the plan is trying to identify an LEP enrollee's language and arrange for an interpreter.

Another concern we have is that the telephone waiting time of fifteen minutes during office hours has been effectively swallowed by the new exception that this does not apply “if no such qualified professional is available.” That language renders the standard meaningless by employing the circular reasoning that a consumer can talk to someone within fifteen minutes unless no one is available. It should be deleted as follows:

§ 1300.67.2.2 (c)(3)(A)(i)(I) During office hours, within 15 minutes ~~(or if no such qualified professional is available, the caller shall be advised of the approximate time a professional will return the call and what to do in an emergency);~~

The new language that applies to providers whose offices use answering machines in subsection (3)(A)(ii) also fails to “ensure that enrollees have access to needed health care services in a timely manner.” Cal. Health & Safety Code §1367.03(a). This language states that if a provider uses an answering machine to answer telephone calls, the office “shall attempt to contact the enrollee in a timely manner consistent with good professional practice.” As we submitted in our last set of comments, while the other standards have a specific time, this one is unworkably vague. The language instructing patients what to do in an emergency does not ensure that a patient will be able to talk to a provider. Many offices simply tell patients to call 911 which is appropriate for emergencies but not when patients need to consult with their provider to determine whether their condition requires urgent care. Given the many options providers have including answering services, pagers, and cellular telephones to ensure sufficient contact with their patients who are in need of triage, it is unreasonable that a consumer not be able to reach a live person within 30 minutes at the longest. We once again urge that language be added requiring that providers instruct patients how to reach someone:

§ 1300.67.2.2 (c)(3)(A)(ii)(I) The machine's recorded message shall include what to do in an emergency, and how to contact a qualified professional, acting within his or her

scope of practice, who is trained to screen and triage. The message shall state that if the caller does not need immediate assistance she or he can leave a message.

Appointment Changes or Cancellations

We are pleased to see the new subsections here requiring that plans have systems in place to avoid repetitive cancellations and to ensure enrollees are promptly notified when an appointment has had to be changed or cancelled. § 1300.67.2.2 (c)(6). We hear from consumers who have had appointments cancelled or changed numerous times – sometimes without advance warning – a clear barrier to care.

Compliance Monitoring

Monitoring compliance with the timely access standards is required by the statute and critical to ensuring that these standards are meaningful. The Department has clearly done considerable work in this version to ensure a statistically valid process for the provider surveys and for that we applaud them. The process laid out is specific, clear, and scientifically based. Plans can follow it without having to develop their own system. However, we still think it is fundamentally flawed to rely on consumer complaints and non-anonymous surveys. When providers know they are being asked what their appointment wait times to measure compliance, they have an incentive to give an answer within the standards. Anonymous surveys would be more reliable. The plan could follow the same process for anonymous surveys as are currently laid out for non-anonymous surveys, e.g. same list of providers, selection process, etc. We find unpersuasive the argument made by some health plans that creating false appointments would interfere with their appointments system. The surveyor could easily cancel the appointment – even at the end of the call.

As to relying on consumer complaints, we know well from our work advising and assisting consumers with problems in the health care arena, that consumers rarely take the time and trouble to file a formal grievance for something like a telephone or appointment waiting time, or even if they are turned away because they are not provided any language assistance. The data on the Office of Patient Advocate website of the number of consumers who filed complaints with the Department is instructive. Of the more than 16 million HMO members only 210 members filed a complaint – .00131%.

There is new language in this version of the regulations **prohibiting** plans from requiring providers to maintain records of various standards.¹ This violates the authorizing statute and undermines the goal of ensuring timely access to care. AB 2179 specifically states that contracts between health plans and providers “shall require reporting by health care providers to health

¹ Subsection 1300.67.2.2 (c)(3)(A) states, “plans shall not require providers to maintain records to demonstrate compliance with telephone access standards.” Subsection 1300.67.2.2 (c)(4) states that health “[p]lans shall not require providers to maintain records of office waiting times unless the quantity of enrollee complaints indicates a substantial pattern of noncompliance with the 30-minute guideline by a provider or provider group and the plan includes such requirement as part of a corrective action plan.” Subsection 1300.67.2.2 (e)(1) states “No plan shall require a contracting health care provider or provider group to maintain log books recording appointment waiting times, office waiting times and telephone waiting times for all enrollees served by the provider or provider group.”

care service plans.” Healthy & Safety Code § 1367.03(f)(1). While we understand the desire to avoid onerous record-keeping requirements, the Department neither has the authority nor should it prohibit plans from requiring a particular type of record keeping. Given that the statute requires reporting by providers to plans and, in turn, by plans to the Department, we are at a loss as to why the Department would prohibit a plan from requiring that providers keep these records. While we understand that it would be counter-productive for providers to record every waiting or appointment time, throughout this process we have urged that there be a sampling methodology where providers, for example, track this information for a statistically significant period

We wholeheartedly agree with the new provision which allows plans that contract with the same medical group to pool resources and share a survey process and results. This makes sense for all parties.

The regulations should specify that the following compliance monitoring tools be implemented in multiple languages to comply with language access requirements: enrollment satisfaction survey, disenrollment survey, non-anonymous telephone surveys of providers’ offices (if this is retained in the regulations), and anonymous (secret shopper) telephone audits of providers’ offices. Our suggested language is the following:

§1300.67.2.2(f): Plan’s Enrollee Satisfaction Survey. Not less than annually, all plans shall conduct a survey ... in the languages identified in the plan’s demographic profile requiring interpreter or translation services, and at a minimum, the plan’s threshold languages.

Language Access

Although we are pleased with the additional language making it clear that the plan must contractually require compliance with and enforce the applicable standards in the regulations, we are disappointed that our recommendations regarding the coordination between the timely access regulations and the Language Assistance Program regulations, under §§1300.67.04-.07, have not been incorporated into the regulations nor cross-referenced. As we explained in our prior set of comments, we have seen that timely access to care is a serious problem for LEP consumers. In fact, the Department hearings held throughout the state clearly illustrated the kinds of problems many LEP enrollees faced when trying to seek health care from managed care plans. When advocates expressed concern with the vague definition of “timely” in §1300.67.04(C)(2)(G)(v), we were told that the timely access regulations were in the process of being amended at the time and would address our concerns.

However, there continues to be no reference of the applicability of the specific standards in the timely access regulations, including appointment waiting times, office waiting times, and telephone waiting times for all types of providers including primary care and specialty care physicians, and for routine, preventive care, and urgent care, to the Language Assistance Programs nor LEP enrollees and their language assistance needs. Thus, there is no assurance that the timely access regulations apply when LEP enrollees require interpreter or translation

services to access health care. As we noted before, the same timely access standards must apply for LEP enrollees who need language assistance services.

We would recommend the following language:

§1300.67.2.2(c) Timely Access Program Requirements. Every plan shall develop and implement ... which shall comply with the requirements and standards established by the Act, this section, and §1300.67.04-.07, including the use of language assistance services, including qualified interpretation and translation services."

We continue to urge the Department to adopt our other suggestions raised in our prior letter:

- 1) The quality assurance standards in the timely access regulations should include those in the Language Assistance Program regulations. §1300.67.04(C)(2)(G)(v) explains that: "A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling."

- a. We suggest adding the following:

§130067.2.2 (a)(2)(B) Standards for timely delivery of language assistance services for emergency, urgent and routine health care services and coordinating interpretation services with appointment scheduling.

- b. We would also urge the incorporation of these two standards/factors to §130067.2.2 (c)(1), Timely Access Program Requirements, as two additional "Indicators for Timely Access." This would ensure that these two indicators would be included in compliance monitoring of the plans. See §130067.2.2 (e).
- c. With regard to compliance monitoring, we would suggest that the demographic profile of the enrollees in the plan be part of the evaluation:

§130067.2.2 (e)(4)(A). The size of the plan and the demographic profile of its enrollee population.

- 2) We would also urge the regulations include a general requirement for the use of qualified interpreters whenever an interpreter is used, as suggested in the above paragraph, or in specific sections such as in §130067.2.2 (c)(3), Quality Assurance Standards for Timely Telephone Access.
- 3) There is no reference to the time requirements regarding the translation of materials into other languages upon request. We would recommend that the statutory time requirements be included in these regulations, or at least a reference to the statute included in the regulations, to remind plans of their obligation to translate written materials within specific time periods. For vital documents that are not standardized but contain enrollee specific information, the enrollee can request the document to be

translated, and the translation must be completed within 21 days. *See* Health & Safety Code §1367.04(b)(1)(C).

Enrollee Education

The Department rightly includes in its Compliance and Implementation section a requirement that health plans include information in their evidences of coverage about how enrollees can get the plan's help in getting a timely appointment, how to file a complaint and "general information" about the plan's standards for timely access. We strongly encourage the Department to strengthen this language to require that plans include the standards themselves. Enrollees have the right to know in what period of time they should be able to get an appointment from the respective types of providers. While we continue to maintain that consumer complaints are not a reliable indicator of compliance with timely access standards, if the regulations continue to rely on these, it is of the utmost important that consumers know the standards. How can they be expected to know that they should not have to wait for four weeks for a routine primary care appointment if no one tells them? We urge that the language be changed as follows:

§ 1300.67.2.2 (h)(2) A description of the plan's educational program and disclosures added in the evidences of coverage and disclosure forms informing enrollees about how to request the plan's assistance in obtaining timely appointments, how to file a complaint about a timely access problem, how to notify the plan regarding timely access problems, and generally describing listing the plan's specific indicators and standards for timely access . . .

Thank you for your consideration of these comments to achieve the goal of ensuring timely access to health care.

Sincerely,

Elizabeth A. Landsberg
Western Center on Law and Poverty

Doreena Wong
National Health Law Program

Barbara Siegel
Neighborhood Legal Services' Health Consumer Center of Los Angeles

Tho Vinh Banh
Protection & Advocacy, Inc.

March 5, 2007

Department of Managed Health Care
Attn: Emilie Alvarez, Regulations Coordinator
Office of Legal Services
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Timely Access to Health Care Services, Control No. 2005-0203

Dear Director Ehnes:

On behalf of the Health Consumer Center of San Mateo, National Health Law Program (NHeLP), Neighborhood Legal Services' Health Consumer Center of Los Angeles, Protection & Advocacy, Inc., and the Western Center on Law and Poverty we submit these comments in response to the Department of Managed Health Care's proposed regulations on timely access to health care services. Most of our organizations are member of the Health Consumer Alliance (HCA) – a partnership of consumer assistance programs operated by nine local Health Consumer Centers that cover thirteen counties in both urban and rural parts of California. HCA's mission is to help low-income people obtain essential health care. NHeLP and Western Center provide statewide policy advocacy for these consumer centers on health care issues impacting low-income consumers.

Consumers regularly call our Health Consumer Center with problems accessing health services in a timely manner. We hear stories of people who cannot get an appointment for weeks or months, problems getting a timely referral for needed specialty services, and problems even getting advice and triage by phone. In calendar year 2006, our Health Consumer Centers heard from almost 300 (297) consumers who could not get care timely.

Overall, the Department has fulfilled the requirements of AB 2179 (Health & Safety Code § 1367.03) and has reached the right balance to ensure timely access, in particular with the time-elapsed standards for appointment times. While the compliance monitoring provisions have been improved, we continue to have some concerns about some of the standards and how compliance with all of the standards will be monitored.

Standards for Timely Appointments

We agree wholeheartedly that the appointment waiting times must include "time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers" § 130067.2.2 (b)(1). We hear from consumers who cannot get a timely appointment precisely because they cannot get a referral promptly made or authorized. Including the referrals within the timeliness standards will help ensure that consumers are not the ones suffering the consequences when plans do not expeditiously process authorizations.

Most of the timeframes set forth in the regulations are appropriate times and in particular we think it right that the time for urgent primary care was set at 24 hours as consumer advocates suggested. The office waiting times of 15 minutes for urgent care and 30 minutes for routine and preventive care also appropriately ensure timely care in keeping with the statute. Our Health Consumer Centers hear from frustrated health care consumers who have had to wait more than an hour to see their provider.

The time standards set forth for dental care appointments are too long. As with urgent primary care, the time for urgent dental care should be changed from 48 to 24 hours. A consumer in intense pain from an infected tooth should not be expected to wait two days for an appointment; they should be seen within one day. Dental health is inextricably intertwined with one's health and should not be treated differently. This was illustrated tragically by the recent story in *The Washington Post* about a boy who eventually died from complications from abscessed teeth in part because of problems getting a dental appointment. Mary Otto, For Want of a Dentist, *Washington Post*, 2/28/07, B1.

Similarly, the other dental care appointment times are much too long. The Department proposes that an appointment for routine dental care may be given within 42 days and for preventive dental care within 180 days. These standards are notably "out of whack" with all the other standards and are hardly timely. It does not make sense that while almost all other types of preventive care must be provided in either 30 days, preventive dental care need not be scheduled for 180 days – a time period six times as long. While we recognize that the practice is that dental check-ups and cleanings are often scheduled every six months, from one cleaning appointment to the next, an enrollee should not as a matter of course have to wait six months for a dental cleaning. Similarly, while most types of routine care would have to be provided within 10 or 14 days, the timeframe proposed for routine dental care is 42 days – three to four times as long. A consumer should not have to wait 42 days to get a cavity filled; the decay could worsen during that time and the tooth could become infected. We propose that the timeframes for routine and preventive dental care be set at 14 days and 60 days respectively. Sixty days to schedule cleanings and check-ups should be sufficient and that consumers should not have to wait longer for this type of care.

The time standard for urgent mental health care should also be changed from 48 to 24 hours. Someone with extreme anxiety or depression should not have to wait 48 hours for intervention. Conforming the standard for urgent mental health with the standard for urgent physical health needs is in keeping with California's policy decision, evidenced by our state's mental health parity law (AB 88), that serious mental illness should not be treated differently from physical health needs. It would also better align these timely access standards with Department of Mental Health's standards as written into contracts with mental health plans. These state that mental health plans "shall make all medically necessary covered services available in accordance with Title 9, CCR, Sections 181 0.345 and 181 0.405 with respect to:

- 1) The availability of services to meet beneficiaries' urgent conditions as defined in Title 9, CCR, Section 1810.253, 24 hours a day, 7 days a week.
- 2) Timeliness of routine services as determined by the Contractor to be sufficient to meet beneficiaries' needs."

Further, the Department should consider conformity with the Medi-Cal Specialty Mental Health Service standards for urgent care which state that each plan shall make mental health services to treat a member's urgent condition available 24 hours a day, seven days per week. If the plan requires that a provider obtain prior approval in order to receive payment for providing a mental health service necessary to treat a member's urgent condition, the plan shall have a statewide, toll-free telephone number available 24 hours a day, seven days per week, to act on the provider's payment authorization request for services necessary to treat the urgent condition. Under these circumstances the plan shall act on the payment authorization request within one hour of the request.

Timely Telephone Access

The telephone waiting times are a critical component of timely access and the times proposed by the Department are reasonable. In most cases telephone waiting times must be no longer than ten or fifteen minutes during office hours and within 30 minutes after hours. The Department rightly provides that these wait times include the time to navigate a telephone tree. We know all too well from our work with consumers and the conference calls we do with them that consumers often wait for more than fifteen minutes on the telephone with their plan or provider during business hours.

The one telephone time standard that does not "ensure that enrollees have access to needed health care services in a timely manner" (§1367.03(a)) is subsection (3)(H). It states that if a provider uses a recorded message the office "shall attempt to contact the enrollee in a timely manner consistent with good professional practice." While the other standards has a specific time, this one is vague. In this day and age with answering services, pagers, cellular telephones and other technologies, it is unreasonable that a consumer in need of triage to determine whether her condition is urgent not be able to reach a live person within 30 minutes at the longest. We suggest the following change to this subsection to require providers to instruct patients how to reach someone:

(H) If a provider's office uses a recorded message to answer telephone calls, part of the recorded message shall state what to do in an emergency, and how to contact a qualified professional, acting within his or her scope of practice, who is trained to screen and triage. The message shall state that if the caller does not need immediate assistance she or he can leave a message and the provider's office shall attempt to contact the enrollee in a timely manner consistent with good professional practice. . ."

Compliance Monitoring

Monitoring compliance with the timely access standards is required by the statute and critical to ensuring that these standards are meaningful. The Department has taken some important steps to strengthen the monitoring requirements in this version of the proposed regulations. In particular, the language in subsection (e) requiring a valid and reliable methodology is important to ensuring a statistically significant sample size. Further, as consumer advocates we think it right that the Department added to the required elements of monitoring systems, a disenrollment

survey to see why consumers left their plan and if lack of timely access was one of the reasons. We still maintain that satisfaction surveys and reviewing grievances are insufficient to monitor compliance. Understandably, many consumers who have problems do not want to take the time to file a formal grievance with their health plan. Provider surveys are also not an effective way to identify failure to comply with the timely access standards. Accordingly, the provider surveys in (B) and (D) should be deleted as options included in subsection (e)(2). Deleting these will require providers not operating on a same-day basis to either audit actual provider records or do secret shopper telephone surveys of provider offices – the two most effective methods to ensure compliance.

Subsection (1)(2) of the proposed regulation would allow a plan that had demonstrated full compliance one year not to submit all the elements of the annual compliance report the following year. This should be deleted because it contravenes the statute which requires annual reporting on compliance (§1367.03(f)(2)). Furthermore, annual monitoring is critical to detect problems within a particular plan's network.

The regulations should specify that the following compliance monitoring tools be done in multiple languages to comply with language access requirements: enrollment satisfaction survey, disenrollment survey, non-anonymous telephone surveys of providers' offices (if this is retained in the regulations), and anonymous (secret shopper) telephone audits of providers' offices.

Language Access

In addition to specifying the compliance monitoring tools that should be conducted in multiple languages, these regulations should incorporate language access requirements in the appointment and telephone standards. Access to an appointment or a telephone triage call without an interpreter is of no use to a sick consumer who is Limited English Proficient (LEP). Of the 297 delay cases presented to the Health Consumer Centers in 2006, 86 of them – almost 30% – had a primary language other than English. This indicates to us that timely access to care is a particular problem for LEP consumers.

Therefore, these timely access standards should specifically require that language services be provided and include a reference to the final regulations regarding the Language Assistance Programs, §1300.67.04-.07, which went into effect on 2/23/07. This is necessary to ensure that the proposed timely access regulations apply to the timely access requirements described in §1300.67.04(C)(2)(G)(v). It is particularly critical that these regulations specify their application to the LEP patient because the potential delay posed by obtaining language assistance services, such as an interpreter, is greater, and there are no timely access standards in the current Language Assistance Program regulations. As it currently states in §1300.67.04(C)(2)(G)(v), “timely” means in a manner appropriate for the situation in which language assistance is needed.” In discussions with DMHC, it was acknowledged that it was unnecessary to include specific time periods because the issue was to be addressed in these timely access regulations, and that the timely access standards would apply to the provision of language assistance services. At a minimum, any time delays for LEP enrollees must not be any longer than those for non-LEP enrollees.

§1300.67.04(C)(2)(G)(v) further explains that: "A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling." We suggest adding the following section to §130067.2.2 (a)(2): (B) "Standards for timely delivery of language assistance services for emergency, urgent and routine health care services and coordinating interpretation services with appointment scheduling." We would also urge the incorporation of these two standards/factors to §130067.2.2 (c)(1), Timely Access Program Requirements, as two additional "Indicators for Timely Access." This would ensure that these two indicators would be included in compliance monitoring of the plans. See §130067.2.2 (e). With regard to compliance monitoring, we would suggest that the demographic profile of the enrollees in the plan be part of the evaluation: "(A) The size of the plan and the demographic profile of its enrollee population." §130067.2.2 (e)(4)(A).

We are also concerned that an exception for contracted health care providers to comply with the timely access requirements for providing language assistance services, including interpreters, might be construed from the language in §130067.2.2 (a)(3)(B). We believe the language should be clarified to make it clear that the plan and/or provider must ensure that it has the capacity to provide language assistance services and cannot simply claim that it does not. Given that these standards provide plans with time to make appropriate arrangements for language assistance services in advance of the LEP enrollee's appointment, especially for routine and preventive care, there should not be any reason for delays in access to health care for LEP enrollees.

We would also urge the regulations include the use of qualified interpreters in §130067.2.2 (c)(3), Quality Assurance Standards for Timely Telephone Access.

Additionally, there is no reference to the time requirements regarding the translation of materials into other languages upon request. We would recommend that the statutory time requirements be included in these regulations, or at least a reference to the statute included in the regulations, to remind plans of their obligation to translate written materials within specific time periods. For vital documents that are not standardized but contain enrollee specific information, the enrollee can request the document to be translated, and the translation must be completed within 21 days. Whenever a requested document requires the enrollee to take action within a certain period of time, the period of time shall not begin until the enrollee obtains. See Health & Safety Code §1367.04(b)(1)(C).

Alternative Standards; Material Modification

The Department rightly changed the requirement for adopting alternative standards, mandating that a plan proposing a different standard must demonstrate that it meets the appropriateness standard in the statute and must be based on specific facts justifying the change. Consumer advocates suggested this change and are pleased to see it was adopted to ensure that the exception does not swallow the rule and that plans do not have unfettered discretion to set alternative standards.

Physician-Enrollee Ratios

We continue to urge the Department to adopt a global cap on the number of patients for whom one primary care physician is responsible to manage their care. The ratio of one primary care physician for each 2,000 enrollees is largely meaningless if that same physician can contract with four different health plans – each with 2,000 enrollees for a total of 8,000 patients. A global ratio is the only effective way to ensure that providers do not contract with multiple health plans and cumulatively have more patients assigned to them than they can effectively and timely serve.

Thank you for your consideration of these comments. If you have any questions I can be reached at 916-442-0753 ext. 18.

Sincerely,

Elizabeth A. Landsberg
Western Center on Law and Poverty

Doreena Wong and Kathleen McGarvey
National Health Law Program

Barbara Siegel
Neighborhood Legal Services' Health Consumer Center of Los Angeles

Tho Vinh Banh
Protection & Advocacy, Inc.

Melissa Rodgers
Health Consumer Center of San Mateo

Jen Flory

From: Elizabeth Landsberg
Sent: Thursday, August 21, 2008 3:48 PM
To: Chammout, Suzanne; Alvarez, Emilie
Cc: Jen Flory; 'Ann Rubinstein'
Subject: Timely Access to Care Regulations - Responses from Western Center and the Health Rights Hotline
Attachments: WCLP-HRH Responses to Issue 7.doc; WCLP-HRH Response to Issue 1.doc; WCLP-HRH Response to Issue 2.doc; WCLP-HRH Response to issue 3.doc; WCLP-HRH Response to Issue 5.doc; WCLP-HRH Response to Issue 6.doc; WCLP-HRH Response to Issue 4.doc

Attached please find Western Center's responses to the 7 issues which we prepared with the Health Rights Hotline.

