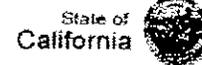


DMHC Note: Documents that were accessible by clicking on “View” are displayed after the Applicant’s certification of the Application.



Application for an Award of Advocacy and Witness Fees

Entity Name: California Pan-Ethnic Health Network
Proceeding: 2002-0018 General Access/ 2005-0203 Timely Access
Date Submitted: 3/16/2010 9:08:08 PM
Submitted By: Martin Martinez
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?

\$11,750.00

- 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.

CPEHN has been instrumental to securing policy changes that have benefited our diverse communities. Since the founding of DMHC, CPEHN has provided our expertise and technical assistance to ensure regulations and decisions are made in the best interests of our communities. CPEHN provided crucial feedback that shaped language assistance regulations, and provided DMHC staff with trainings on cultural competency and language access, as well as how to most effectively audit health plans for compliance. We were pleased to provide DMHC with recommendations on how to improve timely access to care regulations to ensure the needs of diverse populations are met. We provided formal comments on the regulations during nine formal comment periods spanning from 2004 to 2009. We also provided written comments that were solicited from us during an informal comment period in November 2008. We also were invited to participate in the stakeholder process that involved in-person meetings in Sacramento in September 2008. The work we provided for DMHC principally involved reading the proposed regulations drafts, analyzing them for their impact on communities of color and people who speak a language other than English, drafting writing comments, and participating in two of the stakeholder meetings. We believe our most significant contribution to the final regulations would be the requirement that interpreter services 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. Throughout the process we advocated that there should not be additional, unreasonable waits for interpreter services for Californians who speak a language other than English. We believe equality in care provided is an essential element in a just society, and care cannot be equal if there are disproportionate waits for interpreters. We advocated for a provision similar to this even back when we were working with DMHC on language assistance regulations, and through multiple drafts of the timely access regulations. We also were one of many organizations advocating for specific, quantifiable, time-elapsd standards for accessing services, so consumers are concretely aware of what their rights to care are. We are pleased to see these provisions reflected in the final regulation. The experience possessed by CPEHN staff justifies the rate requested. The principle staff member working on the regulations was Martin Martinez, who has a Masters in Public Policy from the University of California at Berkeley, over eight years experience working with CPEHN (and therefore over eight years advocating with DMHC), and an additional five years of policy advocacy before that.

We look forward to your reply and a continued positive working relationship.

Document Name	Date Uploaded	Uploaded By	
CPEHNTimelyaccessattach.pdf	3/16/2010 9:05:57 PM	Martin Martinez	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](#).

Document Name	Date Uploaded	Uploaded By	
Activity_List_CPEHN Timely Access.xls	3/16/2010 9:06:34 PM	Martin Martinez	View

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 Oakland (City), CA (State), on March 16, 2010.

Enter Name: Martin Martinez



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August 26, 2004

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Re: Comments: 2002-0018 Access to Needed Health Care Services

To Whom It May Concern:

Please accept these comments to pending regulations, 2002-0018 Access to Needed Health Care Services, on behalf of CPEHN. CPEHN is a statewide network of over 50 multicultural health organizations, including community-based organizations, health care providers, and policy experts committed to working together to improve health care access and eliminate health status disparities in California's communities of color. CPEHN serves on the Office of the Patient Advocate Cultural and Linguistic Workgroup, and has been advising DMHC on ways to ensure that health plans provide communities of color with culturally and linguistically appropriate services. We also were a chief co-sponsor of SB 853 and have been providing technical assistance to DMHC on the drafting of the implementing regulations.

We believe that the needs of communities of color must be addressed in each and every regulation promulgated by DMHC. With communities of color representing over fifty-three percent of the state's population, a healthy and productive California requires the elimination of racial and ethnic health disparities. Health disparities exist due to numerous and complex factors. Many of these factors have been well-documented, such as the lack of culturally or linguistically appropriate services, discrimination in the health care system, and socioeconomic conditions. Access regulations must take into account the need for equal access among communities of color, many of whom do not have access to quality transportation, and the need for culturally competent and linguistically appropriate care.