Elizabeth A. Landsberg
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3/3/2010

WCLP / HRH Response on Issue #1

Issue 1	Western Center on Law & Poverty	Supporting rationale for each responsive position
	Responsive position on Proposal No.:	
CAHP, ACLHIC, and AHIP	<p>1 NO. The regulation should NOT include more than the three required indicators for timely access to health care set forth in § 1367.03(a) 1-3.</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>Subsection 1367.03(a) allows additional indicators. Timely access to language services is a critical indicator to ensure that the timely access regulations do not grant preferential treatment to English-speaking consumers over Limited English Proficient (LEP) consumers. Physician to patient ratios are another critical component in assessing a plan's ability to provide timely access to health care services. Only with an adequate provider network, can a plan ensure timely access.</p>
California Association of Dental Plans	<p>1 a. For dental plans, as for all specialized plans that do not provide physician services, retain current process whereby indicators of timely access are determined by plans in accordance with current regulations and set forth in DMHC-approved Quality Assessment Programs (QAPs).</p> <p>b. No wait time standard for telephone triage is necessary for dental providers.</p> <p>Oppose</p>	<p>The Department does not have the authority to exclude dental and other specialty plans from the regulations. AB 2179 stated: "It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers have timely access to health care." This intent is not limited to enrollees in non-specialty health care services plan; it extends to all enrollees, as the regulation itself should. Other statutes make it clear when they are excluding specialty plans. Further, subsection 1367.03(a) requires that the Department consider "waiting time to speak to a qualified healthcare professional who is trained to screen or triage an enrollee who may need care" and "timeliness of care in an episode of illness, including referral time and obtaining other services, if needed" as indicators of timeliness to care. Neither of these standards is limited to a restrictive view of health care. Dental health, mental health and all types of health conditions require care by a qualified healthcare professional. All types of health conditions can also induce an episode of illness. The Department must ensure that enrollees in all the plans it regulates have timely access to care.</p>
	<p>2. While we do not believe dental should have new regulations proscribing time-elapsd standards, there is a consensus within the industry, endorsing the following standards regarding appointment availability for urgent, routine and preventive care, which are currently in wide use:</p> <p>a. Wait times for dental appointments are (and should continue to be) calculated from the initial request for services to the first available appointment offered.</p> <p>b. Urgent dental care: Urgent dental care means care for a dental condition that poses an imminent and serious threat to the enrollee's dental health and which requires prompt treatment that cannot be provided through advice given over the phone.</p> <p>c. Wait time for urgent care: 48 hours or the next business day, whichever is longer. The 48-hour urgent care standard shall commence upon the patient's indication to a dental plan of a bona fide urgent care need.</p> <p>d. Routine dental care: within 36 business days.</p> <p>e. Preventive dental care: within 40 business days.</p> <p>f. No phone screening wait time for dental providers.</p>	<p>We concur with a and e, but seek some amendments to this proposal.</p> <p>b. We are concerned that the definition of "urgent dental care" is framed in terms of posing a serious threat to the enrollee's dental health as opposed to simply their health. Dental conditions affect overall health. This is illustrated by the impact research has shown a pregnant woman's dental health has on her baby. Accordingly, we urge that the later term "dental" be deleted.</p> <p>c. All types of urgent care, including urgent dental care should be provided within 24 hours. The definition of urgent care cited by the CADP makes clear that this is when the consumer has a condition that poses an imminent and serious threat to his or her health. This cannot wait up to 48 hours.</p> <p>d. We also believe a consumer should not have to wait seven weeks for routine dental care and propose instead that the standard for routine dental care be fourteen calendar days. A cavity left untreated for seven weeks could worsen such that it requires urgent care, interferes with the consumer's ability to eat, or causes significant pain.</p> <p>f. The phone screening wait time should apply for dental care. Consumers do not have the training and expertise to evaluate whether their condition is urgent or not; they need to be able to speak to a trained professional who can advise them whether they need to be seen immediately.</p>

	<p>g. No mandatory office wait time for dental providers.</p> <p>Oppose Unless Amended</p> <p>3 Wait times for referrals are already in dental plans' QAPs and specific indicators are not necessary.</p> <p>Oppose</p> <p>1 The regulation should not include more than the three "required" indicators for timely access to healthcare. In reality, the most significant measurable factor is that first, "waiting time for appointments with primary and specialty care physicians" and should be the only metric included in the final regulation.</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>Referral times should be incorporated into the wait time for specialty services.</p> <p>The Department does not have the authority to ignore two of the three required indicators in the statute as proposed. Subsection 1367.03(a) does, however, allow additional indicators. Timely access to language services is a critical indicator to ensure that the timely access regulations do grant preferential treatment to English-speaking consumers over Limited English Proficient (LEP) consumers. Physician to patient ratios are another critical component in assessing a plan's ability to provide timely access to health care services. Only with an adequate provider network, can a plan ensure timely access.</p>
<p>California Association of Physician Groups</p>	<p>1 Ideally</p> <p>Yes, the regulation shall confirm and specify a requirement that all mental health plans provide or arrange for the provision of a telephone triage program to ensure enrollees have access to a qualified health professional.</p> <p>A. A mental health enrollee shall have access to a physician who is board certified in psychiatry to screen or triage.</p> <p>B. A mental health provider shall have access to a similarly licensed mental health provider to screen or triage.</p> <p>C. This requirement shall remain the sole responsibility of the plan, or contracting carve out or MBHO, and shall be administered directly or by in-state contract.</p> <p>D. For mental health plan enrollees there shall be a 24/7 dedicated phone number available to all enrollees, printed on the plan card or on a separate card provided by the carve out or MBHO.</p> <p>Provision shall be made for accurate language translation as appropriate.</p> <p>Support</p> <p>3 Minimally Acceptable</p> <p>Yes, the regulation shall confirm and specify a requirement that plans provide or arrange for the provision of a telephone triage program to ensure enrollees have access to a qualified health professional.</p> <p>A. A mental health enrollee shall have access to a mental health professional who is qualified to screen or triage.</p> <p>B. A mental health provider shall have access to a similarly licensed mental health provider to screen or triage.</p> <p>C. This requirement shall remain the sole responsibility of the plan, or contracting carve out or MBHO, and shall be administered directly</p>	

	<p>or by in-state contract.</p> <p>D. For mental health plan enrollees there shall be a 24/7 dedicated phone number, available to all enrollees, printed on the plan card or on a separate card provided by the carve out or MBHO. Provision shall be made for accurate language translation as appropriate.</p> <p>Support</p> <p>1 In light of other factors that may affect timely access to health care and network adequacy issues, a "time elapsed" standard may be unworkable or impractical to implement at this point.</p> <p>Oppose</p>	<p>Section 1367.03(a) of the California Health and Safety Code requires the Department to "develop indicators of timeliness of access to care and, in doing so, shall consider the following as indicators of timeliness of access to care." While § 1367.03 (c) does allow the Department to adopt standards other than time elapsed standards it can only do so if the alternate can be demonstrated as more appropriate. Time elapsed standards are the only standards that go directly to measuring timeliness of access to care. They are objective, measurable, and uniform.</p>
<p>California Medical Association</p>	<p>2</p> <p>3</p> <p>1 In addition to the statutory indicators for timely access to health care enumerated in the law which include:</p> <ol style="list-style-type: none"> 1. waiting time for appointments with primary and specialty care physicians, 2. waiting time for screening or triage of an enrollee, and 3. timeliness of care in an episode of illness, including referral time and obtaining other services) <ul style="list-style-type: none"> • DMHC should require plans to establish and measure office waiting times. • DMHC should establish specific time-elapsed standards based on the indicators shown in Issue #1 and considering the factors in Issue # 2 for all health plans, including specialized plans. Standards should reflect time-elapsed standards across plans for similar services. The following represent examples of time elapsed standards for core services: <ul style="list-style-type: none"> o for urgent primary care: within 24 hours o for routine primary care: within 10 calendar days o for preventative primary care: within 22 calendar days o for urgent specialty care: within 24 hours o for routine specialty care: within 14 calendar days o for specialty preventative care: within 30 calendar days <p>These standards must be consistent with the underlying statutory principles of The Knox Keene Act of 1975 and incorporate the provisions of AB 2179 "Timely Access to Health Care Services (2002).</p> <ul style="list-style-type: none"> • DMHC must apply these standards not only to plans, but to medical groups and other providers to whom the plans delegate the delivery of care and provision of health services. §1367 unequivocally states "the obligation of the plan to comply with this 	

	<p>section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.”</p> <ul style="list-style-type: none"> • Consumers should not be required to choose between timely access to care and cultural and linguistic access to care. Consumers are entitled to both appointments and telephone triage with an appropriate health care professional in the consumer’s spoken language.
	<p>Support</p> <p>2 All of the above in #1 with the following addition: Plans may propose to meet the timely access to care provisions of Knox-Keene and AB 2179 by offering in addition advanced access or same day access. Specific provisions of this alternative standard should be based on guidelines incorporating the nature of the enrollee’s request, its clinical urgency, the availability of the requested physician or alternate, and/or other requirements consistent with good professional practice.</p>
	<p>Support</p> <p>3 All of the above in #1 or #1 and #2 with the following addition: After the Department sets their specific timely access to care standards, temporary circumstances may arise that prevent a plan from meeting them. The Department may grant a time-limited waiver or exemption upon submission of a plan petition and documentation covering a period up to 6 months. In unusual circumstances, the DMHC may grant a final extension of up to 6 months. In each situation, where the plan seeks an exception to network adequacy standards, they must submit a Corrective Action Plan. The plan must describe the circumstances that created their inability to provide an adequate network of providers that resulted in their failure to deliver timely access care for their enrollees. The plan must also describe the exceptional efforts the plan has undertaken to rectify the imbalance. However, after the elapsed time, if the plan is still unable to deliver on the network adequacy standards, the Department will require the plan to execute an orderly and planned withdrawal from the affected area to minimize consumer disruption, accompanied by appropriate administrative remedies and sanctions against the plans.</p> <p>Support</p>
<p>Health Access</p>	

WCLP / HRH Response to Issue #2

Issue 2	Western Center on Law & Poverty	Supporting rationale for each responsive position
<p>CAHP, ACLHIC, and AHIP</p>	<p>Responsive position on Proposal No.:</p> <p>1 NO. The regulations only should consider the statutorily required factors.</p> <p>The Department must consider existing requirements from federal law and the DHCS. In 42CFR 438.206(c) the Centers for Medicare and Medicaid Services ("CMS") have delegated the duty to DHCS to ensure that contracting Managed Care Organizations in Medi-Cal comply with timely access standards. In exercising this duty, the DHCS has enumerated in its Medi-Cal contracts timely access requirements for certain services, such as for prenatal visits and urgent care visits, but has essentially avoided time elapsed standards in favor of allowing the MCO to develop, implement and maintain procedures to monitor timely access. For the DMHC to impose rigid, time elapsed standards in regulations would be in direct conflict with DHCS' express intent for Medi-Cal health plans to internally develop timely access standards and procedures.</p> <p>Oppose Unless Amended</p> <p>2</p> <p>3</p>	<p>We agree the regulations should consider the statutorily required factors and should also consider the current requirements to which Medi-Cal managed care plans are already subjected. However, Medi-Cal managed care plans are also subject to the requirements of the Knox-Keene Act. While the statute requires the Department to consider applicable requirements under federal and state law we believe those should be consulted and serve as a floor. None of the time elapsed standards previously proposed by the Department nor those we propose are in direct conflict with the Medi-Cal managed care standards.</p>
<p>California Association of Dental Plans</p>	<p>1 A very important factor to consider is the nature of the general dentistry practice, and the non-urgent aspect of the majority of all dental treatment.</p> <p>Oppose</p> <p>2 The limited availability of dental specialists in certain geographic areas and its impact on appointment availability and wait times (and on other indicators of timely access) cannot be addressed by dental plans, nor by arbitrary standards of access imposed on dental plans.</p> <p>Oppose</p> <p>3 Time-elapsed standards should be flexible, based on market realities, clinical appropriateness and other relevant considerations.</p> <p>Oppose</p>	<p>While we agree that the nature of different types of care should be considered, dental conditions certainly can worsen to the point where urgent care is needed and someone's life is in jeopardy. This was tragically illustrated by the boy in Maryland who eventually died from complications from abscessed teeth in part because of problems getting a dental appointment. See <u>Mary Otto, For Want of a Dentist, Washington Post, 2/28/07, B1.</u></p> <p>Plans are obligated to contract with sufficient providers to comply with the requirements of the Knox-Keene Act.</p> <p>While we acknowledge there may be extreme extenuating circumstances that interfere with a plan's ability to comply with timeliness standards at a given time, § 1367.03 does not refer to a process to exempt plans from the timeliness standards. If an exemption process is adopted it must be done only in extreme circumstances, be time-limited, be corrected as expeditiously as possible, and be posted on the Department's web page and sent to stakeholders to advise of the exemption. The plan should be required to notify the Department with sufficient information to allow the Department to assess the situation. Then, the plan should be required to submit a corrective action plan to correct the deficiency within a limited time not to exceed six months. See additional detail in our proposal for Issue 2.</p>

<p>California Association of Physician Groups</p>	<p>1 The DMHC should also consider "safe harbors" for current industry standard best practices that obviate the need for time-elapsed prescriptive standards such as "advanced access" programs. . . . Clinical experience has shown that patient satisfaction surveys are even more effective than the mere implementation of "advanced access" programs, providing a metric that measures the effectiveness of giving patients more timely access. The regulation should include a "force majeure" provision if it does include prescriptive standards, to provide relief in cases of bioterrorism, severe epidemic, documented geographic provider workforce shortages and cataclysmic events. The regulation should include a filing mechanism to seek approval.</p> <p>Support if Amended</p>	<p>We can support an "advance access" standard if it is clearly defined and monitored since none of the time elapsed standards for appointment waiting times proposed has been shorter than 24 hours. We would need to ensure that urgent care appointments are available within 24 hours. See above and our proposal for Issue 2 regarding standards for exemptions from the timeliness standards.</p>
<p>California Coalition of Mental Health</p>	<p>1 Ideally</p> <ul style="list-style-type: none"> A. Mental health services shall have separate and distinct time-elapsed standards for each of the prescribed 4 indicators. B. These indicators shall be higher than the current standards prescribed in the California Medi-Cal specialty mental health managed care services regulations. C. No safe harbor provision shall be included. D. Exceptions and flexibility requests shall be permissive but only if vetted utilizing a DMHC prescribed public input process. E. Exceptions and flexibility requests must be approved by DMHC and posted on the plans website in a prominent location. F. DMHC shall produce an annual report detailing all exceptions and flexibility requests granted. G. DMHC shall conduct an annual focused "access" survey at each plan to ensure compliance and post the survey outcomes to the DMHC website. <p>Support</p>	
	<p>2 Moderately Acceptable</p> <ul style="list-style-type: none"> A. Mental health services shall have separate and distinct time-elapsed standards for each of the prescribed 4 indicators. B. These indicators shall mirror those found in the NCQA and APA guidelines. C. No safe harbor provision shall be included. D. Exceptions and flexibility requests shall be permissive but only if vetted utilizing a DMHC-prescribed public input process. E. Exceptions and flexibility requests must be approved by DMHC and 	

	<p>posted on the plans website in a prominent location.</p> <p>F. DMHC shall produce and make available an annual report detailing all exceptions and flexibility requests granted.</p> <p>Support</p>	
	<p>3 Minimally Acceptable</p> <p>A. Mental health services shall have separate and distinct time-elapsed standards for each of the prescribed 4 indicators.</p> <p>B. Indicators would be determined by the DMHC and stakeholders.</p> <p>C. No safe harbor provision shall be included.</p> <p>D. Exceptions and flexibility requests shall be permissive but only if vetted utilizing a DMHC prescribed public input process.</p> <p>E. Exceptions and flexibility requests must be approved by DMHC and posted on the plans website in a prominent location.</p> <p>F. DMHC shall conduct an annual focused "access" survey and publicly report the outcomes to ensure compliance.</p> <p>Support</p>	
<p>California Medical Association</p>	<p>1 In considering other provisions of law or factors that may affect timely access to health care, DMHC should review the existing physician patient ratio and number of contracting physicians with health plans prior to establishing standards on timely access to health care.</p> <p>Neutral</p> <p>2</p> <p>3</p>	<p>We agree that physician-patient ratios are relevant to timely access to care, but should not replace other standards.</p>
<p>Health Access</p>	<p>1 In developing time-elapsed standards for each of the indicators in Issue #1, DMHC should incorporate the four enumerated factors in 1367.03 (b):</p> <ol style="list-style-type: none"> 1. Clinical appropriateness 2. Nature of the specialty 3. Urgency of care <p>Requirements of other provisions of law that affect timeliness of access.</p> <p>Support</p> <p>2</p> <p>3</p>	

WCLP / HRH Response to Issue #3

Issue 3	Western Center on Law & Poverty	Supporting rationale for each responsive position
Responsive position on Proposal No.:		
<p>1 None</p> <p>Oppose</p>		<p>§ 1367.03 requires the Department to adopt regulations to ensure that enrollees have access to needed health care in a timely manner. Not having standards will not meet that requirement. The Department regulates plans that provide all types of health care, so it cannot choose not to include all types of health care in the regulations.</p>
<p>2 Quarterly reviews of plan and DMHC grievances, member requests for change in provider, and member inquiries related to access.</p> <p>Oppose</p> <p>3 Annual member satisfaction survey of a statistically valid number of enrollees who have received services within the last year. Questions should be designed to solicit information regarding the enrollees' satisfaction regarding availability of appointments within time frames set by plan/regulation.</p> <p>Oppose</p>		<p>§ 1367.03 (c) allows the Department to adopt standards other than time-elapsed if they can demonstrate why the adopted standard is more appropriate. Reading consumer complaints will not ensure access to needed health care services in a timely manner. Only a small number of consumers actually file grievances when they have not received timely services. Consumers will not know what timely care is and will not know when to complain. Finally, reading over grievances will only allow for subjective evaluation of the plan's performance and will not allow an objective evaluation that will make it easy to compare plans and relay that information to consumers.</p> <p>See above.</p>
<p>1 Standards other than time-elapsed should be adopted in the regulation, including patient satisfaction surveys and enrollee complaints (as a part of the plan Appeals & Grievance Process) as factors toward determining timeliness of care.</p> <p>Oppose</p>		<p>See above.</p>
<p>2 Alternatively, time-elapsed <i>guidelines</i> should be adopted, rather than prescriptive standards.</p> <p>Oppose</p> <p>3</p>		<p>§ 1367.03 (c) allows the Department to choose standards other than time-elapsed standards. Guidelines are not standards and so would not comply with § 1367.03.</p>

	<p>1 We are not aware of other then time-elapased standards that would meet the intent of the statute. The following must be in place regardless of the standard adopted:</p> <ul style="list-style-type: none"> A. For continuity purpose the standards shall be state wide and not plan specific. B. Compliance determinations must be determined for each provider category. C. Each plan shall be required to provide data to DMHC supporting the adequacy of each provider panel, by category. D. Each plan shall be required to submit to DMHC a written recruitment and retention plan when panels are not sufficient to ensure the access standards are met. 	<p>Only time-elapased standards meet the intent of the statute.</p>
<p>California Coalition of Mental Health</p>	<p>Support</p> <p>2 We would not be adverse to other recommended standards. The following must be in place regardless of the standard adopted:</p> <ul style="list-style-type: none"> A. For continuity purpose the standards shall be state wide and not plan specific. B. Compliance determinations must be determined for each provider category C. Each plan shall be required to provide data to DMHC supporting the adequacy of each provider panel, by category. D. Each plan shall be required to submit to DMHC a written recruitment plan when panels are not sufficient to ensure the access standards are met. 	<p>Time-elapased standards are essential. They provide the patient with knowledge of what timely care is. Without time-elapased standards consumers may know that they should be getting timely care but they will not have an accurate measuring stick to determine if they are or are not receiving timely care. Time-elapased standards give that certainty to patients, allowing them to be clearer on when they are provided correct or incorrect care. Time-elapased standards also ensure consistent timely care across different plans and networks enabling consumers, regardless of their plan, to know what to expect. Compliance with time-elapased standards is measurable and calculable, while many other standards are impossible to measure for compliance.</p>
	<p>Oppose</p> <p>3</p>	
<p>Health Access</p>	<p>1 DMHC should write the timely access to care standards to reflect clear time-elapased standards.</p>	<p>Support for the above reasons.</p>

	<p>2 Plans may offer advanced access or same day access. See explanation in Issue # 1.</p> <p>Support</p> <p>3 DMHC may grant a narrowly defined, time-limited exception or exemption under certain conditions. See explanation in Issue #1.</p> <p>Support</p> <p>1 Measure, track and report member satisfaction and appeals and grievance data relating to access to care.</p> <p>Oppose</p> <p>2 Measure, track, and report the network adequacy standards established by CMS.</p> <p>Oppose</p> <p>3 Measure and report HEDIS measures related to access of care.</p>	<p>Same day access is basically a time-elapsed standard in which all care is delivered in a day; support for the above reasons.</p>
<p>CAHP, ACLHIC, and AHIP</p>	<p>Support</p> <p>1 Measure, track and report member satisfaction and appeals and grievance data relating to access to care.</p> <p>Oppose</p> <p>2 Measure, track, and report the network adequacy standards established by CMS.</p> <p>Oppose</p> <p>3 Measure and report HEDIS measures related to access of care.</p>	<p>§ 1367.03 (c) allows the Department to adopt standards other than time-elapsed if they can demonstrate why the adopted standard is more appropriate. Reading member surveys will not ensure access to needed health care services in a timely manner. Consumers will not know what timely care is, and will not know when to complain. Consumers may fill out the surveys months after an appointment and can't reliably remember the particular experiences with timeliness at that time. Finally reading over surveys will only allow for subjective evaluation of the plan's performance and will not allow an objective evaluation that will make it easy to compare plans and relay that information to consumers.</p> <p>§ 1367.03 requires the Department to adopt regulations to ensure that enrollees have access to needed health care in a timely manner. Looking at other already-established standards that do not deal directly with timely access will not meet that requirement. While there is a link between network adequacy and timeliness and we think the time-elapsed standards could be augmented by network adequacy standards, network measurements by themselves do not meet the statutory requirements. See above.</p>
<p>California Medical Association</p>	<p>Oppose</p> <p>1 CMA supports the use of the Consumer Assessment of Health Plan Surveys (CAHPS) by DMHC to ascertain whether health plans are ensuring timely access to health care, the implementation of a corrective action plan process for health plans that do not receive a 75% or better patient satisfaction rating on the CAHPS, and the development of an exemption process for the corrective action plan for health plans that do not meet the 75% patient satisfaction approval rating due to physician supply shortages or problems associated with practicing in rural areas.</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>§ 1367.03 (c) allows the Department to adopt standards other than time-elapsed if they can demonstrate why the adopted standard is more appropriate. Reading member surveys will not ensure access to needed health care services in a timely manner. Consumers will not know what timely care is and will not know when to complain. Finally, reading over surveys will only allow for subjective evaluation of the plan's performance and will not allow an objective evaluation that will make it easy to compare plans and relay that information to consumers.</p>

WCLP / HRH Response on Issue #4

Issue 4	Western Center on Law & Poverty	Supporting rationale for each responsive position
<p align="center">Responsive position on Proposal No.:</p> <p>1 Additional regulations are not needed for dental plans and other specialized plans that do not provide coverage for physician services. The current rules are more than adequate.</p> <p>Oppose</p> <p>2 New regulations applying to full service plans should be completely separate from any pertaining to dental, vision, and chiropractic plans.</p> <p>Oppose</p> <p>3 Dental PPOs shall be deemed in compliance if they comply with DOI regulations.</p> <p>Oppose</p> <p>1 The regulation should be drafted in a manner that does not impose significant additional administrative burdens on one delivery system, or provider segment, over the other.</p> <p align="center">Neutral</p> <p>2</p> <p>3</p>	<p>§ 1367.03 requires the department to adopt regulations to ensure that enrollees have access to needed health care in a timely manner. Not having standards will not meet that requirement. The Department regulates plans that provide all types of health care, so it cannot choose not to include all types of health care in the regulations.</p> <p>The overall regulation should apply to all plans, full service, dental, vision, etc. as §1367.03 applies to all needed health care that the Department regulates, and all types of plans provide needed health care. The actual time-elapsd standards developed will only apply to a plan that provides that type of care.</p> <p>§ 1367.03 requires the Department to adopt regulations to ensure that enrollees have access to needed health care in a timely manner. Looking at other already established regulations from another Department or entity will not meet the specific needs of beneficiaries in DMHC-regulated plans and will not meet the statute's requirement.</p> <p>If this can be accomplished while still ensuring timely access to care that is fine, but it is too broad a general statement to have an opinion on.</p>	<p>California Association of Dental Plans</p>
<p>1 The regulations must apply to all plans providing mental health services and clearly delineate the various categories of the mental health care delivery system. For mental health providers it is critical the regulations:</p> <ul style="list-style-type: none"> A. Determine if the care is being delivered by an independent/individual, group or institutional provider or a combination. B. Ensure in-patient providers include both general acute care hospital psychiatric units, psychiatric health facilities and acute psychiatric hospitals C. Consider the amount of mental health care which is provided by primary care physical medicine providers in a non-mental health setting <p>Support</p> <p>2. The regulations must clearly articulate the various categories at all health care delivery levels and determine if the care is being delivered by an independent/individual, group or institutional provider or a combination.</p>	<p>The overall regulation should apply to all plans, full service, dental, vision, etc. as §1367.03 applies to all needed health care that the Department regulates and all types of plans provide needed health care.</p>	<p>California Association of Physician Groups</p>
<p>California Coalition of Mental Health</p>		<p align="right">DMHC 000064</p>

	<p>Neutral</p> <p>3</p> <p>1 DMHC should specify categories of health care services as described in AB 2179, including:</p> <ol style="list-style-type: none"> 1. Primary care physicians 2. Specialty physicians 3. Hospital care (inpatient, outpatient, and ancillary services) 4. Other health care <p>Support</p> <p>2</p> <p>3</p>	<p>§1367.03(a) requires that the Department consider "waiting time to speak to a qualified healthcare professional who is trained to screen or triage an enrollee who may need care" and "timeliness of care in an episode of illness, including referral time and obtaining other services, if needed" as indicators of timeliness to care. Neither of these standards is limited to a restrictive view of health care. Dental health, mental health and all types of health conditions create situations where a patient needs to speak to a qualified healthcare professional. All types of health conditions can also induce an episode of illness. The Department must ensure that enrollees in all the plans it regulates have timely access to care.</p>
<p>Health Access</p>	<p>1 The regulation should specify the following categories only:</p> <ul style="list-style-type: none"> ▪ Primary care physicians ▪ Specialty physicians (High Volume only) <p>The regulation should apply only to full service and mental health plans (basic health care services and Section 1374.72 mental health services, or alternatively framed as plans offering physician and hospital services)</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>§1367.03(a) requires that the Department consider "waiting time to speak to a qualified healthcare professional who is trained to screen or triage an enrollee who may need care" and "timeliness of care in an episode of illness, including referral time and obtaining other services, if needed" as indicators of timeliness to care. PCPs and high volume specialty physicians are not the only providers who provide care in an episode of illness.</p>
<p>California Medical Association</p>	<p>1 Any proposed categories of health care services in relation to timely access must be consistent with the plain reading of AB 2179.</p> <p>Support</p> <p>2</p> <p>3</p>	<p>§1367.03(a) requires that the Department consider "waiting time to speak to a qualified healthcare professional who is trained to screen or triage an enrollee who may need care" and "timeliness of care in an episode of illness, including referral time and obtaining other services, if needed" as indicators of timeliness to care. Neither of these standards is limited to a restrictive view health care. Dental health, mental health and all types of health conditions create situations where a patient needs to speak to a qualified healthcare professional. All types of health conditions can also induce an episode of illness. The Department must ensure that enrollees in all the plans it regulates have timely access to care.</p>

WCLP/HRH Response to Issue # 5

Issue 5	Western Center on Law & Poverty	Supporting rationale for each responsive position
<p>CAHP, ACLHIC, and AHIP joint proposal</p>	<p>Responsive position on Proposal No.:</p> <p>1. The regulation should specify the content of the annual compliance report to the Department. However the content of the report should be developed in coordination with health plans to ensure the collection of data that is comparable amongst plans. It is important that any report be meaningful. Until the standards and the framework of the regulation are determined, it is premature to determine how to report compliance to the Department.</p> <p>Support if Amended</p> <p>2</p> <p>3</p>	<p>While we agree that the regulation should specify the content of the annual compliance report, the health plans should not have undue influence as to the content of the report. DMHC's duty is to administer and enforce the Knox Keene Act "to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees." Health & Safety Code § 1341. §1367.03 requires that DMHC develop and adopt regulations to ensure that consumers receive health care services in a timely manner. Health plans are the entities to be regulated, not the entity writing the regulations.</p>
<p>California Association of Dental Plans</p>	<p>1. Number of grievances received by plans from providers/enrollees regarding enrollee access issues.</p> <p>Oppose</p> <p>2. Geographic locations where the plan has identified access issues within specific service areas and any remedial efforts undertaken to address the issue.</p> <p>Oppose</p> <p>3. Corrective action plans ("CAPs") will be required from providers who have shown a pattern of access problems, or alternately, plans will indicate steps taken to accommodate access for enrollees via other dentists. Plans shall report the number of corrective action plans instituted, the number of CAPs completed successfully, the number of CAPs that remain ongoing, and the number that have been successfully completed.</p> <p>Oppose</p>	<p>Grievances are an insufficient way to monitor compliance. Many consumers who have problems with their health plans or providers do not take the time to file grievances.</p> <p>Health plan self-monitoring without clear standards is an insufficient means to measure compliance. This proposal requires plans to identify problems rather than objectively measuring if there are access problems. Furthermore, this proposal implies that compliance with timeliness standards is not expected any time in the near future.</p> <p>While corrective action plans may be utilized, by definition, these cannot be used until a problem is identified. The compliance report must have a statistically significant method of measuring whether plans and providers are in compliance in the first place.</p>
<p>California Association of Physician Groups</p>	<p>1. The regulation should not specify the content of the annual plan, to ensure that sufficient flexibility will be provided for the industry to adapt to changing demographic, technology, cultural and workforce issues over time.</p> <p>Oppose</p> <p>2. Alternatively, should the Department adopt content requirements, it should convene an advisory panel of experts in the fields of clinical practice, and performance measurement to guide itself in the development of appropriate standards. These should be revised every five years to ensure that outdated and obsolete requirements are purged from the filings so as not to impede the pace of clinical development and best practices.</p> <p>Oppose</p> <p>3. N/A</p>	<p>§1367.03(f)(2) requires the Department to specify the manner in which compliance is reported. It also requires that the reported information allows consumers to compare the performance of plans and their contracting providers, as well as determine changes in plans' compliance to the timely access standards. This will not be possible unless all plans are reporting their compliance in the same manner.</p> <p>Just like health plans, physician groups should not have undue influence as to the content of the report. DMHC's duty is to administer and enforce the Knox Keene Act "to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees." Health & Safety Code § 1341. §1367.03 requires that DMHC develop and adopt regulations to ensure that consumers receive health care services in a timely manner.</p>

<p>California Medical Association</p>	<p>1. CMA has no specific comments on what the contents of the annual health plan compliance report to DMHC should include at this point. However, CMA believes that DMHC should have a comprehensive report to the Legislature regarding "the progress toward the implementation of (AB 2179) . . ." as required under Health and Safety Code section 1367.03, subdivision (j).</p>	<p>1. CMA has no specific comments on what the contents of the annual health plan compliance report to DMHC should include at this point. However, CMA believes that DMHC should have a comprehensive report to the Legislature regarding "the progress toward the implementation of (AB 2179) . . ." as required under Health and Safety Code section 1367.03, subdivision (j).</p>	<p>§1367.03(f)(2) requires the Department to specify the manner in which compliance is reported. It also requires that the reported information allows consumers to compare the performance of plans and their contracting providers, as well as determine changes in plans' compliance to the timely access standards. This will not be possible unless all plans are reporting their compliance in the same manner. This proposal addresses our concerns. We would want such survey to also capture timely access for the LEP population.</p>
<p>No Position</p>	<p>2</p>	<p>2</p>	<p>2</p>
<p>Health Access</p>	<p>1. DMHC should specify the scope of the plan's compliance report demonstrating their performance in timely access to care. Regulatory language should require plans to include information concerning their enrollees in the following areas:</p> <ol style="list-style-type: none"> 1. Statistically valid and reliable scientific survey data. 2. Data should be extracted from statistically reliable representative samples from services requested/delivered <ol style="list-style-type: none"> a. In all geographic areas served by the plan, b. for all primary care c. for all specialty services d. across all contracted entities (medical groups, IPAs, etc.) e. by non-contracted providers where there are insufficient providers or consumers experience long delays in receiving services or both or other difficulties the plans experience in actually delivering timely access to care f. including services requested for which no services were delivered g. within a specific time frame to reflect longitudinal information regarding improvement or deterioration of services. h. From anonymous audits of providers <p>3. Statistical data and analysis should be supported by investigation of a sample of case histories to uncover underlying causes of and remedies for dissatisfaction with the plan's performance in timely access including:</p> <ol style="list-style-type: none"> a. consumer complaints, b. grievance and appeal data, c. disenrollment case histories, including reasons for disenrollment, d. provider disputes to uncover underlying causes for dissatisfaction with the plan's (or medical group's or other contracted entity's) performance. <p>4. DMHC should not permit the plans to rely on so-called Customer Satisfaction Surveys because they do not serve as a true measure of health care.</p> <p>5. Analysis of trends, corrective actions undertaken or contemplated.</p> <p>DMHC should require reports based on the statutorily-mandated intervals, but reserve the right to require more frequent or more detailed reports based on indicators of poor performance, indicators of precarious financial stability, or other negative indicators.</p>	<p>1. DMHC should specify the scope of the plan's compliance report demonstrating their performance in timely access to care. Regulatory language should require plans to include information concerning their enrollees in the following areas:</p> <ol style="list-style-type: none"> 1. Statistically valid and reliable scientific survey data. 2. Data should be extracted from statistically reliable representative samples from services requested/delivered <ol style="list-style-type: none"> a. In all geographic areas served by the plan, b. for all primary care c. for all specialty services d. across all contracted entities (medical groups, IPAs, etc.) e. by non-contracted providers where there are insufficient providers or consumers experience long delays in receiving services or both or other difficulties the plans experience in actually delivering timely access to care f. including services requested for which no services were delivered g. within a specific time frame to reflect longitudinal information regarding improvement or deterioration of services. h. From anonymous audits of providers <p>3. Statistical data and analysis should be supported by investigation of a sample of case histories to uncover underlying causes of and remedies for dissatisfaction with the plan's performance in timely access including:</p> <ol style="list-style-type: none"> a. consumer complaints, b. grievance and appeal data, c. disenrollment case histories, including reasons for disenrollment, d. provider disputes to uncover underlying causes for dissatisfaction with the plan's (or medical group's or other contracted entity's) performance. <p>4. DMHC should not permit the plans to rely on so-called Customer Satisfaction Surveys because they do not serve as a true measure of health care.</p> <p>5. Analysis of trends, corrective actions undertaken or contemplated.</p> <p>DMHC should require reports based on the statutorily-mandated intervals, but reserve the right to require more frequent or more detailed reports based on indicators of poor performance, indicators of precarious financial stability, or other negative indicators.</p>	<p>§1367.03(f)(2) requires the Department to specify the manner in which compliance is reported. It also requires that the reported information allows consumers to compare the performance of plans and their contracting providers, as well as determine changes in plans' compliance to the timely access standards. This will not be possible unless all plans are reporting their compliance in the same manner. This proposal addresses our concerns.</p>
<p>Support if Amended (add LEP issue)</p>	<p>2. All of the above in #1. In addition, plans may supplement their data collection and analysis by including demonstration project data, pilot program results, electronic health record advances or other consumer or provider initiatives that support their continuous quality improvement in the area of timely access to care.</p>	<p>2. All of the above in #1. In addition, plans may supplement their data collection and analysis by including demonstration project data, pilot program results, electronic health record advances or other consumer or provider initiatives that support their continuous quality improvement in the area of timely access to care.</p>	<p>§1367.03(f)(2) requires the Department to specify the manner in which compliance is reported. It also requires that the reported information allows consumers to compare the performance of plans and their contracting providers, as well as determine changes in plans' compliance to the timely access standards. This will not be possible unless all plans are reporting their compliance in the same manner. This proposal addresses our concerns.</p>

<p>California Coalition of Mental Health</p>	<p>Support if Amended (add LEP issue) 3.</p> <p>1 Yes, the content of the annual compliance report and public disclosure of that report is critical to study and determine if the access regulations are having their intended effect by enabling the consumer to receive mental health care in a timely manner. For there to be a true test of timely access to care, there must be independent review of the health plans-self monitoring is not acceptable. That review must be publicly posted on both the DMHC website and each plan's website. The plan would contract with a third party who would identify deficiencies.</p> <p>The compliance report shall include all pertinent information relating to the access to services, including, but not limited to the following:</p> <ul style="list-style-type: none"> A. A description of the adequacy of the plan's provider network, including provider capacities available to the plan (on a full-time equivalent basis) B. A summary of enrollee grievances received during the prior calendar year, regarding timely access. C. The results of the previous and current year's enrollee satisfaction surveys (the surveys would contain standardized questions generated from the DMHC) D. Patterns of non-compliance identified E. A summary of corrective action related to the timely access standards (see below re: corrective action) <ul style="list-style-type: none"> • The corrective action summary shall detail the following, with corresponding timelines for compliance: • Recruitment of additional providers • Enhanced efforts to attract non-contracting providers to increase capacity • Increased ease of authorization for referrals to available non-contracting providers in shortage areas • Plan monitoring and documentation of contract providers who previously contracted with plans and are no longer contracting with plans to determine the reason for non-contracting. • Plan documentation of communication to enrollees regarding the plan's applicable timely access standards and how to obtain the plan's assistance in obtaining timely appointments. • All penalties assessed as a result of non-compliance <p>The report must be posted on the DMHC and each individual plan's website</p> <p>Support if Amended 2</p>	<p>We agree that an independent review is essential and that adequacy of network is a good indication of a health plan's ability to offer services in a timely manner. However, we feel strongly that anonymous telephone audits or some other measure that can be conducted in a statistically significant and reliable manner be included.</p>
	<p>3 Same as 1, save for the plan rather than 3rd party would identify deficiencies</p> <p>Support if Amended</p>	<p>Again, we feel strongly that anonymous telephone audits or some other measure that can be conducted in a statistically significant and reliable manner be included.</p>

WCLP/HRH Response to Issue # 6

Issue 6	Western Center on Law & Poverty	Supporting rationales for each responsive position
CAHP, ACLHIC, and AHIP joint proposal	Responsive position on Proposal No.:	Supporting rationales for each responsive position
<p>1. it is premature to evaluate a provider report until it determined whether the regulation will impose an obligation on providers.</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>	<p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>
<p>California Association of Dental Plans</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>1. The Department should not specify the content of the provider report.</p> <p>Oppose</p> <p>2. Alternatively, the Department should only specify the content in broad terminology.</p> <p>Oppose</p> <p>3. Alternatively, should the Department adopt content requirements, it should convene an advisory panel of experts in the fields of clinical practice, and performance measurement to guide itself in the development of appropriate standards. These should be revised every five years to ensure that outdated and obsolete requirements are purged from the filings so as not to impede the pace of clinical development and best practices.</p>	<p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p> <p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p> <p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p> <p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p> <p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p> <p>Additionally, physician groups should not have undue influence as to the content of the report. DMHC's duty is to administer and enforce the Knox Keene Act "to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees." Health & Safety Code § 1341. §1367.03 requires that DMHC develop and adopt regulations to ensure that consumers receive health care services in a timely manner.</p>
<p>California Association of Physician Groups</p> <p>Oppose</p> <p>1. CMA has no specific comments on what contents are necessary to ensure provider reporting is compatible with health plans' reporting requirements at this point. However, CMA urges DMHC to ensure that health plan contract provisions related to timely access to health care comply with provisions of the Knox Keene Act protecting physicians.</p> <p>No position</p> <p>2</p> <p>3</p>		

<p>Health Access</p>	<p>1. DMHC should specify in the regulation the content, format, and frequency of the medical groups or other contracted entities' reports to the plans to ensure consistency, timeliness, comparability, and compliance with the report required by the plans to DMHC and to provide ongoing analysis of the quality of care delivered to their plan enrollees. See specific details outlined in Issue #5.</p> <p>Support</p> <p>2</p> <p>3</p>	<p>We agree with this proposal. §1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>
<p>California Coalition of Mental Health</p>	<p>2</p> <p>3. The regulation shall specify the content of the provider report to the plans. It shall require the same content specified in Issue 5 with the mental health services distinct from other services. It shall be in a standardized format submitted on paper and on digital media.</p> <p>RATIONALE: The regulation must specify the content of the provider report, and must require the same content as in Issue 5 so that the data is consistent and comparable from provider to provider and plan to plan. Mental health services must be distinguished so that meaningful comparisons can be made. Submission of the data in electronic format will facilitate aggregation and analysis of the data.</p> <p>Support</p>	<p>We agree with this position (save for our suggestions to CCMH's issue 5 position). §1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>

WCLP/HRH Response to Issue # 6

Issue 6	Western Center on Law & Poverty	Supporting rationale for each responsive position
	Responsive position on Proposal No.:	
CAHP, ACLHIC, and AHP joint proposal	<p>1. It is premature to evaluate a provider report until it is determined whether the regulation will impose an obligation on providers.</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>
California Association of Dental Plans	<p>1. None</p> <p>Oppose</p> <p>2</p> <p>3</p>	<p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>
California Association of Physician Groups	<p>1. The Department should not specify the content of the provider report.</p> <p>Oppose</p> <p>2. Alternatively, the Department should only specify the content in broad terminology.</p> <p>Oppose</p> <p>3. Alternatively, should the Department adopt content requirements, it should convene an advisory panel of experts in the fields of clinical practice, and performance measurement to guide itself in the development of appropriate standards. These should be revised every five years to ensure that outdated and obsolete requirements are purged from the filings so as not to impede the pace of clinical development and best practices.</p> <p>Oppose</p>	<p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p> <p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p> <p>§1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent. Additionally, physician groups should not have undue influence as to the content of the report. DMHC's duty is to administer and enforce the Knox Keene Act "to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees." Health & Safety Code § 1341. §1367.03 requires that DMHC develop and adopt regulations to ensure that consumers receive health care services in a timely manner.</p>
California Medical Association	<p>1. CMA has no specific comments on what contents are necessary to ensure provider reporting is compatible with health plans' reporting requirements at this point. However, CMA urges DMHC to ensure that health plan contract provisions related to timely access to health care comply with provisions of the Knox Keene Act protecting physicians.</p> <p>No position</p> <p>2</p> <p>3</p>	

<p>Health Access</p>	<p>1. DMHC should specify in the regulation the content, format, and frequency of the medical groups or other contracted entities' reports to the plans to ensure consistency, timeliness, comparability, and compliance with the report required by the plans to DMHC and to provide ongoing analysis of the quality of care delivered to their plan enrollees. See specific details outlined in Issue #5.</p> <p>Support</p> <p>2</p> <p>3</p>	<p>We agree with this proposal. §1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>
<p>California Coalition of Mental Health</p>	<p>2</p> <p>3. The regulation shall specify the content of the provider report to the plans. It shall require the same content specified in Issue 5 with the mental health services distinct from other services. It shall be in a standardized format submitted on paper and on digital media.</p> <p>RATIONALE: The regulation must specify the content of the provider report, and must require the same content as in Issue 5 so that the data is consistent and comparable from provider to provider and plan to plan. Mental health services must be distinguished so that meaningful comparisons can be made. Submission of the data in electronic format will facilitate aggregation and analysis of the data.</p> <p>Support</p>	<p>We agree with this position (save for our suggestions to CCMH's issue 5 position). §1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, thus all steps in the process should be uniform and transparent.</p>