Therefore our comments primarily recommend that all timelines for accessing care and traveling to providers sites take into account the needs of communities who rely on public transportation, and take into account wait times for

interpreter services to be provided. We also recommend Consumer Assessment of Health Plans Study (CAHPS) be utilized in all the languages for which translations are available. The Spanish translation is widely available and highly regarded, and the California Health Care Foundation has translated CAHPS into additional languages.

Please find our comments in the form of bold additions and edits to the regulations as follows:

Amend section 1300.67.2. to read:

§ 1300.67.2. Accessibility of Services

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility. **The plan must assume that enrollees do not have access to vehicles and must rely on public transportation.** All plans shall have a contracting or plan-employed primary care provider within 30 minutes or 15 miles, by public transportation, of each enrollee's residence or workplace except in any portion of the service area where the plan complies with section 1300.67.2.1. This requirement is not intended to prevent the plan from allowing a member to select a primary care provider beyond the 15 mile or 30 minute distance;

(b) Hours of operation and provision for after-hour services shall be reasonable;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a per day, seven days a per week;

(d) The ratio of enrollees to staff, including health professionals, administrative staff and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan, **including all medical services, interpreter services, and**

preventive services, will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. For a plan that covers hospital and physician services, any contract between the plan and a provider organization shall require ~~There shall be~~ at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees. The ratio may be increased by 500 members for each full-time equivalent nurse practitioner or physician assistant affiliated with the primary care physician in the practice. Documented compliance with the standards described in section 1300.67.2.2(a)(1) shall be deemed an acceptable mechanism to demonstrate an adequate ratio of primary care physicians to enrollees in the relevant portion of the plan's service area;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral. The location of facilities providing the specialty health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility. **The plan must assume that enrollees do not have access to vehicles and must rely on public transportation.** The Plan may demonstrate accessibility to specialty services in any portion of its service area in accordance with the requirements of section 1300.67.2.1. In the case of a full-service plan, the plan shall demonstrate compliance with the standards described in section 1300.67.2.2(a)(2) and shall demonstrate the capacity of its physician specialty network to provide timely physician specialty care services to the plan's enrollees;

(f) The location of facilities providing inpatient and other health care services of the plan shall be within reasonable proximity of the workplace or personal residence of enrollees, and must be accessible by public transportation, unless the plan provides shuttles or other forms of transportation. The plan must assume that enrollees do not have access to vehicles and must rely on public transportation. Except in any portion of the service area where the plan meets the requirements of section 1300.67.2.1, a plan that covers hospital and physician services shall have a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population within the service area based on normal utilization within 30 minutes or 15 miles of the residence or workplace of its enrollees. This requirement is not intended to prevent the plan from allowing an enrollee to obtain services at an inpatient facility beyond the 15 mile or 30 minute distance if the enrollee so requests. The plan must assume that enrollees do not have access to vehicles and must rely on public transportation. This requirement is also not intended to require the plan to terminate or prohibit the enrollment of an individual whose residence is not within 30 minutes or 15 miles of a contracting or plan-operated hospital.

(g) A plan may contract with one or more Centers of Excellence to provide inpatient and/or ambulatory specialty services to plan enrollees. A Center of Excellence is defined as a health care provider or facility designated and recognized as a best practice provider of a particular, highly specialized treatment. A plan may provide services to an enrollee residing further than 30 minutes or 15 miles from a Center of Excellence when the enrollee and his or her physician determine that such services are in the best interest of the enrollee.

~~(f) (h)(1) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which~~

shall include, ~~but is not limited to,~~ waiting time and for appointments, waiting time for the provision of interpreters, provision for after-hours services, and the capacity of the plan's network, including numbers and locations of providers, the language capabilities, and accessibility of providers by public transportation, to assure enrollees are provided accessibility to health care services. **Plans must also have a documented system to ensure that persons are receiving adequate and timely care regardless of income, race, ethnicity or primary language, as well as a system for taking corrective action and tracking the progress and effectiveness of the corrective action, if disparities in access are identified.** Each plan shall implement appropriate corrective actions when plan monitoring identifies patterns of non-compliance with the access standards required by this section. All health care service plans that cover hospital and physician services shall comply with section 1300.67.2.2.