WCLP/HRH Response to Issue # 7

Issue 7	Western Center on Law & Poverty	Supporting rationale for each responsive position
<p>CAHP, ACLHIC, and AHP Joint proposal</p>	<p>Responsive position on Proposal No.:</p> <p>1. No Oppose</p> <p>2. 3.</p>	<p>The regulation should specify requirements for plan monitoring of provider network accessibility, availability and/or continuity of services, including e.g., compliance with geographic standards, provider-to-enrollee ratio standards, and a global cap standard. § 1367.03(f)(1) specifically requires that all contracts that the health plans make with health care providers "assure compliance with the standards developed under this section." Health plans may in fact be fined for repeated failure to act promptly and reasonably to "assure timely access to care" and to "require contracting providers to assure timely access to care." § 1367.03(g)(3)(A)&(B). Uniform monitoring requirements will make timely access more likely and subject providers who contract with multiple health plans subject to the same monitoring by all plans.</p>
<p>California Association of Dental Plans</p>	<p>1. The regulation should not specify requirements for dental plan monitoring of provider network accessibility and/or continuity of services. Oppose</p> <p>2. Plan monitoring of accessibility can include a yearly assessment of the plan's ability to meet its own accessibility standards as approved by the DMHC. Oppose</p> <p>3. A plan's access assessment should focus on detecting patterns and trends. The failure of any one specific provider to meet the access standards should not rise to the level of plan noncompliance. Neutral</p>	<p>The regulation should specify requirements for plan monitoring of provider network accessibility, availability and/or continuity of services, including e.g., compliance with geographic standards, provider-to-enrollee ratio standards, and a global cap standard. § 1367.03(f)(1) specifically requires that all contracts that the health plans make with health care providers "assure compliance with the standards developed under this section." Health plans may in fact be fined for repeated failure to act promptly and reasonably to "assure timely access to care" and to "require contracting providers to assure timely access to care." § 1367.03(g)(3)(A)&(B). Uniform monitoring requirements will make timely access more likely and subject providers who contract with multiple health plans subject to the same monitoring by all plans.</p> <p>§ 1367.03(f)(1) specifically requires that all contracts that the health plans make with health care providers "assure compliance with the standards developed under this section." Health plans may in fact be fined for repeated failure to act promptly and reasonably to "assure timely access to care" and to "require contracting providers to assure timely access to care." § 1367.03(g)(3)(A)&(B). Uniform monitoring requirements will make timely access more likely and subject providers who contract with multiple health plans subject to the same monitoring by all plans.</p> <p>This merely restates the law.</p>
<p>California Association of Physician Groups</p>	<p>1. The Department should not specify requirements for plan monitoring of provider network accessibility, etc. over and above what is currently provided to it in periodic filings and surveys. Oppose</p> <p>2. N/A 3. N/A</p>	<p>The regulation should specify requirements for plan monitoring of provider network accessibility, availability and/or continuity of services, including e.g., compliance with geographic standards, provider-to-enrollee ratio standards, and a global cap standard. § 1367.03(f)(1) specifically requires that all contracts that the health plans make with health care providers "assure compliance with the standards developed under this section." Health plans may in fact be fined for repeated failure to act promptly and reasonably to "assure timely access to care" and to "require contracting providers to assure timely access to care." § 1367.03(g)(3)(A)&(B). Uniform monitoring requirements will make timely access more likely and subject providers who contract with multiple health plans subject to the same monitoring by all plans.</p>

<p>California Medical Association</p>	<p>1. To address the issue of whether there are adequate numbers of contracting physicians in a health plan's network, DMHC should ensure health plans are complying with existing access standards, as discussed in section II. In addition, because network adequacy is difficult to assess without having the appropriate information, DMHC must adopt the language below to better assess the adequacy of plan networks</p> <p>Non-responsive</p> <p>2. 3.</p>	<p>We agree that network adequacy is an essential component of timely access to care. This proposal, however, does not address health plan monitoring of provider accessibility.</p>
<p>Health Access</p>	<p>1. DMHC may offer alternative measurement of timely access to care by designating minimum enrollee ratio standards to primary care physicians or physicians (including specialists).</p> <p>Support, if amended</p> <p>2. 3.</p>	<p>We agree that minimum enrollee ratio standards are an effective measure of network adequacy and thus increase the likelihood of timely access to care. However, the regulation should specify requirements for plan monitoring of provider network accessibility, availability and/or continuity of services, including e.g., compliance with geographic standards, provider-to-enrollee ratio standards, and a global cap standard.</p>
<p>California Coalition of Mental Health</p>	<p>1. Yes, this is a critical component of access regulations and at the heart of access problems. There must be both standards for measuring access that are measurable and enforceable as well as assure that patients have improved access to health care providers—including individual, group, and institutional providers. Provider networks must be mental health specific, address parity issues, provide for adequate physicians and other mental health professionals, have sufficient ratios to meet consumer needs, be kept up-to-date and accurate, have panels that are accessible and available, distinguish specialties, adequately provide for varying cultural and linguistic differences, as well as adequately delineate providers who can effectively serve persons with physical disabilities.</p> <p>Ideally</p> <p>A. Require plans to update networks monthly B. Require plans/plan networks that contract to others for the provision of services (contract to "carve-outs"/specialized health care service plans) to clients to be responsible for, oversee, and impose the same or substantially similar requirements on those with whom they contract C. Require that terminated/ing providers be removed from panels by plans within thirty days D. Require plans to have networks that are accessible online E. Require plans to have networks that are specific to mental health care</p>	<p>We agree that the regulation should specify requirements for plan monitoring of provider network accessibility, availability and/or continuity of services, including e.g., compliance with geographic standards, provider to enrollee ratio standards, and a global cap standard. This seems to address the majority of our concerns [save for global cap].</p>

	<p>F. Require that plan networks have an adequate specified full time equivalent (FTE) ratio of mental health care providers to potential clients</p> <p>G. Require plan networks to delineate provider areas of emphasis or specialization</p> <p>H. Require plan networks to have an adequate specified ratio of providers who are culturally and linguistically competent</p> <p>I. Require plans to have networks with an adequate specified ratio of providers who can accommodate persons with physical disabilities</p> <p>J. Require plans to have networks delineating providers' availability to see clients referred by the managed care organization</p> <p>K. Require plans to have within their networks, or make every reasonable effort to have, an adequate supply of mental health providers in rural areas, or if not possible due to provider unavailability, provide optional methods of service delivery that are clear and understandable to consumers</p> <p>L. DMHC will audit plans or have another reasonable mechanism to ensure that managed care organizations meet the specified standards and DMHC will take action when plans fall beneath the standards</p> <p>M. Provide incentives to managed care organizations that exceed the specified standards</p> <p>N. Provide for penalties to managed care organizations that fail to meet the specified standards and enforce the penalties</p>	
<p>Support</p> <p>2.</p> <p>3. Minimally Acceptable</p> <p>A. Require plans to update networks monthly</p> <p>B. Require plans/plan networks that contract to others for the provision of services (contract to "carve-outs"/specialized health care service plans) to clients to be responsible for, oversee, and impose the same or substantially similar requirements on those with whom they contract</p> <p>C. Require that terminated/ing providers be removed from panels by plans within thirty days</p> <p>D. Require plans to have networks that are accessible online</p> <p>E. Require plans to have networks that are specific to mental health care</p> <p>F. Require plans to have networks with an adequate specified ratio of mental health care providers to potential clients</p> <p>G. Require plan networks to have an adequate specified ratio of</p>		<p>We agree that the regulation should specify requirements for plan monitoring of provider network accessibility, availability and/or continuity of services, including e.g., compliance with geographic standards, provider to enrollee ratio standards, and a global cap standard. This seems to address the majority of our concerns (save for global cap).</p>

	<p>providers who are culturally and linguistically competent Require plans to have networks with an adequate specified ratio of providers who can accommodate persons with physical disabilities DMHC will audit plans or have another reasonable mechanism to ensure that managed care organizations meet the specified standards and DMHC will take action when plans fall beneath the standard Require plan networks to have an adequate specified ratio of mental health care providers to potential clients J. Require plan networks to have an adequate specified ratio of providers who are culturally and linguistically competent K. Require plan networks to have an adequate specified ratio of providers who can accommodate persons with physical disabilities</p> <p>DMHC shall provide plan auditing or another reasonable mechanism to ensure that managed care organizations meet the standards and take action when they fall beneath the standards</p> <p>Support</p>	
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Jen Flory

From: Elizabeth Landsberg
Sent: Thursday, July 24, 2008 4:37 PM
To: Chammout, Suzanne; Alvarez, Emilie
Cc: Jen Flory; Ann Rubinstein
Subject: Timely Access Proposals
Attachments: WCLP-HRH Timely Access Proposal 7 24 08.doc

Attached please find Western Center's proposals for the timely access to care regulations. We worked with the Health Rights Hotline in developing them.

Elizabeth

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3/3/2010

Timely Access Proposals

Western Center on Law & Poverty	"Top Three" proposals	Supporting rationale for proposals
<p>The regulations should focus on the three required indicators set forth in the statute:</p> <ol style="list-style-type: none"> 1. Waiting time for appointments with primary and specialty care physicians. 2. Waiting time to speak to an MD, RN or other qualified healthcare professional who is trained to screen or triage an enrollee who may need care. 3. Timeliness of care in an episode of illness, including referral time and obtaining other services. <p>Three additional indicators should be incorporated into the regulations:</p> <ol style="list-style-type: none"> 4. Office waiting time. 5. Timely access to language services. LEP consumers must be able to get the appointment and telephone triage within the required time period with an interpreter or other necessary language services. 6. As laid out under Issue 3, we believe the regulations should have a global cap of the number of patients assigned to each physician. <p><u>Related Considerations:</u></p> <ol style="list-style-type: none"> 1. Yes, the regulation should require that plans provide or arrange for a telephone triage program. 2. The triage services must be made available at all times. Plans must ensure that their enrollees have access to triage services. Some plans may delegate that responsibility to medical groups 	<p>1-3. The statute states that the indicators in 1367.03(a) – appointment waiting times, timeliness of care and triage waiting times – shall be included, but allows for additional indicators.</p> <p>4. An office waiting time indicator is necessary to implement (a)(1) “waiting time for appointments.” This indicator included in the statute includes not only how many hours or days a consumer has to wait for an appointment, but also when she arrives at the appointment how long she has to wait.</p> <p>5. Access to an appointment or a telephone triage call without an interpreter is of no use to a sick consumer who is Limited English Proficient (LEP). Therefore, the timely access standards should specifically require that language services be provided and include a reference to the final regulations regarding the Language Assistance Programs, §1300.67.04-.07. This is necessary to ensure that the proposed timely access regulations apply to the timely access requirements described in §1300.67.04(C)(2)(G)(v). This is critical because there are no timely access standards in the current Language Assistance Program regulations. In §1300.67.04(C)(2)(G)(v), “timely” means in a manner appropriate for the situation in which language assistance is needed.” In discussions with DMHC, advocates were told that it was unnecessary to include specific time periods because the issue was to be addressed in these timely access regulations, and that the timely access standards would apply to the provision of language assistance services.</p> <p>6. Physician to patient ratios are another critical component in assessing a plan’s ability to provide timely access to care. Consumers only receive timely access to care when there is an adequate provider network.</p>	<p>1. Subsection 1367.03(a)(3) makes it clear that a key indicator of timely care is telephone triage times. Consumers are not doctors and need help to determine whether they are in need of urgent or emergency care.</p> <p>2-3. It is critical for consumers to be able to reach a trained medical professional for triage at all times, including during nights and weekends when they do not have access to their providers. Many</p>

	<p>or providers but consumers must have information on their member services card of who to call for triage.</p> <p>3. All health plans should be required to ensure their enrollees have access to telephone triage, whether they delegate it to medical groups or providers or provide it themselves.</p>	<p>consumers do not understand the difference between a medical group, IPA and health plan. They just need to know what number to call in the middle of the night when their child has a high fever or other worrisome symptoms. The last unnumbered sentence of section 1367 makes clear that the plan's obligation to delegate a responsibility to a medical group, IPA or other contracting entity, does not relieve the plan of their responsibilities. Plans must make sure consumers know where to call.</p>
<p>Issue 2</p>	<p>In developing time-elapsed standards, the DMHC should consider the four factors in §1367.03(b).</p> <p><u>Related Considerations</u></p> <p>2. DMHC should consider other requirements as laid out in §1367.03(e). For example, state contracts with Medi-Cal health plans require that urgent care appointments be given within 48 hours and that prenatal appointments be given within one week. State contracts with Medi-Cal dental plans require that initial appointments be given within 3 weeks and have specific language access requirements. These standards serve as a useful floor. Timeliness standards developed by professional associations should also be considered.</p> <p>3. A safe harbor provision that sets standards for same-day access for appointments could be incorporated.</p> <p>5. If plans know they do not have an adequate provider network to comply with the standards they should be required to inform the Department, request an exemption for a specified time period not to exceed six months and propose a corrective action plan for how they will come into compliance within the time period. The request for exemption should include:</p> <ol style="list-style-type: none"> What portion of the plan's service area is affected, The category of provider(s) affected, The extent of the provider shortage, The particular timeliness standard or standards for which the plan seeks a waiver, The steps the plan will take to provide timely access to enrollees within the services area, including allowing enrollees to use out-of-network providers, and educate 	<p>2. Subsection 1367.03(e)</p> <p>3. None of the time-elapsed standards for appointment waiting times proposed to date as part of the regulatory process has been shorter than 24 hours, so same-day access in addition to availability of urgent care appointments within 24 hours on the weekends and holidays would comply with these standards. The regulations would need to set requirements for the same-day access safe harbor provisions as previous versions did to ensure the plan can demonstrate routine compliance with same-day access.</p> <p>5. Section 1367.03 does not refer to a process to exempt plans from the timeliness standards, so if one is allowed in extenuating circumstances it must be justified, time-limited and the non-compliance must be corrected as aggressively and expeditiously as possible</p>

	<p>them regarding how to access services, and</p> <p>f. The specific corrective steps the plan will take to correct the deficiencies within six months.</p> <p>With their request for an exemption plans should be required to file information indicating:</p> <ol style="list-style-type: none"> a. The distribution of enrollees in the affected service area; b. Population density in the affected service area; c. Availability and distribution in the affected service area of the type of providers for which the plan seeks an exemption of timeliness standards; and d. Materials the plan will send to affected enrollees advising them how to access services. <p>In evaluating requests for exemptions, the DMHC should consider:</p> <ol style="list-style-type: none"> a. The scope of the exemption sought; b. The harm to enrollees and how the plan proposes to ameliorate such harm, including by offering access to out-of-plan providers; c. How the plan proposes to correct the deficiency within the required timeframe; d. Whether other plans are able to comply with the timely access standards in the affected service area; e. The number and availability of providers in the affected service area; and f. Whether the deficiency in provider network was caused by the plan's own failure to contract or an external circumstance
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<p>Issue 3</p>	<p>No, the regulations should not establish standards other than time-elapsed standards. Below are the specific time-elapsed standards we think are appropriate. In issue 4 each category is defined.</p> <p>Primary Care Urgent- within 24 hours Routine- within 10 calendar days Preventive- within 22 calendar days Specialty Care Urgent- within 24 hours Routine- within 14 calendar days Preventive- within 30 calendar days Hospital Care Urgent- within 24 hours Non-Urgent Care- within 60 calendar days, unless a shorter time is appropriate based on the nature of the enrollee's condition Mental Health Urgent- within 24 hours Routine initial evaluation- within 12 calendar days Routine subsequent- within 14 calendar days Follow-up after inpatient stay- within 5 calendar days Dental Health Urgent- within 24 hours Routine within 14 calendar days Preventive within 60 calendar days Ancillary & Other Health Care Urgent- within 24 hours Routine within 14 calendar days Preventive within 30 calendar days</p> <p>In addition to the specific standards categorized by type of health care sought there should be specific standards for office waiting time and for waiting times on hold with a triage service and responses to calls to a triage service. Office waiting times should not exceed 30 minutes. Triage systems should be available to each and every enrollee 24 hours a day seven days a week. When an enrollee contacts a triage service, if they are placed on hold while waiting to speak with a qualified health professional the hold time should not exceed ten</p>	<p>Time-elapsed standards are essential. They provide the patient with knowledge of what timely care is. Without time-elapsed standards consumers may know that they should be getting timely care but they will not have an accurate measuring stick to determine if they are or are not receiving timely care. Time-elapsed standards give that certainty to patients, allowing them to be clearer on when they are provided correct or incorrect care. Time-elapsed standards also ensure consistent timely care across different plans and networks enabling consumers, regardless of their plan, to know what to expect. Compliance with time-elapsed standards is measurable and calculable, while many other standards are impossible to measure for compliance.</p> <p>The rationale for standards for office waiting times and triage response are discussed in issue 1.</p>
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minutes. If the enrollee calls the triage service and leaves a message he or she should be called back within 30 minutes by a qualified health professional.

Plans or medical groups that operate on an advanced or same-day access system should not have to comply with time-elapsed standards for the type of care which they provide on a same-day access system assuming they demonstrate compliance with the same-day standard set in the regulation.

In addition to time-elapsed standards and same-day access there should be a global cap of how many patients each physician is assigned, regardless of the patient's health care coverage.

Related Considerations

1. No, time-elapsed standards are the only appropriate standard, but same day access can work in conjunction with them.
2. There should not be an alternate standard as only time-elapsed standards can meet the necessary criteria. Time-elapsed standards are essential as they are both amenable to monitoring, documenting, and enforcement and they make it easy for consumers to gauge if they are receiving timely care. Both providers and consumers can report back on how strictly time-elapsed standards are being adhered to without yielding subjective results. Any other alternative would not be easy to objectively monitor and measure and be easy for consumers to comprehend.
3. There should not be a different standard.

Same-Day Access (Advanced Access) would function along side time-elapsed standards. Same-day access would allow enrollees to access their primary care of any type within one day or as soon thereafter as they desired. This would work in conjunction with time-elapsed standards for hospital care and for specialty care, unless the plan is using a same-day access system for specialty care. Any plan or medical group that did not offer same-day, open, or advanced access would still have to comply with the time-elapsed standards. Same-day access is a good companion to the time-elapsed standards as it provides care to patients that is either as timely or more timely than the time-elapsed standards.

A global cap will ensure that physician-patient ratios are at a reasonable level, not just within each individual plan or network but in total global caps will go far towards eliminating the problems of phantom networks, where networks have a certain number of providers in them but they never actually accept new patients or have time to see all the patients assigned to them. A global cap will work in conjunction with the time-elapsed standards, not to replace the standards. The global cap will enable plans and medical groups to comply with the time-elapsed standards. A global cap will fulfill the legislation's requirement for the Department to know and take into account the "nature of the plan's network," and guarantee that physicians in the network have time to assist their patients in a timely manner. § 1367.03(d).

<p>The Department regulates plans that provide all types of health care, so it cannot choose not to include all types of health care in the regulations. AB 2179 stated: "It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers have timely access to health care." This intent is not limited to enrollees in non-specialty health care services plan; it extends to all enrollees, as the regulation itself should. §1367.03(a) requires that the Department consider "waiting time to speak to a qualified healthcare professional who is trained to screen or triage an enrollee who may need care" and "timeliness of care in an episode of illness, including referral time and obtaining other services, if needed" as indicators of timeliness to care. Neither of these standards is limited to a restrictive view of health care. Dental health, mental health and all types of health conditions require care by a qualified healthcare professional. All types of health conditions can also induce an episode of illness. The Department must ensure that enrollees in all the plans it regulates have timely access to care.</p>	<p>The regulations should include the listed areas of primary care physicians, specialty physicians and hospital care. Mental and dental health categories should be added. The category "other health care" should be expanded to "ancillary & other health care."</p> <ul style="list-style-type: none"> Primary care physicians Specialty physicians Hospital care Mental health Dental health Ancillary & other health care <p><u>Related Considerations</u></p> <ol style="list-style-type: none"> 1. The scope of hospital care should include inpatient and outpatient surgeries. 2. "Ancillary & other health care services" should include all ancillary care such as radiology, laboratory, pathology, physical therapy, occupational therapy, speech therapy, chemotherapy, dialysis, preventive screening and diagnostic procedures. It should include vision, chiropractic, and acupuncture care. Ancillary & other health care should also include any health care that does not fall into one of the listed categories but is a service provided by a plan that the Department regulates. 3. The standards should apply to all types of plans that the Department regulates. <p>Dental health care should have its own category, as should mental health care.</p>	<p>Issue 4</p>
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<p>The regulations should specify the content of the annual plan compliance report to the Department. The report should contain the results of anonymous telephone audits of providers. The audits must be statistically significant and conducted in multiple languages. The Department should set benchmark levels plans must meet to show compliance. Health plans can also include other information that might be useful to the Department, such as reviews of timely-access related grievances or reviews of disenrolled members, but all reports should contain a comparable, methodologically sound test of timeliness.</p> <p><u>Related Considerations</u></p> <p>1-2. The standard above will ensure adequate information to the Legislature and the OPA. Using just one statistically significant and reliable method of testing most enables consumers to compare across the board. DMHC should produce the results of anonymous telephone audits to OPA.</p> <p>3. Yes, the regulation should specify the nature and frequency of plan monitoring activities to ensure adequate plan oversight, including of delegated programs, as well as collection of information necessary to include in the report. Plan monitoring through telephone audits must be statistically significant and conducted at least annually. Delegated programs must be monitored as well and held to the same standards.</p> <p>4. Yes, the regulation should specify the timeframe & scope of plan corrective actions when the plan identifies access or compliance deficiencies. We support the previous versions of the timely access regulations which require health plans to respond immediately and correct deficiencies within 60 days, with an additional 60-day extension if a corrective action plan is filed which would increase timely access of enrollees.</p>	<p>§1367.03(f)(2) requires the Department to specify the manner in which compliance is reported. It also requires that the reported information allows consumers to compare the performance of plans and their contracting providers, as well as determine changes in plans' compliance to the timely access standards. This will not be possible unless all plans are reporting their compliance in the same manner.</p> <p>Health plans should not be permitted to use self-serving methodologies to demonstrate their compliance with the Timely Access regulations. Anonymous telephone audits are the most reliable. Choosing one reliable method will also limit the costs spent in this and further enable health plans to share costs in auditing providers who accept more than one health plan.</p> <p>Anonymous telephone audits can be quantified and easily compared and should be provided to OPA for inclusion in its report card.</p> <p>Again, as consumers should be able to compare compliance both among plans and through time, the nature and frequency of monitoring activities should be uniform. § 1367.03 regulates health plans, thus responsibility for timely access cannot be delegated even when programs are. § 1367.03(f)(1) specifically requires that all contracts that the health plans make with health care providers "assure compliance with the standards developed under this section." Health plans may in fact be fined for repeated failure to act promptly and reasonably to "assure timely access to care" and to "require contracting providers to assure timely access to care." § 1367.03(g)(3)(A)&(B). The last unnumbered sentence in 1367(i) prohibits delegation of responsibilities to medical groups or other entities.</p> <p>If there is no timeframe for corrective actions, there is little incentive to comply. Furthermore, setting standards for the timeframe and scope of plan corrective actions where compliance deficiencies occur would enable the Department to monitor compliance as required by § 1367.03(g) in a fair and consistent manner.</p>
<p>Issue 5</p>	

<p>Issue 6</p>	<p>The regulation should specify the content of the provider report to the plans. Providers should report on the information not otherwise accessible to the health plan such as what their patient care load is and whether when they are using a same-day access system they are actually providing same-day access. If telephone triage services are delegated to the providers, these should be monitored by the plans as well as reported by the providers. Providers should also report on timely access to interpreter services.</p> <p><u>Related Considerations</u></p> <p>Providers need not track every appointment waiting time, but should be prepared to give their policies and procedures to the plans so that this information may be measured against the results of the anonymous telephone audits.</p>	<p>Again, as §1367.03(f)(2) states that consumers are supposed to be able to compare health plan and provider compliance with the timely access requirements, all steps in the process should be uniform and transparent.</p>
<p>Issue 7</p>	<p>The regulation should specify requirements for plan monitoring of provider network accessibility, availability and/or continuity of services, including e.g., compliance with geographic standards, provider to enrollee ratio standards, and a global cap standard.</p> <p><u>Related Considerations</u></p> <p>2. As with all other requirements, delegation does not relieve health plans from complying with the law. Health plans should put QA standards and requirements in their contracts to ensure that timely access requirements are followed and correctly reported on to DMHC.</p> <p>3. There should be no exceptions for urgent care. Only in extreme extenuating circumstances should any exemptions be granted such as the withdrawal of a health care services plan in a county covered by the geographical accessibility standard in § 1366.1. Similarly, the Department shall not approve any block transfer filings pursuant to § 1373.65 that do not account for how the health plan will continue to adhere to the timely access requirements save for in the most exigent circumstances.</p>	<p>See reasons above for inclusion of these additional items.</p> <p>The last unnumbered sentence of 1367 prohibits delegation of responsibilities to medical groups or other entities.</p> <p>As mentioned above, section 1367.03 does not refer to a process to exempt plans from the timeliness standards, so if one is allowed in extenuating circumstances it must be justified, time-limited and corrected as aggressively and expeditiously as possible.</p>

**DECLARATIONS IN SUPPORT OF
HOURLY RATES CLAIMED**

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**DECLARATION OF
RICHARD M. PEARL**

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**Declaration of Richard M. Pearl in Support of Western Center on Law and Poverty's
Application to the Department of Managed Health Care for Advocacy Fees**

I, Richard M. Pearl, declare:

1. I make this Declaration of my own personal knowledge, and if called to testify, I could and would testify competently to the matters stated herein.