(2) All plans that cover hospital and physician services shall assure that contracted general acute care hospital facilities have the capacity to provide necessary services, including interpreter services, to enrollees within the plan's service area, and the plan shall monitor the capacity of such facilities to assure that enrollees have access to services at reasonable times. All plans that cover hospital and physician services shall have contracted hospitals in a service area sufficient to assure accessibility—including accessibility by public transportation and accessibility for interpreter services—and continuity of care for plan enrollees as medically necessary.

~~(g)(i) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.~~ The plan shall designate a section of the health education program required by section 1300.67(f)(8) to inform enrollees about the availability of plan services in their geographic area and how to access those services. The information must be presented in

the enrollee's primary language, or in the form of a form letter with the information presented in all the languages likely to be encountered in the area. The information provided must include information on accessing services through public transportation. A plan that covers hospital and physician services shall also inform enrollees about the standards for non-emergency appointments. The information must be presented in the enrollee's primary language, or in the form of a form letter with the information presented in all the languages likely to be encountered in the area.

(j) Plans may devise additional methods of access to providers as appropriate, which may include group visits, e-mail, video and telephone to complement traditional in-person medical treatment.

NOTE: AUTHORITY CITED: SECTION 1351, HEALTH AND SAFETY CODE; SECTIONS 1342, 1367, AND 1367.03, HEALTH AND SAFETY CODE (AB 2179, CH. 797, STATS. 2002).

Add section 1300.67.2.2, Access to Non-Emergency Appointments, to read:

§1300.67.2.2. Access to Non-Emergency Appointments

(a) All health care service plans that cover hospital and physician services shall offer or arrange non-emergency physician appointments for enrollees as set forth below. All timelines set forth below must take into account the travel time and accessibility by public transportation, and the need to arrange interpreter services.

(1) Primary Care. An appointment shall be offered with a primary care physician, or, if appropriate and acting within his or her scope of practice with a physician assistant or nurse practitioner, or certified nurse midwife for OB-GYN care at the primary care location or practice to which the enrollee is assigned:

(A) For routine non-urgent care, within 7 days;

(B) For urgent care, in a timely fashion appropriate for the nature of the enrollee's health care condition as determined when necessary by a qualified health professional acting within his or her scope of practice, trained to screen or triage, but not to exceed 24 hours;

(C) For preventive care, within 30 days.

(D) If a solo practitioner or small group practitioner is unavailable, an appointment may be offered with a similar practitioner at an alternative location that is reasonably accessible to the enrollee. The plan must assume that enrollees do not have access to vehicles and must rely on public transportation. The plan must also assume that enrollees may require interpreter services.

(2) Specialty Care. An appointment shall be offered with a geographically accessible, and accessible by public transportation, board certified or board eligible specialty care physician appropriate for that enrollee's health care needs, or via telemedicine with a board-certified or board-eligible specialty care physician as appropriate for the enrollee's health care needs:

(A) For routine, non-urgent specialty care, within an appropriate time as medically necessary, not to exceed 30 calendar days. For routine, non-urgent specialty care appointments for which the plan requires prior authorization, the time for an appointment shall begin to run concurrently with the request for the referral authorization described in section 1367.01(h)(1). An alternative standard may apply in situations where an enrollee is offered specialty care through a Center of Excellence provider pursuant to section 1300.67.2(g).

(B) For urgent specialty care, in a timely fashion, appropriate for the nature of the enrollee's health care condition as determined to be necessary by a health care professional acting within his or her scope of practice, trained to screen or triage, but not to exceed 24 hours for urgent care. For urgent specialty care appointments for which the plan requires prior authorization, the time

for the appointment shall run concurrently with the period to obtain authorization described in section 1367.01(h)(2).

(C) For preventive specialty care, within 30 calendar days.

(b) This section is not intended to preclude the use of recall appointment systems for enrollees who require appointments for on-going health care monitoring, follow-up care, or preventive care on a periodic basis. In these instances, an appointment may be scheduled in advance, beyond the standards in this section, when the appointment date is consistent with the health care needs of the enrollee as determined by the enrollee's health care provider and consistent with professionally recognized standards of practice.

(c) This section is not intended to preclude a plan from adopting more stringent appointment standards than the minimum standards described in subsection (a). This section is not intended to preclude plan compliance with Medicare or Medi-Cal program requirements when any standards for these programs are in addition to or more stringent than the standards described in subsection (a).