2. I am a member in good standing of the California State Bar. I am in private practice as the principal of my own law firm, the Law Offices of Richard M. Pearl. I specialize in issues related to court-awarded attorneys' fees, including the representation of parties in fee litigation and appeals, serving as an expert witness, and serving as a mediator and arbitrator in disputes concerning attorneys' fees and related issues. In this case, I have been asked by Plaintiff's counsel to render my opinion regarding the reasonableness of their requested hourly rates.

3. Briefly summarized, my background is as follows: I am a 1969 graduate of Boalt Hall School of Law, University of California, Berkeley, California. After graduation, I spent fourteen years in federally-funded legal services programs before going into private practice in 1982. From 1977 to 1982, I was Director of Litigation for California Rural Legal Assistance, Inc., a statewide legal services program with more than fifty attorneys. Since April 1987, I have been a sole practitioner in the San Francisco Bay Area. Martindale Hubbell rates my law firm "AV." I also have been selected as a Northern California "Super Lawyer" in Appellate Law for 2005, 2006, 2007, 2008, and 2010. A copy of my Resume is attached hereto as Exhibit A.

4. Since 1982, my practice has been a general civil litigation and appellate practice, with an emphasis on cases and appeals involving court-awarded attorneys' fees. I have lectured and written extensively on court-awarded attorneys' fees. I have been a member of the California State Bar's Attorneys Fees Task Force and have testified before the State Bar Board of Governors and the California Legislature on attorneys' fee issues. I am the author of California Attorney Fee Awards, 2d Ed. (Calif. Cont. Ed. of Bar 1994), and its 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, and 2008 Supplements. This treatise has been cited by the California appellate courts on more than 30 occasions. I have completed the manuscript for the third edition of the book and it should be published in the next few months. I also authored the 1984, 1985, 1987,

1988, 1990, 1991, 1992, and 1993 Supplements to its predecessor, CEB's California Attorney's Fees Award Practice. In addition, I authored a federal manual on attorneys' fees entitled *Attorneys' Fees: A Legal Services Practice Manual*, published by the Legal Services Corporation. I also co-authored the chapter on "Attorney Fees" in Volume 2 of CEB's *Wrongful Employment Termination Practice*, 2d Ed. (1997).

5. More than 90% of my practice is devoted to issues involving court-awarded attorney's fees. I have been counsel in over 140 attorneys' fee applications in state and federal courts, primarily representing other attorneys. I also have briefed and argued more than 40 appeals, at least 25 of which have involved attorneys' fees issues. In the past ten or so years, I have successfully handled four cases in the California Supreme Court involving court-awarded attorneys' fees: 1) *Delaney v. Baker* (1999) 20 Cal.4th 23, which held that heightened remedies, including attorneys' fees, are available in suits against nursing homes under California's Elder Abuse Act; 2) *Ketchum v. Moses* (2001) 24 Cal.4th 1122, which held, *inter alia*, that contingent risk multipliers remain available under California attorney fee law, despite the United States Supreme Court's contrary ruling on federal law (note that in *Ketchum*, I was primary appellate counsel in the Court of Appeal and "second chair" in the Supreme Court); 3) *Flannery v. Prentice* (2001) 26 Cal.4th 572, which held that in the absence of an agreement to the contrary, statutory attorneys' fees belong to the attorney whose services they are based upon; and 4) *Graham v. DaimlerChrysler Corp.* (2004) 34 Cal.4th 553, which I handled, along with trial counsel, in both the Court of Appeal and Supreme Court. I also successfully represented the plaintiffs in a previous attorneys' fee decision in the Supreme Court, *Maria P. v. Riles* (1987) 43 Cal.3d 1281, and represented *amicus curiae*, along with Richard Rothschild, in the Supreme Court's most recent fee decision, *Vasquez v. State of California* (2009) 45 Cal.4th 243. I also have handled several Ninth Circuit attorneys' fees matters, including *Davis v. City & County of San Francisco* (9th Cir. 1992) 976 F.2d 1536, *Mangold v. CPUC* (9th Cir. 1995) 67 F.3d 1470, *Velez v. Wynne* (9th Cir. 2007) 2007 U.S.App.LEXIS 2194, and *Camacho v. Bridgeport Financial, Inc.* (9th Cir. 2008) 523 F.3d 973. See Exhibit A.

6. The 2010 rate for my services is \$650 per hour, which is the rate I charge new market-rate paying clients for my services. I currently have and have had numerous clients paying my

market rates over the years. My hourly rates also have been found reasonable by numerous courts and paid by numerous defendants in settlement. My 2009 hourly rate of \$600 per hour was found reasonable in *Alcoser et al v. Thomas*, Alameda County Superior Court No. RG03112134, Order Granting in Part Plaintiffs' Motion for Attorneys' Fees and Costs, filed June 30, 2009. My 2008 rate of \$550 per hour was found reasonable in *Cruz v. Alhambra*, Ninth Circuit Court of Appeals No. 06-55811, Order, filed January 28, 2010, and in *Saephan v. Oakland Unified School District*, N.D.Cal. No. C-06-4428 JCS, Fee Order dated January 20, 2009; it also was paid in full by the State for my appellate work in *Naidu v. California Public Utilities Commission*, 2008 Cal.App.Unpub. 6350. My 2008 hourly rate was also found reasonable in *Camacho v. Bridgeport Financial, Inc.*, N.D. Cal.No. C-04-00478 CRB, Order filed August 25, 2008, and in *Chacon v. Litke*, San Francisco Superior Court No. CGC-06-448337, Opinion and Order on Plaintiffs' Motion for Award of Attorneys' Fees, filed November 26, 2008, *affirmed* (2010) 181 Cal.App.4th 1234. My 2007 rate of \$535 per hour was found reasonable in five different cases: *Graham v. DaimlerChrysler*, Los Angeles County Superior Court No. BC215624, Fee Order filed December 10, 2007; *Moore v. Bank of America*, 2008 U.S.Dist.LEXIS 904 (S.D.Cal. 2008); *Denenberg v. CalTrans*, San Diego County Superior Court No. GIC 836582, Fee Order filed January 11, 2008; *Naidu v. California Public Utilities Commission*, San Francisco Superior Court No. CGC-05-444782, Order Awarding Attorneys' Fees, filed September 27, 2007; and *Marin v. Costco Wholesale Corp.*, Alameda County Superior Court No. RG 04-150447, Order Granting Motion of Plaintiff for Attorneys' Fees and Costs, filed April 17, 2007.

7. Through my writing and practice, I have become familiar with the non-contingent market rates charged by attorneys in California and elsewhere. This familiarity has been obtained in several ways: (1) by handling attorneys' fee litigation; (2) by discussing fees with other attorneys; (3) by obtaining declarations regarding prevailing market rates in cases in which I represent attorneys seeking fees; and (4) by reviewing attorneys' fee applications and awards in other cases, as well as surveys and articles on attorney's fees in the legal newspapers and treatises.

Reasonableness of Rates Sought by Western Center

8. I am informed that the Western Center on Law and Poverty is seeking \$415 per hour for the services of Elizabeth Landsberg, an experience health law attorney who graduated from law school in 1998; and \$315 per hour for Jen Flory, a 2005 graduate. These rates are well in line with the non-contingent market rates charged by litigation attorneys of similar qualifications and experience in the major California legal markets.

a. Rates found reasonable in other cases.

Set forth below are rates that were awarded by the courts in the following cases:

2009 Rates

(1) *Santa Fe Pointe, L.P. v. Greystone Servicing Corp.* (N.D.Cal. 2009)

2009 U.S.Dist.LEXIS 100448, in which the court found the following hourly rates reasonable:

<u>Years of Experience</u>	<u>Rate</u>
20	\$675
2	350

(2) *Center for Biological Diversity v. California Fish & Game Commission*, San

Francisco Superior Court No. CPF-08-508759, Order Granting Petitioners' Motion for Attorneys' Fees, filed December 1, 2009, in which the court found reasonable the following hourly rates:

<u>Years of Experience</u>	<u>Rate</u>
25	\$650
8	375
4	250
Law Clerks	150

(3) *A.D. v. State of California Highway Patrol*, U.S.D.C., Northern District of

California No. C 07-5483 SI, Order Granting Plaintiffs' Motion for Attorneys' Fees and Costs, filed November 10, 2009, in which the court found reasonable the following hourly rates:

<u>Years of Experience</u>	<u>Rate</u>
33	\$600
30	600

(4) *Multi-Ethnic Immigrant Workers Organizing Network v. City of Los Angeles*,

U.S.D.C., Central District of California No. CV-07-3072, Order Awarding Class Counsel Fees and Costs, filed June 24, 2009, in which the court found the following hourly rates reasonable:

<u>Years of Experience</u>	<u>Rate</u>
40	\$800
33	750
34	710
31	710
15	490
8	425

(5) *Fitzgerald v. City of Los Angeles*, U.S.D.C., Central District of California No. CV-03-01876 DDP (R2x), Order Granting Motion for Attorneys' Fees, filed April 7, 2009, in which the court found the following hourly rates reasonable:

<u>Years of Experience</u>	<u>Rate</u>
35	\$740
20	575
15	525
7	375

2008 Rates:

(1) *Jones v. City of Los Angeles*, U.S.D.C., Central District of California No. CV-03-1142 R (RNBx), Order Granting Plaintiff's Motion for Attorneys' Fees and Costs, filed December 8, 2008, in which the court found reasonable the following hourly rates:

<u>Years of Experience</u>	<u>Rate</u>
34	\$725
30	695
14	480-490
12	455
9	400
8	390-425
7	365-380
Law Students	175-200

(2) In *Kashmiri et al v. Regents of U.C.*, San Francisco Superior Court, Order Granting Plaintiffs' Motion for Common Fund Attorneys' Fees and Expenses, filed September 30, 2008, the court found the following rates reasonable, plus a 3.7 lodestar multiplier:

<u>Years of Experience</u>	<u>Rate</u>
40	\$750
22	690
14	590
7	420
4	345
2	295
Law Clerks	200

(3) In *Environmental Law Foundation v. Laidlaw Transit, Inc.*, San Francisco Superior Court No. CGC-06-451832, Order Granting Motion for Court Approval of Parties Joint Stipulated Judgment, filed September 22, 2008, Judge Ernest H. Goldsmith found the following hourly rates reasonable in a Proposition 65, action, plus a 1.25 multiplier:

<u>Years of Experience</u>	<u>Rate</u>
29	\$750
26	700
24	700
23	650
18	650
16	625
14	600
10	560
9	495-575
8	475
7	450
6	395
4	325
2	300
1	250
Paralegals	145-175
Interns	125

b. Rate Information from Surveys and Other Cases.

I have reviewed numerous declarations and depositions filed in other cases, as well as various surveys of legal rates. These include the Westlaw CourtExpress Legal Billing Reports for May, August, and December 2009 (attached hereto as Exhibit B). These sources show the hourly rates for litigation undertaken on a non-contingent basis by the following California law firms, listed in alphabetical order:

Altshuler Berzon LLP

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
32	\$775
15	625
8	475

Law Clerks	200
Paralegals	195

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
23	\$700
15	550
5	325
Paralegals	155-190

Bingham McCutchen
2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
11	\$585
19	580
42	640
7	485
3	420
3	380
2	345
3	345
2	325
Paralegal	230
Litigation Specialist	125-210
Research Specialist	140

Cooley Godward Kronish LLP
2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$525-980
Associates	285-570

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$470-875 (average \$673)
Associates	250-555 (average \$403)

Coughlin Stoia Geller Rudman & Robbins, LLP
2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
42	\$700
19	600
14	650

14	600
13	585
11	510
6	460
5	285

Duane Morris LLP

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$325-795
Associates	225-450

Epstein Becker & Green LLP

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$350-855
Associates	180-475

Fenwick & West

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$500-775 (average \$590)
Associates	245-500 (average \$370)

Goldstein, Demchak, Baller, Borgen & Dardarian

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	
33	\$700
27	650
22	600
16	550
14	500
Associates	
39	\$675-700
14	495
9	425
8	425
7	375
6	375
5	350
4	340

2	325
Law Clerks	195
Paralegals	150-225

2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	
38	\$650
32	650
27	625
21	575
15	500
14	500
Associates	
13	465
6	430
8	420
7	395
2	305
Law Clerks	195
Paralegals	135-195

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	
37	\$600
31	600
26	575
20	535
14	460
13	460
Associates	
12	425
10	380
11	365
9	350
8	335
7	325
6	340
Law Clerks	285-300

Hadsell Stormer

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
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35	\$775
20	575

Howard, Rice, Nemerovski, Canady, Falk & Rabkin

2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$515-795
Associates	275-510

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$495-775
Associates	275-485

Litt, Estuar, Harrison & Kitson, LLP

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
39	\$800
16	550
3	320
2	285
Paralegals	125-235
Law Clerks	225

Loeb & Loeb

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$475-950
Associates	285-450

2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$450-925
Associates	260-500

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$475-875 (average \$606)
Associates	240-500 (average \$384)

Manatt, Phelps & Philips

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$495-850
Associates	250-505

2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$495-850
Associates	290-505

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$520-785 (average \$600)
Associates	265-480 (average \$395)

Morrison Foerster

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
24	\$750

2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
45	\$675
36	725
33	785
14	650
12	600
9	560
7	535
5	485
1	520
Paralegals	185-230

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
44	\$675
11	550
8	520
6	475
3	250

O'Melveny & Myers

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
36-37	\$860-950
21	820
16-18	700-710
14	595-675
10	590
8	565
7	540-565
5-6	480-520
2-4	395-450
Paralegals	225-310

Reed Smith

2008 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$375-900 (average \$626)
Associates	235-580 (average \$423)

2007 Rates:

<u>Years Experience</u>	<u>Rate</u>
Partners	\$350-825 (average \$558)
Associates	200-510 (average \$374)

Rosen, Bien & Galvan, LLP

2010 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	
48	\$800
30	700
26	575
13	560
Of Counsel	
27	520
Associates	
17	510
13	490
9	430
8	415
7	390
5	360

3	325
1	285
Paralegals	200-275
Litigation support/ Paralegal clerks	135-220
Law clerks/Students	190
Word Processing	70

2009 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	
47	\$760
29	674
25	520
12	500
Of Counsel	
26	490
Associates	
16	475
12	475
9	425
8	400
7	385
6	360
4	330
2	295
Paralegals	180-250
Litigation support/ Paralegal clerks	125-200
Law clerks/Students	190
Word Processing	60

2008 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	
46	\$740
28	640
24	475
10	450
Of Counsel	
25	460
Associates	
15	440
11	425
8	380

7	370
6	360
5	340
4	320
3	295
Paralegals	170-190
Litigation support/ Paralegal clerks	110-160
Law clerks/Students	170
Word Processing	60

Rudy, Exelrod & Zieff

2009 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	
31	\$700
Associates	
3	305

2007 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	
29	\$700
12	500
Associates	
10	400
8	330
Law Clerk	200
Paralegal	150

Schonbrun, DeSimone, Seplow, Harris & Hoffman

2009 Rates:

<u>Years Experience</u>	<u>Rate</u>
33	\$750
25	625
24	625
8	375
6	370
Paralegals	125

Sheppard, Mullin, Richter & Hampton

2008 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	\$475-795
Associates	275-455

2007 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	\$425-795
Associates	260-550

Townsend and Townsend and Crew

2009 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	\$480-750
Associates	260-460

Winston & Strawn

2009 Rates:

<u>Years of Experience</u>	<u>Rate</u>
Partners	\$400-995
Associates	210-670

9. My research regarding attorneys' fees in California has indicated a consistent increase in fees over the last several years. Virtually every firm whose rates I am aware of increased their rates over these periods. Consistent with this market, I raised my rates in 2009 and 2010 to reflect both the demand for my services and inflation in costs and legal rates; my rate is still significantly less than many attorneys with comparable experience, expertise, and skills at other firms.

10. The hourly rates set forth above are those charged where full payment is expected promptly upon the rendition of the billing and without consideration of factors other than hours and rates. If any substantial part of the payment were to be deferred for any substantial period of time, for example, or if payment were to be contingent upon outcome or any other factor, the fee arrangement would be adjusted accordingly to compensate the attorneys for those factors.

11. In my experience, fee awards are almost always determined based on current rates, i.e., the attorney's rate at the time a motion for fees is made, rather than the historical rate at the time the work was performed. This is a common and accepted practice to compensate attorneys for the delay in being paid.

If called as a witness, I could and would competently testify from my personal knowledge to the facts stated herein. I declared under penalty of perjury under the laws of the state of California the foregoing is true and correct.

Dated: March 15, 2010


RICHARD M. PEARL

EXHIBIT A

EXHIBIT A

RESUME OF RICHARD M. PEARL

RICHARD M. PEARL

LAW OFFICES OF RICHARD M. PEARL

1816 Fifth Street

Berkeley, CA 94710

(510) 649-0810

(510) 548-5074 (facsimile)

rpearl@interx.net (e-mail)

EDUCATION

University of California, Berkeley, B.A., Economics (June 1966)

Boalt Hall School of Law, Berkeley, J.D. (June 1969)

BAR MEMBERSHIP

Member, State Bar of California (admitted January 1970)

Member, State Bar of Georgia (admitted June 1970) (inactive)

Admitted to practice before all California State Courts; the United States Supreme Court; the United States Court of Appeals for the District of Columbia and Ninth Circuits; the United States District Courts for the Northern, Central, Eastern, and Southern Districts of California, for the District of Arizona, and for the Northern District of Georgia; and the Georgia Civil and Superior Courts and Court of Appeals.

EMPLOYMENT

LAW OFFICES OF RICHARD M. PEARL (April 1987 to Present): Civil litigation practice ("AV" rating), with emphasis on court-awarded attorney's fees, class actions, and appellate practice.

QUALIFIED APPELLATE MEDIATOR, APPELLATE MEDIATION PROGRAM, Court of Appeal, First Appellate District (October 2000 to Present).

ADJUNCT PROFESSOR, HASTINGS COLLEGE OF THE LAW (January 1988 to Present): Teach "Public Interest Law Practice," a 2-unit course that focuses on the history, strategies, and issues involved in the practice of public interest law.

PEARL, McNEILL & GILLESPIE, Partner (May 1982 to March 1987): General civil litigation practice, as described above.

RICHARD M. PEARL

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CALIFORNIA RURAL LEGAL ASSISTANCE, INC. (July 1971 to September 1983) (part-time May 1982 to September 1983):

Director of Litigation (July 1977 to July 1982)

Responsibilities: Oversaw and supervised litigation of more than 50 attorneys in CRLA's 15 field offices; administered and supervised staff of 4-6 Regional Counsel; promulgated litigation policies and procedures for program; participated in complex civil litigation.

Regional Counsel (July 1982 to September 1983 part-time) Responsibilities:

Served as co-counsel to CRLA field attorneys on complex projects; provided technical assistance and training to CRLA field offices; oversaw CRLA attorney's fee cases; served as counsel on major litigation.

Directing Attorney, Cooperative Legal Services Center (February 1974 to July 1977) (Staff Attorney February 1974 to October 1975)

Responsibilities: Served as co-counsel on major litigation with legal services attorneys in small legal services offices throughout California; supervised and administered staff of four senior legal services attorneys and support staff.

Directing Attorney, CRLA McFarland Office (July 1971 to February 1974) (Staff Attorney July 1971 to February 1972)

Responsibilities: Provided legal representation to low income persons and groups in Kern, King, and Tulare Counties; supervised all litigation and administered staff of ten.

HASTINGS COLLEGE OF THE LAW, Instructor, Legal Writing and Research Program (August 1974 to June 1978)

Responsibilities: Instructed 20 to 25 first year students in legal writing and research.

CALIFORNIA AGRICULTURAL LABOR RELATIONS BOARD, Staff Attorney, General Counsel's Office (November 1975 to January 1976, while on leave from CRLA)

Responsibilities: Prosecuted unfair labor practice charges before Administrative Law Judges and the A.L.R.B. and represented the A.L.R.B. in state court proceedings.

ATLANTA LEGAL AID SOCIETY, Staff Attorney (October 1969 to June 1971)

Responsibilities: Represented low income persons and groups as part of 36-lawyer legal services program located in Atlanta, Georgia.

RICHARD M. PEARL

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PUBLICATIONS

Pearl, *California Attorney Fee Awards, Second Edition* (Cont. Ed. Bar 1994), and 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, and 2008 Supplements

Graham v. DaimlerChrysler Corp. and *Tipton-Whittingham v. City of Los Angeles*, Civil Litigation Reporter (Cont. Ed. Bar Feb. 2005)

Current Issues in Attorneys' Fee Litigation, California Labor and Employment Law Quarterly (September 2002 and November 2002)

Flannery v. Prentice: Shifting Attitudes Toward Fee Agreements and Fee-Shifting Statutes, Civil Litigation Reporter (Cont. Ed. Bar Nov. 2001)

A Practical Introduction to Attorney's Fees, Environmental Law News (Summer 1995)

Wrongful Employment Termination Practice, Second Edition (Cont. Ed. Bar 1997) (co-authored chapter on "Attorney Fees")

California Attorney's Fees Award Practice (Cont. Ed. Bar 1982) (edited), and 1984 through 1993 Supplements

Program materials on attorney fees, prepared as panelist for CEB program on "Attorneys' Fees: Practical and Ethical Considerations in Determining, Billing, and Collecting" (October 1992)

Program materials on "Attorney's Fees in Administrative Proceedings" California Continuing Education of the Bar, prepared as panelist for CEB program on "Effective Representation Before California Administrative Agencies" (October 1986)

Program materials on "Attorney's Fees in Administrative Proceedings" California Continuing Education of the Bar, prepared as panelist for CEB program on "Attorneys' Fees: Practical and Ethical Considerations" (March 1984)

Settlers Beware/The Dangers of Negotiating Statutory Fee Cases, (September 1985) Los Angeles Lawyer

Program Materials on "Remedies Training" (Class Actions), Sponsored by Legal Services Section, California State Bar, San Francisco (May 1983)

Attorneys' Fees: A Legal Services Practice Manual (Legal Services Corporation 1981)

RICHARD M. PEARL

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PUBLIC SERVICE

Member, Attorneys' Fee Task Force, California State Bar

Vice President, Board of Directors, California Rural Legal Assistance Foundation

REPRESENTATIVE REPORTED CASES

Boren v. California Department of Employment
(1976) 59 Cal.App.3d 250

Cabrera v. Martin
(9th Cir. 1992) 973 F.2d 735

Camacho v. Bridgeport Financial, Inc.
(9th Cir. 2008) 523 F.3d 973

Campos v. E.D.D.
(1982) 132 Cal.App.3d 961

Committee to Defend Reproductive Rights v. A Free Pregnancy Center
(1991) 229 Cal.App.3d 633

David C. v. Leavitt
(D. Utah 1995) 900 F.Supp. 1547

Delaney v. Baker
(1999) 10 Cal.4th 23

Employment Development Dept. v. Superior Court (Boren)
(1981) 30 Cal.3d 256

Environmental Protection Information Center, Inc. v. Pacific Lumber Co.
(N.D. Cal. 2002) 229 F. Supp.2d 993, *aff'd* (9th Cir. 2004) 103 Fed. Appx. 627

Flannery v Prentice
(2001) 26 Cal. 4th 572

Graham v. DaimlerChrysler Corp.
(2004) 34 Cal. 4th 553

Horsford v. Board of Trustees of Univ. of Calif.

RICHARD M. PEARL

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(2005) 132 Cal.App.4th 359

Ketchum v. Moses

(2001) 24 Cal.4th 1122

Kievlan v. Dahlberg Electronics

(1978) 78 Cal.App.3d 951, *cert. denied* (1979)
440 U.S. 951

Lealao v. Beneficial California, Inc.

(2000) 82 Cal.App.4th 19

Lewis v. California Unemployment Insurance Appeals Board

(1976) 56 Cal.App.3d 729

Local 3-98 etc. v. Donovan

(N.D. Cal. 1984) 580 F.Supp. 714,
aff'd (9th Cir. 1986) 792 F.2d 762

Mangold v. California Public Utilities Commission

(9th Cir. 1995) 67 F.3d 1470

Maria P. v. Riles

(1987) 43 Cal.3d 1281

Martinez v. Dunlop

(N.D. Cal. 1976) 411 F.Supp. 5
aff'd (9th Cir. 1977) 573 F.2d 555

McSomebodies v. Burlingame Elementary School Dist.

(9th Cir. 1990) 897 F.2d 974

McSomebodies v. San Mateo City School Dist.

(9th Cir. 1990) 897 F.2d 975

Moore v. Bank of America

(9th Cir. 2007) 2007 U.S. App. LEXIS 19597

Moore v. Bank of America

(S.D. Cal. 2008) 2008 U.S. Dist. LEXIS 904

RICHARD M. PEARL

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Mora v. Chem-Tronics, Inc.

(S.D. Cal. 1999) 1999 U.S. Dist. LEXIS 10752,
5 Wage & Hour Cas. 2d (BNA) 1122

Pena v. Superior Court of Kern County

(1975) 50 Cal.App.3d 694

Ponce v. Tulare County Housing Authority

(E.D. Cal 1975) 389 F.Supp. 635

Ramirez v. Runyon

(N.D. Cal. 1999) 1999 U.S. Dist. LEXIS 20544

Rubio v. Superior Court

(1979) 24 Cal.3d 93 (amicus)

Sokolow v. County of San Mateo

(1989) 213 Cal. App. 3d. 231

S.P. Growers v. Rodriguez

(1976) 17 Cal.3d 719 (amicus)

Tongol v. Usery

(9th Cir. 1979) 601 F.2d 1091,
on remand (N.D. Cal. 1983) 575 F.Supp. 409,
revs'd (9th Cir. 1985) 762 F.2d 727

Tripp v. Swoap

(1976) 17 Cal.3d 671 (amicus)

United States (Davis) v. City and County of San Francisco

(N.D. Cal. 1990) 748 F.Supp. 1416, *aff'd in part*
and revs'd in part sub nom Davis v. City and County
of San Francisco (9th Cir. 1992) 976 F.2d 1536,
modified on rehearing (9th Cir. 1993) 984 F.2d 345

United States v. City of San Diego

(S.D. Cal. 1998) 18 F.Supp.2d 1090

Velez v. Wynne

(9th Cir. 2007) 2007 U.S. App. LEXIS 2194

REFERENCES

RICHARD M. PEARL
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Furnished upon request.

June 2009

EXHIBIT B

EXHIBIT B

Westlaw CourtExpress

LEGAL BILLING REPORT

VOLUME 11, NUMBER 1

May 2009

BY BILLING RATE

California Rate Report

PROFESSIONAL	FIRM	GRADUATED	ADMITTED	STATE	RATE	HOURS	TOTAL
P Kelly, Jr., Daniel	Devis Polk & Wardwell (CA)	1986	1986	CA	\$ 980.00	4.50	\$ 4,320.00
P Cowles, Julia	Davis Polk & Wardwell (CA)	1990	1990	CA	955.00	17.00	16,235.00
P Dunham, Scott	O'Maheny & Myers LLP (CA)	1975	1975	CA	850.00	1.10	945.00
P Tuchin, Michael	Klee, Tuchin, Bogdanoff & Stern, LLP	1980	1980	CA	850.00	0.50	425.00
P Ballack, Karen	Wei, Gotschal & Mangos LLP (CA)	1986	1986	CA	798.00	0.80	638.20
P Arnold, Dennis	Gibson Dunn & Crutcher, LLP (CA)	1978	1978	CA	780.00	4.50	3,555.00
OC Morris, Michael	Hennigan Bennett & Dorman LLP	1979	1979	CA	760.00	65.20	49,552.00
P Averch, Craig	White & Case LLP (CA)	1984	1984	CA	750.00	126.10	96,075.00
P Kharasch, Ira D.	Pachulski Slag Ziehl Young Jones & Weintraub (CA)	1982	1982	CA	730.00	2.90	2,175.00
P Kornfield, Alan	Pachulski Slag Ziehl Young Jones & Weintraub (CA)	1987	1987	CA	725.00	0.80	580.00
A Lamb, Peter	Davis Polk & Wardwell (CA)	2005	2005	CA	690.00	101.40	68,952.00
P Inlora, Jeanne E.	Hennigan Bennett & Dorman LLP	1978	1978	CA	680.00	10.10	6,868.00
P Keating, Henry	Pachulski Slag Ziehl Young Jones & Weintraub (CA)	1985	1985	CA	675.00	19.10	12,892.50
A Gorsich, Ronald	White & Case LLP (CA)	2001	2001	CA	665.00	176.20	117,173.00
P Brown, Kenneth H.	Pachulski Slag Ziehl Young Jones & Weintraub (CA)	1977	1981	CA	660.00	27.30	17,745.00
P Fisher, David	Klee, Tuchin, Bogdanoff & Stern, LLP	1997	1998	CA	650.00	23.10	15,015.00
P Weissman, Henry	Munger Toiles & Olson LLC	1987	1987	CA	650.00	0.50	325.00
P Bertenthal, David M.	Pachulski Slag Ziehl Young Jones & Weintraub (CA)	1989	1993	CA	645.00	35.60	22,862.00
P Montgomery, Cromwell	Gibson Dunn & Crutcher, LLP (CA)	1997	1997	CA	635.00	0.80	508.00
P Brown, Dennis	Munger Toiles & Olson LLC	1970	1970	CA	625.00	17.80	11,135.00
A Newman, Samuel	Gibson Dunn & Crutcher, LLP (CA)	2001	2001	CA	610.00	13.50	6,235.00
A Dalzheim, Shiva	White & Case LLP (CA)	2003	2003	CA	600.00	183.70	110,220.00
P Vincenti, Garth	Munger Toiles & Olson LLC	1988	1988	CA	600.00	124.60	74,760.00
A Scott, Melanie	White & Case LLP (CA)	2004	2004	CA	600.00	20.90	12,540.00
P Buchanan, Laura	Klee, Tuchin, Bogdanoff & Stern, LLP	1991	1991	CA	590.00	0.20	118.00
A Gai Kwang-chien, B.	Wei, Gotschal & Mangos LLP (CA)	2003	2003	CA	580.00	29.50	16,300.00
A Esdall, David	Gibson Dunn & Crutcher, LLP (CA)	2003	2003	CA	570.00	2.90	1,653.00
P Heintz, Jeffrey	Munger Toiles & Olson LLC	1984	1984	CA	550.00	35.10	18,305.00
P Fried, Joshua	Pachulski Slag Ziehl Young Jones & Weintraub (CA)	1995	1995	CA	535.00	21.40	11,448.00
P Rurigen, James	Munger Toiles & Olson LLC	1997	1997	CA	525.00	25.80	13,545.00
A Morae, Joshua	Hennigan Bennett & Dorman LLP	2000	2000	CA	505.00	13.10	6,616.50
A Maleris, Michael	Wei, Gotschal & Mangos LLP (CA)	2005	2005	CA	500.00	36.50	18,250.00
A Bergfjord, Melissa	Gibson Dunn & Crutcher, LLP (CA)	2006	2006	CA	470.00	14.00	6,580.00
A Liu, Leslie	Wei, Gotschal & Mangos LLP (CA)	2006	2006	CA	465.00	45.90	21,343.50
A Kaufman, Derek	Munger Toiles & Olson LLC	2005	2005	CA	450.00	508.30	228,738.00
A Hochleitner, Brian	Munger Toiles & Olson LLC	2002	2002	CA	435.00	0.30	130.50
A Nelson, Joseph	Wei, Gotschal & Mangos LLP (CA)	2007	2007	CA	415.00	25.20	10,458.00
A Jasper, M. Lance	Munger Toiles & Olson LLC	2006	2006	CA	400.00	95.20	38,480.00
A Estrandi, Berny	Munger Toiles & Olson LLC	2005	2005	CA	400.00	8.80	3,520.00
A Rubin, Eandria E.	O'Maheny & Myers LLP (CA)	2006	2006	CA	395.00	6.40	3,318.00

California Rate Report

PROFESSIONAL	FIRM	GRADUATED	ADMITTED	STATE	RATE	HOURS	TOTAL
A. Schneider, Bradley	Munger, Tolles & Olson LLC	2004	2004	CA	\$ 385.00	1.30	\$ 513.50
A. Reagen, Matthew	Wall, Golshal & Mangos LLP (CA)	2008	2008	CA	355.00	13.50	4,792.50
A. Guzman, Tanya	O'Melveny & Myers LLP (CA)	2007	2007	CA	230.00	2.50	825.00
PP Nuclea, Ross	O'Melveny & Myers LLP (CA)				260.00	6.20	1,612.00
PP Finlayson, Keitha	Pachulski Slagisz Ziehl Young Jones & Weintraub (CA)				225.00	27.60	6,210.00
PP Jirfries, Patricia J.	Pachulski Slagisz Ziehl Young Jones & Weintraub (CA)				265.00	0.40	90.00
PP Pearson, Sandra	Kiss, Tscheln, Boydemann & Stern, LLP			CA	215.00	1.90	408.90
PP Flory, Kevin	Hendriks, Bernhart & Dorman LLP				210.00	0.30	63.00
PP Inoue, Cheryl	Pachulski Slagisz Ziehl Young Jones & Weintraub (CA)				205.00	2.20	451.00
GMA Pflum, Sheryle	Pachulski Slagisz Ziehl Young Jones & Weintraub (CA)				125.00	2.60	325.00

Westlaw CourtExpress

LEGAL BILLING REPORT

VOLUME 11, NUMBER 2

August 2009

BY BILLING RATE

California Rate Report

PROFESSIONAL	FIRM	GRADUATED	ADMITTED	STATE	RATE	HOURS	TOTAL
P Tobias, Stephen L.	Gibson Dunn & Crutcher, LLP (CA)	1992	1992	CA	\$ 880.00	0.10	\$ 88.00
P Patterson, Thomas	Klee, Tuchin, Bogdanoff & Stern, LLP	1984	1984	CA	850.00	225.00	191,250.00
P Tuchin, Michael	Klee, Tuchin, Bogdanoff & Stern, LLP	1980	1980	CA	850.00	74.40	63,240.00
P Stern, David	Klee, Tuchin, Bogdanoff & Stern, LLP	1975	1975	CA	850.00	32.80	27,965.00
P Isler, Paul S.	Gibson Dunn & Crutcher, LLP (CA)	1986	1986	CA	840.00	6.35	5,334.00
P Arnold, Dennis	Gibson Dunn & Crutcher, LLP (CA)	1976	1976	CA	840.00	4.10	3,444.00
P Timmons, Karen	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1981	1981	CA	820.00	72.80	58,896.00
P Ballack, Karen	Weil, Gotshal & Manges LLP (CA)	1988	1988	CA	810.00	40.40	32,724.00
P Ziehl, Dean A.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1976	1976	CA	795.00	20.30	16,136.50
P Gilmore, Danielle	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1983	1983	CA	775.00	9.50	7,382.50
P Averch, Craig	White & Case LLP (CA)	1984	1984	CA	750.00	189.20	141,900.00
P Keller, Tobias	Jones Day (CA)	1980	1980	CA	750.00	1.90	1,425.00
P Baker, James	Jones Day (CA)	1980	1980	CA	750.00	0.20	150.00
P Winston, Eric D.	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1999	1999	CA	740.00	7.10	5,264.00
P Ong, Johanna Y.	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1997	1997	CA	740.00	6.30	4,662.00
P Kornfeld, Alan	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1987	1987	CA	725.00	10.10	7,222.50
A Bight, Jeffrey E.	Staley Austin Brown & Wood LLP (CA)	1998	1998	CA	700.00	110.90	77,630.00
P Myra, Maglin	Jones Day (CA)	1987	1987	CA	700.00	26.50	18,650.00
P Grassgreen, Dabra I.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1991	1992	CA	695.00	5.50	3,822.50
A Gustafson, Mark E.	White & Case LLP (CA)	1988	1988	CA	685.00	117.70	80,824.50
P Arash, Dora	Gibson Dunn & Crutcher, LLP (CA)	1985	1985	CA	675.00	39.40	26,695.00
A Gorsich, Ronald	White & Case LLP (CA)	2001	2001	CA	665.00	221.50	147,237.50
P Montgomery, Chermell	Gibson Dunn & Crutcher, LLP (CA)	1987	1987	CA	635.00	2.50	1,587.50
A Newman, Samuel	Gibson Dunn & Crutcher, LLP (CA)	2001	2001	CA	610.00	1.40	701.50
A Delrahim, Shiva	White & Case LLP (CA)	2003	2003	CA	600.00	217.90	130,500.00
A Scott, Maligne	White & Case LLP (CA)	2004	2004	CA	600.00	74.90	44,340.00
P Trozelle, Robert	Jones Day (CA)	1996	1996	CA	600.00	35.30	21,180.00
A Ger, Kwang-chien, B.	Weil, Gotshal & Manges LLP (CA)	2003	2003	CA	580.00	54.20	31,436.00
OC Metcalf, Brian	Klee, Tuchin, Bogdanoff & Stern, LLP	1998	1998	CA	575.00	12.40	7,130.00
A Egdal, David	Gibson Dunn & Crutcher, LLP (CA)	2003	2003	CA	570.00	0.50	285.00
C Crosby IV, Peter	Jones Day (CA)	1994	1994	CA	565.00	13.30	7,514.50
A March, Jill	White & Case LLP (CA)	2006	2006	CA	550.00	45.80	25,190.00
A Correa, Michaeline	Jones Day (CA)	2001	2001	CA	525.00	1.70	892.50
OC Brandt, Gina F.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1976	1976	CA	525.00	1.30	682.50
A Majetic, Michael	Weil, Gotshal & Manges LLP (CA)	2005	2005	CA	500.00	175.30	87,650.00
A Rodriguez, Nigel	Jones Day (CA)	2003	2003	CA	500.00	41.80	20,900.00
A Heyn, Matthew	Klee, Tuchin, Bogdanoff & Stern, LLP	2003	2003	CA	495.00	111.80	55,341.00
A Barshob, Melissa	Gibson Dunn & Crutcher, LLP (CA)	2006	2006	CA	470.00	4.10	1,927.00
A Liu, Leslie	Weil, Gotshal & Manges LLP (CA)	2008	2008	CA	465.00	352.70	140,755.00
A Chun, Sebyul	White & Case LLP (CA)	2008	2008	CA	460.00	162.10	74,568.00

California rate Report

PROFESSIONAL	FIRM	GRADUATED	ADMITTED	STATE	RATE	HOURS	TOTAL
A. Montson, Kelley M.	White & Case LLP (CA)	2008	2008	CA	\$ 460.00	105.50	\$ 48,530.00
A. Hawk, Jonathan	White & Case LLP (CA)	2007	2007	CA	460.00	20.30	9,338.00
P. Philip, Laurence	McKenna Long & Aldridge LLP (CA)	1997	1997	CA	460.00	15.00	6,750.00
P. Lewis, J David	McKenna Long & Aldridge LLP (CA)	1997	1997	CA	460.00	10.00	4,600.00
A. Guess, David	Klee, Tuchin, Bogdanoff & Stern, LLP	2005	2005	CA	430.00	366.70	157,681.00
A. Pozmanski, Courtney	Klee, Tuchin, Bogdanoff & Stern, LLP	2005	2005	CA	430.00	23.20	9,976.00
A. Dickerson, Matthew	Sidley Austin Brown & Wood LLP (CA)	2007	2007	CA	425.00	29.30	10,734.50
A. Tran, William	Sidley Austin Brown & Wood LLP (CA)	2006	2006	CA	425.00	5.40	2,295.00
A. Nathan, Joseph	Well, Goshal & Manos LLP (CA)	2007	2007	CA	415.00	61.50	25,622.50
A. Wilson, Lorna S.	Gibson Dunn & Crutcher, LLP (CA)	2008	2008	CA	400.00	4.00	1,600.00
A. Simonds, Ariella	Sidley Austin Brown & Wood LLP (CA)	2008	2008	CA	375.00	49.30	18,487.50
A. Dearthan, Kevin	Klee, Tuchin, Bogdanoff & Stern, LLP	2008	2008	CA	300.00	4.70	1,410.00
A. Elliot, Korin	Klee, Tuchin, Bogdanoff & Stern, LLP	2008	2008	CA	300.00	2.10	630.00
LIB Forrester, Leslie A.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)				250.00	4.90	1,225.00
PP Harris, Denise A.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)				225.00	8.50	1,612.50
PP Grynolter, Michelle	McKenna Long & Aldridge LLP (CA)				215.00	40.60	8,729.00
PP Pearson, Sandra	Klee, Tuchin, Bogdanoff & Stern, LLP				195.00	30.00	7,740.00
PP Brown, Thomas J.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)				195.00	2.00	390.00
LIG Jones, Cate H.	Gibson Dunn & Crutcher, LLP (CA)				165.00	0.90	81.50