(d) Each plan shall adopt reasonable and effective mechanisms using valid methodology to monitor on a periodic basis provider compliance with the access standards required by this section. Plan monitoring of providers shall also assess whether waiting time to speak to a physician, registered nurse, or other qualified professional acting within his or her scope of practice, who is trained to screen or triage an enrollee, **and whether the wait time to access interpreter services to allow such communication,** is adequate to assure timely access to urgent care appointments. Each plan shall implement appropriate corrective actions when plan monitoring identifies patterns of non-compliance with the access standards required by this section, including taking appropriate action to ensure the availability of primary care physicians.

specialty care physicians, physician assistants, nurse practitioners, medical groups and ancillary providers and hospitals, or interpreter services, if necessary.

(e) Any health care service plan contract with a provider or provider organization entered into, amended or renewed on or after July 1, 2004, shall require documented compliance by the provider or provider organization with the standards in subsection (a), or the plan's access standards if modified in accordance with subsection (c), and require provider or provider organization documented compliance with reasonable plan reporting requirements and/or necessary corrective actions to ensure compliance with this section.

(f) By March 31, 2006, and no later than March 31 of each year thereafter, every plan shall file an annual report with the Department of the plan's compliance in meeting each of the standards in subsection (a), or the plan's compliance in meeting the plan's access standards, if modified in accordance with subsection (c), during the prior calendar year, in accordance with any Department filing instructions. The plan's report shall include sufficient detail to allow the Department to evaluate the performance of plans and their contracting providers in complying with the standards and at a minimum include reporting by specialty and service area. The plan's report shall also describe all corrective actions if any, implemented by the plan during the prior calendar year to assure compliance with this section. The plan's report shall include sufficient detail to allow the Department to determine if all enrollees regardless of income, race, ethnicity, and primary language, are receiving timely services.

(g) Generally, when evaluating plan compliance with these standards, the Department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

NOTE: AUTHORITY CITED: SECTION 1351, HEALTH AND SAFETY CODE; SECTIONS 1342, 1367, AND 1367.03, HEALTH AND SAFETY CODE (AB 2179, CH. 797, STATS. 2002).

Add section 1300.67.2.3, Enrollee Satisfaction with Accessibility to Health Care Services, to read:

§1300.67.2.3 Enrollee Satisfaction with Accessibility to Health Care Services

(a) Beginning January 1, 2005, health care service plans shall conduct the Consumer Assessment of Health Plans Study (CAHPS) 3.0 or 3.0H 2003 on an annual basis, and in each language in which CAHPS translations are available, for each covered population:

For each of the survey questions in the category, Getting Care Quickly, the plan shall annually monitor the plan's performance in comparison with a) the plan's prior year's performance; b) the mean (average) performance of the health plans published in the annual HMO Report Card published by the Office of Patient Advocate pursuant to section 1368.02(c)(3)(B), including the linguistic services in other languages portion of the HMO Report Card; and c) the plan's performance goal, which the plan shall file with the Department in an amended description of its quality assurance program. Where the plan's performance falls ten percent or more as a relative decrease below any target level, the plan shall adopt a corrective action plan to improve performance. The scope of the plan's corrective action shall be relative to the improvement needed to achieve an acceptable level of performance. The plan shall further monitor the effectiveness of its corrective action plan. This section is not intended to prevent a plan from adopting a more stringent standard for initiating a corrective action plan than the ten percent relative decrease stated above.

(b) For each of the plan's contracting provider organization that participate in the California Consumer Assessment Survey 2003, the plan shall monitor the provider organization's annual reported performance for each rating aspect of the category, Timely Care and Service. The plan

shall use any applicable findings that impact plan performance to inform any plan corrective action plan required by subsection (a)(2).

(c)The Department shall assess the plan's compliance with the requirements in this section.

NOTE: AUTHORITY CITED: SECTION 1351, HEALTH AND SAFETY CODE; SECTIONS 1342, 1367, AND 1367.03, HEALTH AND SAFETY CODE (AB 2179, CH. 797, STATS. 2002).



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October 8, 2004

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Re: Comments: **2002-0018 Access to Needed Health Care Services**

To Whom It May Concern:

Please accept these comments to pending regulations, 2002-0018 Access to Needed Health Care Services, on behalf of CPEHN. CPEHN is a statewide network of over 50 multicultural health organizations, including community-based organizations, health care providers, and policy experts committed to working together to improve health care access and eliminate health status disparities in California's communities of color. CPEHN serves on the Office of the Patient Advocate Cultural and Linguistic Workgroup, and has been advising DMHC on ways to ensure that health plans provide communities of color with culturally and linguistically appropriate services. We also were a chief co-sponsor of SB 853 and have been providing technical assistance to DMHC on the drafting of the implementing regulations.

We believe that the needs of communities of color must be addressed in each and every regulation promulgated by DMHC. With communities of color representing over fifty-three percent of the state's population, a healthy and productive California requires the elimination of racial and ethnic health disparities. Health disparities exist due to numerous and complex factors. Many of these factors have been well-documented, such as the lack of culturally or linguistically appropriate services, discrimination in the health care system, and socioeconomic conditions. Access regulations must take into account the need for equal access among communities of color, many of whom do not have access to quality transportation, and the need for culturally competent and linguistically appropriate care.

Therefore our comments primarily recommend that all timelines for accessing care and traveling to providers sites take into account the needs of communities who rely on public transportation, and take into account wait times for interpreter services to be provided. We also recommend Consumer Assessment of Health Plans Study (CAHPS) be utilized in all the languages for which translations are available. Translations for

CAHPS are often available through public programs, such as the Managed Risk Medical Insurance Board, or through foundations or other sources.

Please find our comments in the form of **bold** additions and edits to the regulations as follows:

CPEHN Comments:

Amend section 1300.67.2. to read:

§ 1300.67.2. Accessibility of Services

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility. **The plan must assume that enrollees do not have access to vehicles and must rely on public transportation.** All plans shall have a contracting or plan-employed primary care provider within 30 minutes or 15 miles, by public transportation, of each enrollee's residence or workplace except in any portion of the service area where the plan complies with section 1300.67.2.1. This requirement is not intended to prevent the plan from allowing a member to select a primary care provider beyond the 15 mile or 30 minute distance;

(b) Hours of operation and provision for after-hour services shall be reasonable;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a per day, seven days a per week;

(d) The ratio of enrollees to staff, including health professionals, administrative staff and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan, **including all medical services, interpreter services, and preventive services,** will be

accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. For a plan that covers hospital and physician services, any contract between the plan and a provider organization shall require ~~There shall be~~ at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees. The ratio may be increased by 500 members for each full-time equivalent nurse practitioner or physician assistant affiliated with the primary care physician in the practice. Documented compliance with the standards described in section 1300.67.2.2(a)(1) shall be deemed an acceptable mechanism to demonstrate an adequate ratio of primary care physicians to enrollees in the relevant portion of the plan's service area;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral. The location of facilities providing the specialty health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility. The plan must assume that enrollees do not have access to vehicles and must rely on public transportation. The Plan may demonstrate accessibility to specialty services in any portion of its service area in accordance with the requirements of section 1300.67.2.1. In the case of a full-service plan, the plan shall demonstrate compliance with the standards described in section 1300.67.2.2(a)(2) and shall demonstrate the capacity of its physician specialty network to provide timely physician specialty care services to the plan's enrollees;

(f) The location of facilities providing inpatient and other health care services of the plan shall be within reasonable proximity of the workplace or personal residence of enrollees, and must be accessible by public transportation, unless the plan provides shuttles or other forms of transportation.

The plan must assume that enrollees do not have access to vehicles and must rely on public transportation. Except in any portion of the service area where the plan meets the requirements of section 1300.67.2.1, a plan that covers hospital and physician services shall have a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population within the service area based on normal utilization within 30 minutes or 15 miles of the residence or workplace of its enrollees. This requirement is not intended to prevent the plan from allowing an enrollee to obtain services at an inpatient facility beyond the 15 mile or 30 minute distance if the enrollee so requests. In calculating the travel time, the plan must assume that many enrollees do not have access to vehicles and must rely on public transportation. Public transportation availability must be made a factor in this calculation. This requirement is also not intended to require the plan to terminate or prohibit the enrollment of an individual whose residence is not within 30 minutes or 15 miles of a contracting or plan-operated hospital.