Westlaw CourtExpress

LEGAL BILLING REPORT

VOLUME 11, NUMBER 3

December 2009

BY BILLING RATE

California Rate Report

PROFESSIONAL	FIRM	SEALED	ADMITTED	STATE	RATE	HOURS	TOTAL
					\$		\$
P Pachulski, Richard M.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1978	1978	CA	885.00	287.62	257,419.90
P Peterson, Thomas	Klee, Tuchin, Bogdanoff & Stern, LLP	1984	1984	CA	850.00	362.40	333,710.00
P Tuckin, Michael	Klee, Tuchin, Bogdanoff & Stern, LLP	1990	1990	CA	850.00	201.40	171,190.00
P Stern, David	Klee, Tuchin, Bogdanoff & Stern, LLP	1975	1975	CA	850.00	68.80	58,480.00
P Pachulski, Richard M.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1978	1978	CA	850.00	68.00	57,800.00
P Ampid, Dennis	Gibson Dunn & Crutcher, LLP (CA)	1978	1978	CA	340.00	1.00	340.00
P Ziehl, Dean A.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1978	1978	CA	825.00	258.25	211,406.25
P Timmons, Brian	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1991	1991	CA	820.00	240.80	197,282.00
P Lyons, Duane	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1986	1986	CA	320.00	50.20	55,764.00
P Orsini, Robert B.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1981	1981	CA	795.00	357.30	284,053.50
P Richards, Jeremy	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1980	1981	CA	795.00	158.50	126,007.50
P Ziehl, Dean A.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1978	1978	CA	795.00	94.00	74,730.00
P Ziehl, Dean A.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1978	1978	CA	785.00	20.30	16,138.50
P Whiston, Eric O.	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1989	1989	CA	740.00	54.00	38,980.00
P Ono, Johanna Y.	Quinn Emanuel Urquhart Oliver & Hedges, LLP	1997	1997	CA	740.00	11.20	8,284.00
P Kornfeldt, Alan	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1987	1987	CA	725.00	10.10	7,322.50
P Grassgroben, Debra I.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1991	1991	CA	695.00	5.50	3,822.50
C Galina, Andrew	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1983	1983	CA	695.00	3.40	2,363.00
P Parker, Dayl	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1989	1970	CA	875.00	60.60	41,040.00
P Mahoney, James	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1988	1987	CA	875.00	16.60	11,205.00
P Arash, Dara	Gibson Dunn & Crutcher, LLP (CA)	1995	1995	CA	675.00	14.80	9,992.00
P Davies, Ronn	Klee, Tuchin, Bogdanoff & Stern, LLP	1995	1995	CA	650.00	1.40	910.00
A Newman, Samuel	Gibson Dunn & Crutcher, LLP (CA)	2001	2001	CA	610.00	3.70	2,257.00
C Hochman, Harry	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1987	1987	CA	595.00	100.80	59,976.00
A Newman, Victoria	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1998	1997	CA	595.00	32.50	19,337.50
C Cho, Shirley	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1997	1997	CA	595.00	19.40	11,543.00
C Hochman, Harry	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1987	1987	CA	575.00	57.80	33,120.00
A Dinkelman, Jennifer	Klee, Tuchin, Bogdanoff & Stern, LLP	1998	1998	CA	575.00	1.40	805.00
OC Matcalf, Brian	Klee, Tuchin, Bogdanoff & Stern, LLP	1999	1999	CA	575.00	0.70	402.30
QC Brandt, Gina F.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1978	1978	CA	525.00	1.30	682.50
A Hryn, Matthew	Klee, Tuchin, Bogdanoff & Stern, LLP	2003	2003	CA	495.00	109.70	54,301.50
P Burson, Gillian	Pachulski Stang Ziehl Young Jones & Weintraub (CA)	1999	1999	CA	495.00	0.90	247.50
A Barstrop, Melissa	Gibson Dunn & Crutcher, LLP (CA)	2006	2006	CA	470.00	2.10	987.00
A Liu, Leslie	Walt, Gotschal & Manross LLP (CA)	2006	2006	CA	465.00	8.60	4,557.00
P Philip, Laurence	McKenna Long & Akridge LLP (CA)	1997	1997	CA	460.00	2.70	1,219.00
A Guess, David	Klee, Tuchin, Bogdanoff & Stern, LLP	2005	2005	CA	430.00	402.80	173,247.00
PP Series, Joseph C	Quinn Emanuel Urquhart Oliver & Hedges, LLP				360.00	4.80	1,748.00
A Elliot, Karin	Klee, Tuchin, Bogdanoff & Stern, LLP	2008	2008	CA	300.00	16.90	4,983.00
PP Lacroix, Nadine	Quinn Emanuel Urquhart Oliver & Hedges, LLP				250.00	20.30	5,075.00
LIB Forrester, Leslie A.	Pachulski Stang Ziehl Young Jones & Weintraub (CA)				250.00	4.90	1,225.00

California Rate Report

PROFESSIONAL	FIRM	GRADUATED	ADMITTED	STATE	RATE	HOURS	TOTAL
LIB Fomberg, Leslie A.	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				\$ 250.00	1.80	\$ 450.00
PP Harris, Denise A.	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				225.00	47.80	10,777.50
PP Harris, Denise A.	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				225.00	8.50	1,812.50
PP Hartman, Felice	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				225.00	0.40	50.00
PP Grybaner, Michelle	McKenna Long & Aldridge LLP (CA)				215.00	60.40	12,886.00
PP Peterson, Sandra	Kline, Tschin, Bogdanoff & Stern, LLP				215.00	52.40	11,268.00
PP Brown, Thomas J.	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				185.00	59.75	11,651.25
PP Mando, Mike	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				195.00	6.00	1,170.00
PP Brown, Thomas J.	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				185.00	2.00	390.00
LS Everheart, Christine	McKenna Long & Aldridge LLP (CA)				180.00	3.00	540.00
PP Sam, Andrea	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				150.00	16.00	2,535.00
PP Bass, John	Pachulski Slano Ziehl Young Jones & Weintraub (CA)				150.00	0.80	120.00

**DECLARATION OF
RICHARD A. ROTHSCHILD**

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RICHARD A. ROTHSCHILD**

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**DECLARATION OF RICHARD A. ROTHSCHILD IN SUPPORT OF APPLICATION
FOR ADVOCACY FEES**

I, Richard A. Rothschild, declare that if called as a witness I would testify competently from first-hand knowledge as follows:

1. I am an attorney duly admitted to the practice of law in the State of California and am Director of Litigation at the Western Center on Law and Poverty,
2. I received my Bachelor of Arts degree in 1971 from Yale University and my law degree in 1975 from the University of Southern California, where I finished second in my class. I was a law clerk from 1975 to 1976 to the Honorable Stanley M. Mosk, Associate Justice of the California Supreme Court. Since that time, I have worked at the Western Center on Law and Poverty, first as a staff attorney and since 1984 as Director of Litigation.
3. One of my areas of responsibility has been litigating the Western Center's claims for attorneys' fees and expenses. I have handled more than 150 claims for court awarded attorneys' fees for the Western Center, other legal aid programs and private lawyers, including *Fontana Redevelopment Agency v. All Persons Interested, etc.*, No.SCVSS 100688, Order Awarding Attorneys' Fees (San Bernardino Super. Ct. Nov. 5, 2008) (nearly \$2 million award; later settled on appeal for \$1.7 million); *Roe v. Saenz*, 2000 WL 33128689, 2000 U.S. Dist. LEXIS 19377 (E.D. Cal. 2000) (\$728,000 fee award in case resulting in landmark Supreme Court privileges and immunities decision) *Emily Q. v. Bonta*, CV 98-4181 AHM (C.D. Cal. 2002) (\$1.37 million awarded in Medicaid case); *Lopez v. Sullivan*, Civ. No. 83-069WPG(C.D. Cal.) the Court awarded \$1.73 million, then the largest court awarded fee under the Equal Access to Justice Act (EAJA), and settled during appeal for \$1.4 million); *Serrano v. Unruh*, 32 Cal. 3d 621(1982) (plaintiffs in private attorney general cases entitled to attorneys' fees for time reasonably spent litigating entitlement to fees; legal services programs entitled to fee computed at market rates rather than on basis of salaries paid to program's attorney); *County of San Luis Obispo v. Abalone Alliances* 173 Cal. App. 3d 848 (1986) (defendants who vindicate important public

1 policy may be eligible for private attorney general fees), *Coalition for Economic Survival v.*
2 *Deukmejian*, 171 Cal. App. 3d 954 (1985) (plaintiffs who obtained an interim Supreme Court
3 order requiring AFCD benefits to be paid on time in the absence of an enacted budget were
4 prevailing parties entitled to attorneys' fees; fees awarded against the state under 42.U.S.C. §
5 1988); and *Serrano v. Priest* 131 Cal.App.3d 188(1982) (prevailing party in fee litigation entitled
6 to payment of fees from supported budget of state agency defendant despite absence of legislative
7 appropriation to pay fees). In addition, I wrote major portions of the Supreme Court brief in
8 *Pierce v. Underwood*, 487 U.S. 552 (1988), the first high court opinion to construe the EAJA. I
9 am the principal author of "*Foreword: The Private Attorney General Rule and Public Interest*
10 *Litigation in California*," 66 Cal. L Rev. 138 (1978); and have written and continue to update the
11 chapter on attorneys' fees for the Federal Practice Manual for Legal Aid Attorneys. I have
12 lectured on the subject of attorneys' fees to numerous legal services and bar association groups.
13 In addition, I was appointed in 2003 by United States District Judge Margaret Morrow to serve
14 as a Special Master on attorneys' fees issues in a civil rights case in the Central District of
15 California.

16
17 4. In the course of attorneys' fees litigation, I have talked to attorneys from many private
18 law firms and taken their declarations concerning hourly rates at their firms in Los Angeles and
19 the Bay Area. I have also reviewed many attorneys' fees requests and awards in other cases, and
20 available survey data.

21 5. Western Center seeks \$415 for the work of Elizabeth Landsberg, a 1998 law school
22 graduate who is experienced in health law and legislative advocacy; and \$325 for Jen Flory,
23 another experienced health lawyer and litigator. These rates are based on rates awarded by the
24 Insurance Commissioner in File No. 2007-00006, a copy of which is attached as Exhibit A. In
25 my opinion, those rates are well within the range of rates that private attorneys charge their fee-
26 paying clients, and indeed are at the lower end of that range.

27 6. I base that observation on, among other things, a May 2009 survey by Westlaw Court
28

1 Express, entitled Legal Billing Report, which details California billing rates. The survey is
2 attached as Exhibit B to the Declaration of Richard M. Pearl.

3
4 7. I also base my opinion on Mr. Pearl's declaration itself, which is submitted
5 separately. Mr. Pearl is the author of the leading California treatise on attorneys' fees and is the
6 leading expert in the State on court-awarded fees. The Pearl declaration has more examples of
7 Bay Area rates than of Los Angeles rates. I have negotiated and litigated fee applications in both
8 areas. In my experience, Los Angeles hourly rates, year in and year out, tend to be roughly equal
9 with Bay Area rates.

10 8. A previous opinion by the Department of Managed Health Care awarding fees noted
11 that Western Center had not attached to its application fee award orders. For the past several
12 years, every fee award Western Center has recovered in Los Angeles and the Bay Area has been
13 through stipulated orders. In each case, the hourly rates sought in my initial demand letter have
14 been consistent with the rates sought here, albeit increased over the years. In each case, we
15 reached an agreement – usually totaling 85 - 95% of what I initially asked for – that did not
16 specify hourly rates awarded.

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19 I declare under penalty of perjury under the laws of the State of California that the
20 foregoing is true and correct.

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22 Executed on March 16, 2010 in Los Angeles, California.

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27 **RICHARD A. ROTHSCHILD**

EXHIBIT A

EXHIBIT A

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BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of the Request for Final
Compensation of

FOUNDATION FOR TAXPAYER
AND CONSUMER RIGHTS,

Intervenor.

File No. IP-2007-00006

DECISION AWARDED COMPENSATION
TO FOUNDATION FOR TAXPAYER AND
CONSUMER RIGHTS

*In the Matter of the Rate Applications of
Explorer Insurance Company (PA-2007-00013)*

Application No. 06-5567 (Auto)

The Foundation for Taxpayer and Consumer Rights, now known as Consumer Watchdog ("FTCR" or "Intervenor"), requests an Award of Advocacy Fees and Expenses in the total amount of \$514,145.27 pursuant to California Insurance Code (CIC) §1861.10 and California Code of Regulations (CCR) §§2662.3 and 2662.5, for its substantial contribution to the Decision of California Insurance Commissioner Steve Poizner ("Commissioner") in the Matter of the Rate Applications of Explorer Insurance Company ("Explorer" or "Applicant"). The Commissioner hereby awards FTCR \$504,295.27 in reasonable advocacy, expert and witness fees and costs for its substantial contribution to the Commissioner's Order Adopting Proposed Decision on Remand in the above-referenced matter. The compensation shall be paid to FTCR by Explorer.

Explorer's initial rate application in this case requested a 17.5% rate increase. The Department set a hearing on its own motion. FTCR evaluated the rate application and set out eleven factors that they thought made the requested rate increase excessive. The ALJ's decision,

1 adopted by the Commissioner, denied Explorer's request for a 17.5% rate increase, and instead
2 ordered a 15% rate *decrease*, resulting in savings to consumers of \$8,271,272. FTCR played a
3 key role in the litigation of this matter and the Commissioner's Decision in this matter constitutes
4 a victory for California consumers.

5 I. PROCEDURAL BACKGROUND

6 A. Explorer's Rate Application.

7 On August 16, 2006, Explorer Insurance Company ("Explorer") filed its initial rate
8 application ("Application"), seeking a 0% rate change to its auto liability and physical damage
9 lines of insurance in its Universal automobile insurance program.

10 On April 13, 2007, Explorer amended the application, ("April 07 Amended Application"),
11 requesting four variances and a rate increase of 17.5%.

12 Explorer amended its application once again on August 29, 2007 to comply with
13 ratemaking regulations that took effect in April 2007 ("August 07 Amended Application").

14 B. The Department's Notice of Hearing.

15 On May 16, 2007, the California Department of Insurance ("Department") issued a Notice
16 of Hearing on its own motion. Explorer filed its Notice of Defense on
17 June 1, 2007.

18 C. FTCR's Intervention and Explorer's Opposition.

19 FTCR participated, as an interested party, in the first scheduling conference
20 on June 18, 2007.

21 FTCR filed its Petition to Intervene and Notice of Intent to Seek Compensation
22 ("Petition") on July 2, 2007. FTCR stated that it represents the interests of consumers, that it was
23 eligible to seek compensation in Department proceedings, and that it sought to intervene in the
24 proceeding to ensure that Explorer's auto insurance policyholders are charged rates that comply
25 with California law. (Petition, 2:4-8, 5:21-25.)

26 FTCR said that it would present and elicit evidence to show that Explorer's requested
27 rates are excessive, in violation of the prior approval law and regulations.

28 //

1 FTCR said that it would specifically seek evidence regarding the following factors that contribute
2 to Explorer's excessive proposed rate:
3 1. Excessive loss trend
4 2. Inadequate premium trends
5 3. Improper underwriting profit provision
6 4. Low asset yield
7 5. Low premium to surplus ratio
8 6. Improper loss development factors
9 7. High expense ratios
10 8. Improper expenses for technology spending
11 9. Loss trend not based on insurers' most recent twelve quarters of data
12 10. Fails to identify sufficient detail regarding the requested variances
13 11. Fails to provide the expected impact on permitted earned premium
14 12. Fails to identify justification for the requested variances
15 13. Seeks variances not provided for in the regulations
16 14. Improper profit factor calculation
17 15. Fails to use proper loss development time periods
18 (Petition, 4:11-5:13.)

19 FTCR requested that the variances and rate increase be denied. (Petition 5:14-16.) FT
20 stated that it would be able to attend and participate in the proceeding without causing delay.
21 (Petition 6:22-24.)

22 FTCR's Petition included a Preliminary Budget, estimating that it would spend \$183,750
23 in attorneys and experts' fees and costs in this matter. (Petition, Exhibit A.)

24 On July 9, 2007, Explorer filed its response to the Petition, saying that FT
25 would duplicate the Department's case. Explorer also objected to FT
26 proposed budget.

27 On July 9, 2007, the Department notified the ALJ that it had no objection to FT
28 petition to intervene.

29 ALJ Lisa Williams granted FT
30 Petition to Intervene on July 17, 2007.

31 **D. The proceeding.**

32 Explorer argued that prior approval regulations that took effect in April 2007 should not
33 apply, but rather, that the regulations in effect at the time of its initial Application (August 2006)
34 should apply. On August 24, 2007, the ALJ rejected Explorer's arguments, agreeing with FT
35 and the Department, ruling that the April 2007 regulations properly apply to this matter.

36 //

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1 Explorer lodged pre-filed written direct testimony in September 2007. On
2 October 19, 2007, in response to motions filed by the Department and FTICR, the ALJ struck
3 portions of the testimony and exhibits. Later in October 2007, the Department and FTICR lodged
4 prefiled written direct testimony. On November 16, 2007, in response to Explorer's motion, the
5 ALJ struck portions of the Schwartz testimony. On November 19, 2007 the ALJ ordered the
6 parties to submit their third joint statement of facts and issues, exhibit lists, and calculations for
7 Explorer's requested variances.

8 On November 26, 2007, the first day of the evidentiary hearing, Explorer filed another
9 amended rate application ("November 07 Amended Application"). On
10 November 28, 2007 the parties filed another revised Joint Exhibit list and Regulatory Formula
11 Calculations of Parties to Reflect Joint-Issue and Facts in Dispute and Not in Dispute. The
12 evidentiary hearing continued through November 30, 2007 and also convened on January 4, 2008
13 and February 19, 2008.

14 The ALJ ordered the evidentiary hearing closed February 27, 2008 and the parties filed
15 post-hearing briefs on March 27, 2008 and reply briefs on April 11, 2008. On
16 April 30, 2008, the ALJ denied Explorer's and FTICR's requests for official notice and closed the
17 record.

18 On June 25, 2008, Commissioner Poizner rejected the ALJ's proposed decision and
19 ordered the evidentiary hearing reopened in order to gather additional evidence on the appropriate
20 amount, if any, of Variance 3B ("Remand Order").

21 The record was reopened July 23, 2008. The parties notified the ALJ that they had
22 reached a settlement as to the appropriate amount for Variance (3)(B). On August 8, 2008, the
23 parties submitted a written stipulation and attendant declarations. The ALJ asked for and
24 received some additional evidence from Explorer and admitted the Stipulation and declarations
25 into evidence on August 26, 2008. The record was closed September 19, 2008. The ALJ's
26 Revised Proposed Decision on Remand issued October 6, 2008.

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28 //

1 **E. The Decision.**

2 Two issues were determined at the hearing:

- 3 • What is the correct rate change without variance?
4 • Does Explorer qualify for any of its requested variances?

5 Correct rate without variance. The parties presented evidence on the various elements of
6 the regulatory formula:

- 7 1. Loss Development (FTCR and CDI provided different methodologies, both
8 allowable in the regulations). The ALJ found CDI's loss development factors
9 to be the most accurate.
10 2. Catastrophe Load. The ALJ found that Explorer did not have any catastrophe
11 losses in the past 10 years and so was entitled to 0% for CAT load.
12 3. Loss and Premium Trending. (FTCR and CDI objected to separate aspects of
13 Explorer's Loss and Premium Trending). The ALJ rejected Explorer's
14 analysis.
15 4. The ALJ found that Explorer did not adequately explain its loss development
16 factors and that the loss development factors submitted by the Department
17 were more accurate. The ALJ found that Explorer had not experienced
18 catastrophe losses in the past ten years and so was not entitled to a CAT load.
19 The ALJ found that Explorer was required to use premium and loss trend
20 factors using company specific data.
21 5. The ALJ found the proper rate indication, without variances, per the regulatory
22 formula to be a rate decrease of 16.5%.

23 Explorer's Variance Requests. Variance 1 – altered mix of business. CDI and FTCR put
24 forth different reasons for their disagreement with Explorer's contention that it had experienced a
25 changed mix of business. The ALJ found that Explorer failed to meet its burden of proof and
26 denied Variance 1.

27 Variance (3)(B) – Service to underserved communities. The parties disagreed as to the
28 definition of "demonstrably superior or inferior service." Initially, the Department agreed with
Explorer that it qualified for this variance, but they disagreed as to the percentage amount. FTCR
argued that Explorer did not qualify for the variance. The parties ultimately reached stipulation,
approved by the ALJ, of a 1.3% adjustment to Explorer's efficiency standard pursuant to
Variance 3B.

Variance (3)(C) – Significantly smaller than average policy size. The Department and
FTCR disagreed as to the meaning of the word "significantly" with regard to this variance, and

1 both disagreed with Explorer. The ALJ found Explorer's arguments unpersuasive and found that
2 Explorer did not satisfy its burden with regard to Variance (3)(C).

3 Variance 5 - Investment risks for one line or investment risks for California are different
4 from investment risks typical of the line as a whole. The Department and FTCR asserted
5 different reasons why Explorer did not qualify for this variance. The ALJ found that Explorer did
6 not satisfy its burden of proof with regard to Variance 5.

7 Variance (10)(A) - Modified trend formula due to change in mix of business. The
8 Department and FTCR put forth different reasons for why Explorer did not qualify for Variance
9 (10)(A) and the ALJ, finding that Explorer's analysis was not actuarially sound, denied this
10 variance.

11 Variance 11 - Constitutional or confiscatory variance. FTCR and the Department both
12 argued that Explorer was not entitled to the confiscatory variance and posited different reasons
13 support of that argument. Both FTCR and the Department disagreed with Explorer's "end result
14 test" for confiscation, although the Department did not present any evidence on that issue. The
15 ALJ found that Explorer failed to prove that the regulatory formula, as applied without variances,
16 would result in a confiscatory rate.

17 The ALJ concluded:

- 18 • Explorer's requested 17.6% rate increase is excessive.
19 • The ratemaking formula without variance, indicates a rate decrease of 16.5%.
20 • The rulings on the various variances as set forth above, together with the parties'
21 stipulation to a 1.3% increase pursuant to variance 3B results in a rate decrease of
22 15%.

23 On November 12, 2008, the Commissioner Adopted the ALJ's Proposed Decision on
24 Remand, dated October 6, 2008. The Decision took effect December 12, 2008 and so the 15%
25 decrease took effect 20 days thereafter.

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1 **F. FTCR's Request for Compensation.**

2 On January 12, 2009, FTCR submitted a verified Request for Final Compensation,
3 ("Request") seeking \$506,486.77 for its substantial contribution to the Commissioner's Decision.
4 The Request was received timely.

5 FTCR summarized the proceeding and set described its role in the proceeding. FTCR
6 analyzed the Initial Application in order to determine whether to request a hearing, and identified
7 several problems with the filing. FTCR analyzed the subsequent applications as well. FTCR
8 propounded discovery, as ordered by the ALJ. Explorer refused to comply with several of
9 FTCR's requests and it took over two months to resolve, but FTCR's discovery resulted in
10 Explorer producing over 3,100 pages of documents. FTCR argued that the April 2007 regulations
11 should apply in this matter and prevailed. With regard to the six variances that Explorer
12 requested in its April 07 Amended Application, FTCR researched and put forth legal and actuarial
13 arguments separate and distinct from those made by the Department. FTCR submitted pre-filed
14 testimony, and filed the only direct testimony in opposition to Explorer's variance requests.
15 FTCR participated fully in the evidentiary hearing and complied with all of the ALJ's orders,
16 including extensive post hearing briefing. FTCR participated in settlement discussions that
17 resolved the Variance 3B value. FTCR's work in this case contributed to the Commissioner's
18 ordering a 15% rate decrease (compared with the Explorer's requested 17.6% rate increase)
19 resulting in \$38.4 million per year in auto rate savings for California drivers.