(g) A plan may contract with one or more Centers of Excellence to provide inpatient and/or ambulatory specialty services to plan enrollees. A Center of Excellence is defined as a health care provider or facility designated and recognized as a best practice provider of a particular, highly specialized treatment. A plan may provide services to an enrollee residing further than 30 minutes or 15 miles from a Center of Excellence when the enrollee and his or her physician determine that such services are in the best interest of the enrollee.

~~(f) (h)(1)~~ Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, ~~including a system for addressing problems that develop,~~ which shall include, ~~but is not limited to,~~ waiting time and for appointments, , **waiting time for the provision of interpreters,** provision for after-hours services, and the capacity of the plan's network, including numbers and locations of providers, the language capabilities, and accessibility of providers by public

transportation, to assure enrollees are provided accessibility to health care services. Plans must also have a documented system to ensure that persons are receiving adequate and timely care regardless of income, race, ethnicity or primary language, as well as a system for taking corrective action and tracking the progress and effectiveness of the corrective action, if disparities in access are identified. Each plan shall implement appropriate corrective actions when plan monitoring identifies patterns of non-compliance with the access standards required by this section. All health care service plans that cover hospital and physician services shall comply with section 1300.67.2.2.

(2) All plans that cover hospital and physician services shall assure that contracted general acute care hospital facilities have the capacity to provide necessary services, including interpreter services, to enrollees within the plan's service area, and the plan shall monitor the capacity of such facilities to assure that enrollees have access to services at reasonable times. All plans that cover hospital and physician services shall have contracted hospitals in a service area sufficient to assure accessibility—including accessibility by public transportation and accessibility for interpreter services—and continuity of care for plan enrollees as medically necessary.

(g)(i) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area. The plan shall designate a section of the health education program required by section 1300.67(f)(8) to inform enrollees about the availability of plan services in their geographic area and how to access those services. The information must be presented in the enrollee's primary language, or in the form of a form letter with the information presented in all the languages likely to be encountered in the area. The information provided must include information on accessing services through public transportation. A plan that covers hospital and physician

services shall also inform enrollees about the standards for non-emergency appointments. The information must be presented in the enrollee's primary language, or in the form of a form letter with the information presented in all the languages likely to be encountered in the area.

(j) Plans may devise additional methods of access to providers as appropriate, which may include group visits, e-mail, video and telephone to complement traditional in-person medical treatment.

NOTE: AUTHORITY CITED: SECTION 1351, HEALTH AND SAFETY CODE; SECTIONS 1342, 1367, AND 1367.03, HEALTH AND SAFETY CODE (AB 2179, CH. 797, STATS. 2002).

Add section 1300.67.2.2, Access to Non-Emergency Appointments, to read:

§1300.67.2.2. Access to Non-Emergency Appointments

(a) All health care service plans that cover hospital and physician services shall offer or arrange non-emergency physician appointments for enrollees as set forth below. All timelines set forth below must take into account the travel time and accessibility by public transportation, and the need to arrange interpreter services.

(1) Primary Care. An appointment shall be offered with a primary care physician, or, if appropriate and acting within his or her scope of practice with a physician assistant or nurse practitioner, or certified nurse midwife for OB-GYN care at the primary care location or practice to which the enrollee is assigned:

(A) For routine non-urgent care, within 7 days;

(B) For urgent care, in a timely fashion appropriate for the nature of the enrollee's health care condition as determined when necessary by a qualified health professional acting within his or her scope of practice, trained to screen or triage, but not to exceed 24 hours;

(C) For preventive care, within 30 days.

(D) If a solo practitioner or small group practitioner is unavailable, an appointment may be offered with a similar practitioner at an alternative location that is reasonably accessible to the enrollee. The plan must assume that enrollees do not have access to vehicles and must rely on public transportation. The plan must also assume that enrollees may require interpreter services.

(2) Specialty Care. An appointment shall be offered with a geographically accessible, and accessible by public transportation, board certified or board eligible specialty care physician appropriate for that enrollee's health care needs, or via telemedicine with a board-certified or board-eligible specialty care physician as appropriate for the enrollee's health care needs:

(A) For routine, non-urgent specialty care, within an appropriate time as medically necessary, not to exceed 30 calendar days. For routine, non-urgent specialty care appointments for which the plan requires prior authorization, the time for an appointment shall begin to run concurrently with the request for the referral authorization described in section 1367.01(h)(1). An alternative standard may apply in situations where an enrollee is offered specialty care through a Center of Excellence provider pursuant to section 1300.67.2(g).