20 **G. Explorer's Response to Request for Compensation.**

21 Explorer submitted its Opposition to FTCR's Fee Request on January 22, 2009. Explorer
22 did not dispute that FTCR made a substantial contribution to the decision ordering a 15% rate
23 decrease and did not take issue with FTCR's requested hourly rates or the appropriateness of fees
24 requested by FTCR's lawyers.

25 Explorer raised challenges regarding work done by FTCR's actuary, Allan Schwartz.
26 Explorer attached the bills paid to its actuary (Ms. Ackerman) and to its economist (Dr. Appel).

27 Explorer argued that FTCR submitted billing records for its actuarial experts AIS Risk
28 Consultants, Inc. (AIS) that were out of compliance with CCR §2662.3(b) because the records do

1 not specify time in 5 minute or tenth of an hour increments and also violated the requirements of
2 CCR §2662.3(d) because the records do not provide adequately detailed descriptions of the work
3 performed.

4 Alternatively, Explorer argued that the amount of time that AIS spent on this case was
5 excessive, especially when compared with the amount of time that Ms. Ackerman and Dr. Apel
6 spent on the matter.

7 Accordingly, Explorer requests that FTICR's compensation for AIS' work be denied
8 entirely or reduced by 20%.

9 **H. FTICR'S Reply in Support of its Request for Final Compensation.**

10 FTICR submitted its Reply in Support of its Request for Final Compensation on
11 February 6, 2009. FTICR included a declaration from Mr. Schwartz saying that the hours he
12 billed are an accurate accounting of the time he actually spent working on this case. FTICR also
13 included a request for additional hours spent by Mr. Foreman and Ms. Pressley in defending its
14 compensation request.

15 FTICR argued that CCR Sec. 2662.3(g) requires that a party that questions the market rate
16 or reasonableness of an intervenor's compensation request must provide the fees, rates and costs
17 it expects to expend in the matter. FTICR argued that since Explorer provided only billing
18 information with regard to its actuary and economist only, it is in violation of the regulation and
19 the Commissioner should disregard its Opposition to the fee request.

20 FTICR argued that the required detailed description of time billed as in CCR §2662.3(b)
21 and (d) does not apply to the AIS actuaries, as it applies to time worked by the intervenor only.
22 FTICR pointed out that Mr. Schwartz's staff billed in tenth of an hour increments and also that
23 Explorer's witnesses billed in quarter hour, not tenth of an hour increments.

24 FTICR argued that the AIS actuaries' descriptions of the work they did were sufficiently
25 detailed as the hearing dates and which witnesses testified, etc. can be gleaned from FTICR's
26 entire compensation request and therefore the billing records are in compliance with the
27 regulations.

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1 FTCR argued that Explorer did not make any specific objection to the amount of time
2 worked by Mr. Schwartz and his staff, and that its comparison the time and hourly rates of
3 FTCR's experts with Explorer's experts is inappropriate. FTCR pointed out that Explorer also
4 presented testimony from additional witnesses who covered issues that were covered by
5 Mr. Schwartz, and were not covered by Ms. Ackerman and Dr. Appel. FTCR claimed Dr. Appel
6 spent twice as much time as did Mr. Schwartz, on the issue of the constitutional, or confiscation,
7 variance.

8 II. LEGAL REQUIREMENTS FOR AN AWARD OF COMPENSATION

9 A. Standard.

10 Proposition 103 provides:

11 Any person may initiate or intervene in any proceeding permitted or established
12 pursuant to this chapter, challenge any action of the commissioner under this
13 article, and enforce any provision of this article.

14 The commissioner or a court shall award reasonable advocacy and witness fees
15 and expenses to any person who demonstrates that (1) the person represents the
16 interests of consumers, and, (2) that he or she has made a substantial contribution
17 to the adoption of any order, regulation or decision by the commissioner or a court.
18 Where such advocacy occurs in response to a rate application, the award shall be
19 paid by the applicant. (CIC §1861.10.)

20 The Department's regulations define "substantial contribution":

21 "Substantial Contribution" means that the intervenor substantially
22 contributed, as a whole, to a decision, order, regulation, or other
23 action of the Commissioner by presenting relevant issues, evidence,
24 or arguments which were separate and distinct from those
25 emphasized by the Department of Insurance staff or any other party,
26 such that the intervenor's participation resulted in more relevant,
27 credible, and non-frivolous information being available for the
28 Commissioner to make his or her decision than would have been
available to a Commissioner had the intervenor not participated. A
substantial contribution may be demonstrated without regard to
whether a petition for hearing is granted or denied. (CCR §
2661.1(k).)

The Department's regulations explain further:

(a) Subject to subdivision (b) herein, advocacy fees, witness fees, and
other expenses of participation in a proceeding shall be awarded to any
petitioner, intervenor or participant who complies with section 2662.3
and satisfies both of the following requirements:

(1) The intervenor or participant's presentation makes a
substantial contribution as evidenced by specific citations to
the intervenor's direct testimony, cross-examination, legal

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arguments, briefs, motions, discovery, or any other appropriate evidence; and

(2)The intervenor or participant represents the interests of consumers.
(CCR §2662.5.)

B. Procedural requirements for requesting compensation.

A rate proceeding is established upon the submission of a Petition for Hearing:

“Rate Proceeding” means any proceeding conducted pursuant to Insurance Code Sections 1861.01 and 1861.05. For purposes of section 1861.05, a “rate proceeding” is established upon the submission of a petition for hearing in accordance with section 2653.1 of this subchapter, or if no petition for hearing is filed, upon notice of hearing.
(CCR §2661.1(h) (Emphasis added.)

The Department’s regulations provide, in relevant part:

- (a) petitioner, intervenor or participant whose Petition to Intervene or Participate has been granted and who has been found eligible to seek compensation may submit to the Public Advisor, within 30 days after the service of the order, decision, regulation or other action of the Commissioner in the proceeding for which intervention was sought, or at the requesting petitioners, intervenor’s or participant’s option, within 30 days after the conclusion of the entire proceeding, a request for an award of compensation.
- (b) The request shall...include,...
 - 1. a detailed description of services and expenditures;
 - 2. legible time and/or billing records...which show the date and the exact amount of time spent on each specific task; and
 - 3. a description of the ...intervenor’s ...substantial contribution... The phrase “exact amount of time spent” as used in this subdivision refers either to five (5) minute or tenth (10th) of an hour increments.
- (d) The phrase “each specific task,” ...refers to activities including, but not limited to: (A) telephone calls or meetings/conferences, identifying the parties participating in the telephone call, meeting or conference and the subject matter discussed; (B) legal pleadings or research, identifying the pleading or research and the subject matter; (C) letters, correspondence or memoranda, identifying the parties and the subject matter; and, (D) attendance at hearings, specifying when the hearing occurred, the subject matter of the hearing and the names of witnesses who appeared at the hearing, if any.
- (g) Any party questioning the market rate or reasonableness of any amount set forth in the request shall, at the time of questioning the market rate or reasonableness of that amount, provide a statement setting forth the fees, rates and costs it expects to expend in the proceeding. (CCR §2662.3.)

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1 FTCR IS ENTITLED TO COMPENSATION

2 A. FTCR represents the interests of consumers and is eligible to seek compensation.

3 The Commissioner finds that FTCR "represents the interests of consumers" pursuant to
4 the meaning of CIC §1861.10 and CCR §2661.1(j).

5 The Commissioner finds that FTCR is eligible to seek compensation pursuant to
6 CIC §1861.10 and CCR §2662.2. See, Determination re Eligibility of The Foundation for
7 Taxpayer and Consumer Rights, effective July 14, 2006 – July 14, 2008, and Finding of
8 Consumer Watchdog's Eligibility to Seek Compensation, effective July 14, 2008-July 14, 2010.

9 B. FTCR made a "substantial contribution" to the Decision that was "separate
10 and distinct" from the Department's contribution.

11 FTCR has established that it made a substantial contribution warranting an award of fees
12 and expenses.

- 13 1. FTCR had an actuarial witness who was provided testimony to rebut the
14 points made by Explorer's actuaries.
- 15 2. FTCR went into great depth in its cross examination of Explorer's
16 witnesses.
- 17 3. For the six variances requested by Explorer, FTCR put forth arguments
18 separate and distinct from those argued by the Department.
- 19 4. FTCR used a different method of calculating Loss Development, necessary
20 for determination of the proper rate change without variance.
- 21 5. FTCR used the sum of paid losses and case-specific reserved. CDI used
22 paid losses. Both are allowed in the regulations.
- 23 6. FTCR and CDI objected to different aspects of Explorer's calculation of its
24 Loss and Premium Trending, necessary for determination of the proper rate
25 change without variance.
- 26 7. With regard to Explorer's request for Variance 1, CDI and FTCR put forth
27 different reasons for their disagreement with Explorer's contention that it
28 had experienced a changed mix of business.
8. FTCR propounded discovery and argued against Explorer's refusal to
submit the requested documentation. As a result, FTCR and the
Department were eventually able to obtain over 3,000 pages of additional
documentation.
9. FTCR was successful in arguing that the April 2007 rate regulations should
apply in this matter.
10. FTCR submitted the only direct testimony in opposition to Explorer's
variance requests.
11. FTCR worked closely with the Department in settlement discussions that
resolved the Variance 3B value.

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1 IV. AMOUNT OF AWARD

2 A. Standard.

3 Proposition 103 provides:

4 "The Commissioner or a court shall award reasonable advocacy and witness fees
5 and expenses to any person who demonstrates" that he or she meets the
6 requirements for compensation. (CIC §1961.10(b).) "The compensation awarded
7 shall equal the market rate of the services provided." (CCR §2662.6(b).)

8 The Department's regulations define "Market Rate":

9 "Market Rate" means, with respect to advocacy and witness fees, the prevailing
10 rate for comparable services in the private sector in the Los Angeles and San
11 Francisco Bay Areas at the time of the Commissioner's decision awarding
12 compensation for attorney advocates, non-attorney advocates, or experts with
13 similar experience, skill and ability. Billing rates shall not exceed the market rate.
14 (CCR §2661.1(c).)

15 B. Requested hourly rates.

16 FTCR seeks compensation for legal fees for work done by its in house attorneys,
17 Harvey Rosenfield, Pamela Pressley and Todd Foreman, as well as compensation for actuarial
18 witnesses.

19 FTCR submitted the Declaration of Todd M. Foreman attesting to the reasonableness of
20 its attorneys' requested hourly rates, the hours they worked, the tasks they worked on, and the
21 costs they incurred. FTCR requested the attorneys' 2008 rates for their work done in this matter.

22 FTCR's Request for Compensation included as Exhibit 2 to the declaration of
23 Mr. Foreman, a declaration submitted in a different matter, written by Richard M. Pearl, an expert
24 on attorneys' fees. Mr. Pearl is the author of books on attorneys' fees, including a California
25 Continuing Education of the Bar publication entitled *California Attorney Fee Awards*.

26 Mr. Rosenfield: FTCR requests Mr. Rosenfield's 2008 rate of \$575/hour. As of 2008,
27 Mr. Rosenfield had 29 years of legal experience. Mr. Pearl's November 2008 declaration
28 specifies that FTCR's requested 2008 rate of \$575/hour for Mr. Rosenfield is consistent with the
2008 market rate for the San Francisco and Los Angeles legal markets for attorneys with similar
experience. Accordingly, the Commissioner grants FTCR its requested rate for Mr. Rosenfield's
work in this matter.

Ms. Pressley: FTCR requests Ms. Pressley's 2008 rate of \$425/hour. As of 2008,
Ms. Pressley had 13 years of legal experience. Mr. Pearl's declaration specifies that FTCR's

1 requested 2008 rate of \$425/hour for Ms. Pressley is consistent with the 2008 market rate for the
2 San Francisco and Los Angeles legal markets for attorneys with similar experience. Accordingly,
3 the Commissioner grants FTICR its requested rate for Ms. Pressley's work in this matter.

4 Mr. Foreman: FTICR requests Mr. Foreman's 2008 rate of \$325/hour. As of 2008, Mr.
5 Foreman had 5 years of legal experience. Mr. Pearl's declaration specifies that FTICR's requested
6 2008 rate of \$325/hour for Mr. Foreman is consistent with the 2008 market rate for the San
7 Francisco and Los Angeles legal markets for attorneys with similar experience. Accordingly, the
8 Commissioner grants FTICR its requested rate for Mr. Foreman's work in this matter.

9 **C. Hours.**

10 FTICR provided timesheets for the lawyers and actuaries who worked on the case.

11 The Commissioner finds that FTICR billed a very small amount time spent on a press
12 release. The Commissioner finds that although that time spent in this matter was very little, time
13 spent on public relations and publicity for FTICR is unrelated to the rate proceeding before the
14 Commissioner, and is therefore not compensable. Accordingly, that time has been deducted from
15 the final award.

16 The Commissioner finds that, except for Mr. Boer, the AIS actuaries' descriptions of work
17 are sufficiently vague to be inadequate. Furthermore, except for Mr. Boer, the AIS actuaries
18 failed to provide their time in 5 minute or tenth of an hour increments. Accordingly, FTICR's
19 requested time for Mr. Schwartz, Ms. Tollar and Ms. Dwyer is reduced by 5%. FTICR is strongly
20 cautioned that in future, the time records of its actuaries must comply with the regulations. //

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1 Explorer shall make the payment as ordered herein within 30 days from the date of this
2 Decision and shall notify the Department's Office of the Public Advisor when such payment has
3 been made.

4 Date: November 16, 2009

STEVE POIZNER
Insurance Commissioner

By:



Adam M. Cole
Chief Counsel

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SERVICE LIST
In the Matter of the Request for Final Compensation of FOUNDATION FOR
TAXPAYER AND CONSUMER RIGHTS, Intervenor.
Case No. IP-2007-00006

<u>Name/Address</u>	<u>Phone/Fax Numbers</u>	<u>Method of Service</u>
Harvey Rosenfield Pamela Pressley Todd M. Foreman CONSUMER WATCHDOG Formerly known as: FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS 1750 Ocean Park Blvd., Suite 200 Santa Monica, CA 90405 harvey@consumerwatchdog.org pam@consumerwatchdog.org todd@consumerwatchdog.org	Tel: (310) 392-0522 Fax: (310) 392-8874	EMAIL
Stephen H. Weinstein Spencer Y Kook BARGER & WOLEN, LLP 633 West Fifth Street, 47 th Floor Los Angeles, CA 90071 sweinstein@barwol.com skook@barwol.com	Tel: (213) 680-2800 Fax: (213) 614-7399	EMAIL
Donald P. Hilla, Jr. James Stanton Bair, III Alec C. Stone CALIFORNIA DEPARTMENT OF INSURANCE Legal Division Rate Enforcement Bureau 45 Fremont Street, 21 st Floor San Francisco, CA 94105 hillad@insurance.ca.gov bairs@insurance.ca.gov stonea@insurance.ca.gov	Tel: (415) 538-4500 Fax: (415) 904-5490	EMAIL

TIME RECORDS
(In response to
Question #4)

TIME RECORDS
(In response to
Question #4)

Date	Description	Hours
2/7/2008	Reviewed authorizing legislation and statutes	1
	Researched judicial deference on quasi-leg actions and the legality of the	
2/21/2008	finalized regulations	2
6/30/2008	Spoke w/ E. Landsberg re stakeholder process	0.4
7/2/2008	Reviewed docs sent by DMHC for stakeholder process	0.3
7/2/2008	Divided up issues for proposal w/ E. Landsberg & A. Rubenstein	0.3
7/21/2008	Drafted proposals for issues #5-7	3.5
7/21/2008	Went over draft proposals and problems w/ E. Landsberg & A Rubenstein	1.2
7/22/2008	Revised issues #5-7	2.2
7/23/2008	Reviewed compiled version of reg proposals	0.5
7/24/2008	Reviewed comments and finalized reg proposal	0.2
8/5/2008	Reviewed other org's proposals	1.5
8/6/2008	Began comments/positions on other proposals	1.8
8/7/2008	Finished comments to issues #5-7	1.8
11/19/2008	Drafted comments to informal revised regs re compliance and other standards	3
2/17/2009	Drafted comments to formal revised regulations	0.6
2/20/2009	Discussed changes in new version of regs w/ E Landsberg and position we should	0.2
2/23/2009	Revised comments and finalized letter	1.2
6/1/2009	Previewed portions of draft of final regs and gave E Landsberg input on changes	0.8
6/22/2009	Reviewed final text of regs for comment	0.8
6/23/2009	Reviewed DMHC response to previous comments and drafted comments to revisi	2
6/25/2009	Revised and finalized WCLP comments to DMHC second draft regs	1
10/6/2009	Reviewed 4th round of timely access revisions and drafted WCLP comments	1.5
10/8/2009	Added additional points to comments	1
10/13/2009	Finalized WCLP comments	0.5
Total		29.3

ELIZABETH LANDSBERG

Date	Description	Hours	
1/31/06	Received CAHP's proposed changes to regs., Health Access proposed version, called HRH to join consumer pre-meeting, meeting of advocates to discuss strategy at Health Access	2.5	
2/6/06	Meeting with CAHP, CMA, CAPG, CHA	2.2	
10/17/06	Read the discussion draft and had conference call with other advocates to discuss draft regs.	1.5	
10/24/06	Conversation with Doreena Wong from NHeLP about how draft regs interact with SB 853 C & L reqs, read AB 2179, old versions of regs., old consumer letters re: regs., reread over current draft of regs., talked to Beth C. re: C and L issues, drafted notes re: concerns, attended consumer advocate meeting with Steve Hansen to discuss draft regs.	5.3	
10/25/06	Email to HCA partners to get info on HealthyFamilies and Medi-Cal contract appointment times	0.2	
10/30/06	Read Shelley Rouillard's email on Medi-Cal contract times, looked up relevant MC regs., called K. Lewis to see if she had HFKs, checked MRMIB website, emailed B. Abbott, emailed Laura Rosenthal at MRMIB re: appointment time req.'s in HFKs	0.4	12.1
2/5/07	Printed and read new revised regs.	0.5	
2/13/07	Wrote query request and search HCA database for delayed care cases, emailed HCA group re: regs	0.3	
2/26/07	Read through HCA delay cases	0.8	
2/28/07	Rereading regs. and drafting comments, sent comments to HCA partners	4.7	
3/2/07	Reading comments from other consumer adovates	0.3	
3/3/07	Incorporating comments, suggestions from other consumer advocates	0.8	
3/4/07	Edited written comments and worked on hearing testimony	1	
3/5/07	Went to hearing on proposed regs., coordinated with other consumer advocates after meeting, finalized written comments and sent them	4.2	
7/17/07	Coordinated among HCA partners on reg comments	0.3	
9/5/07	Read revised regs.	0.6	
9/6/07	Read revised regs.	0.5	
9/7/07	Read revised regs and starting to draft letter/comments	0.4	
9/11/07	Drafted comments	2	
9/12/07	Drafted comments; finished draft and sent out to HCA senior advocates, talked to Ann re: HRH	2.5	
9/17/07	Prepared hearing testimony, coordinated with Doreena Wang and Ann Rubinstein	1	
9/18/07	Coordinated with Doreena, prepared for testimony, attendance at hearing and testifying	6.3	
9/20/07	Coordinating final arguments, editing	1.4	
12/11/07	Printed out new proposed regs & emailed HCA parnters that I would comment & begin reading new regs	0.4	
12/12/07	Read draft regs	0.8	

12/18/07	Coordination with other consumer groups, review of Depts. chart of comments and responses, drafting comments, sent draft comments to HCA partners	3	
12/19/07	Discussing comments with other advocates	0.5	
12/21/07	Finalized comments and submitted.	0.6	32.4
2/5/08	Pre-call with Health Access before meeting with Cindy Ehres, meeting with Ehres and other DMHC staff re: 12/07 regs.	2.5	
3/26/08	Timely access testimony prep for Senate Health Committee hearing.	2	
3/27/08	Attended hearing and testified re: timely access regs.	2	
6/27/08	Discussion with Ed Heidig re: timely access reg process.	0.2	
6/30/08	Stakeholder meeting with Dept. on reg process and principles and post meeting with consumer advocates. Email to HCA advocates on process and asking who would like to coordinate.	3.3	
7/1/08	Email to Dept. personnel re: process.	0.3	
7/11/08	talked with Ed Heidig re: process	0.2	
7/20/08	Drafting proposal for issue 1	1	
7/21/08	Drafting proposals for issues 1 & 2, call with J Flory and A Rubenstein.	3.5	
7/24/08	Finalizing timely access proposals and submitting them.	1.5	
8/13/08	Talked to Beth Abbot re: process and format for responding to proposals.	0.2	
8/18/08	Printing draft responses on issues 3 & 4, reading proposals for issue 3, editing response.	0.8	
8/19/08	Printing comments from CHA, CPEHN. Drafting response on issue 1. Starting response on issue 2.	2.8	
8/20/08	Finished draft response on issue 2, reviewed response on issues 4, 5, 6 & 7 and sent suggested edits to J Flory and A Rubenstein. Editing all responses.	3.3	
8/21/08	Finalized all 7 responses and sent them to the dept.	1.5	
9/2/08	Reviewing responsive positions.	1.5	
9/3/08	DMHC meeting on issue 1. Discussion with other consumer advocates, B Cappell, E Abbott, A Rubenstein.	3.8	
9/4/08	DMHC meeting on issue 2.	2.5	
9/10/08	Meeting on issues 3 & 4, coordination with other consumer advocates, issue 4, review of issue 5-7 proposals and responses, some materials sent by participants.	3.7	
10/30/08	Meeting with Rick Martin, Tim LeBas, Beths re: proposed informal regs.	1	
11/4/08	Call with J Flory and A Rubenstein re: proposed informal regs.	0.5	
11/19/08	Reviewing set of informal draft regs, emails/calls with Peter Schroeder, Doreena Wong, Jen Flory re: draft regs. Drafted comments on subsections (a)-(c). Reviewed J Flory's comments on (d)-(h), sent to HCA consumers for feedback and sign-on.	3.5	
12/10/08	Meeting with Ed Heidig re: timely access regs & dicount plan regs	1	

2/20/09 Reading regs, commenting on draft letter, preparing testimony.	2
6/1/09 Got email from R Martin at DMHC re: revisions to regs; sent to J Flory and discussed them; set up meeting with R Martin to discuss.	0.3
6/3/09 reviewed proposed As to regs	0.4
6/4/09 Call w/R Martin and S Crammout from DMHC and B Capell re: proposed As. Noted consumer concerns.	1
7/28/09 Reviewed 7/23/09 amendments and regs and emailed J Flory.	0.3
10/13/09 Reviewed new draft regulations and comment letter.	0.5
10/14/09 Sent in timely access 4th round reg comments	0.1
Total Hours	92.2