(B) For urgent specialty care, in a timely fashion, appropriate for the nature of the enrollee's health care condition as determined to be necessary by a health care professional acting within his or her scope of practice, trained to screen or triage, but not to exceed 24 hours for urgent care. For urgent specialty care appointments for which the plan requires prior authorization, the time for the appointment shall run concurrently with the period to obtain authorization described in section 1367.01(h)(2).

(C) For preventive specialty care, within 30 calendar days.

(b) This section is not intended to preclude the use of recall appointment systems for enrollees who require appointments for on-going health care monitoring, follow-up care, or preventive care on a periodic basis. In these instances, an appointment may be scheduled in advance, beyond the standards in this section, when the appointment date is consistent with the health care needs of the enrollee as determined by the enrollee's health care provider and consistent with professionally recognized standards of practice.

(c) This section is not intended to preclude a plan from adopting more stringent appointment standards than the minimum standards described in subsection (a). This section is not intended to preclude plan compliance with Medicare or Medi-Cal program requirements when any standards for these programs are in addition to or more stringent than the standards described in subsection (a).

(d) Each plan shall adopt reasonable and effective mechanisms using valid methodology to monitor on a periodic basis provider compliance with the access standards required by this section. Plan monitoring of providers shall also assess whether waiting time to speak to a physician, registered nurse, or other

qualified professional acting within his or her scope of practice, who is trained to screen or triage an enrollee, and whether the wait time to access interpreter services to allow such communication, is adequate to assure timely access to urgent care appointments. Each plan shall implement appropriate corrective actions when plan monitoring identifies patterns of non-compliance with the access standards required by this section, including taking appropriate action to ensure the availability of primary care physicians, specialty care physicians, physician assistants, nurse practitioners, medical groups and ancillary providers and hospitals, or interpreter services, if necessary.

(e) Any health care service plan contract with a provider or provider organization entered into, amended or renewed on or after July 1, 2004, shall require documented compliance by the provider or provider organization with the standards in subsection (a), or the plan's access standards if modified in accordance with subsection (c), and require provider or provider organization documented compliance with reasonable plan reporting requirements and/or necessary corrective actions to ensure compliance with this section.

(f) By March 31, 2006, and no later than March 31 of each year thereafter, every plan shall file an annual report with the Department of the plan's compliance in meeting each of the standards in subsection (a), or the plan's compliance in meeting the plan's access standards, if modified in accordance with subsection (c), during the prior calendar year, in accordance with any Department filing instructions. The plan's report shall include sufficient detail to allow the Department to evaluate the performance of plans and their contracting providers in complying with the standards and at a minimum include reporting by specialty and service area. The plan's report shall also describe all corrective actions if any, implemented by the plan during the prior calendar year to assure compliance with this section. The plan's report shall include sufficient detail to allow the Department to determine if all enrollees regardless of income, race, ethnicity, and primary language, are receiving timely services.

(g) Generally, when evaluating plan compliance with these standards, the Department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

NOTE: AUTHORITY CITED: SECTION 1351, HEALTH AND SAFETY CODE; SECTIONS 1342, 1367, AND 1367.03, HEALTH AND SAFETY CODE (AB 2179, CH. 797, STATS. 2002).

Add section 1300.67.2.3, Enrollee Satisfaction with Accessibility to Health Care Services, to read:

§1300.67.2.3 Enrollee Satisfaction with Accessibility to Health Care Services

(a) Beginning January 1, 2005, health care service plans shall conduct the Consumer Assessment of Health Plans Study 3.0 or 3.0H 2003 on an annual basis, and in each language in which CAHPS translations are available, for each covered population:

For each of the survey questions in the category, Getting Care Quickly, the plan shall annually monitor the plan's performance in comparison with a) the plan's prior year's performance; b) the mean (average) performance of the health plans published in the annual HMO Report Card published by the Office of Patient Advocate pursuant to section 1368.02(c)(3)(B)), including the linguistic services in other languages portion of the HMO Report Card; and c) the plan's performance goal, which the plan shall file with the Department in an amended description of its quality assurance program. Where the plan's performance falls ten percent or more as a relative decrease below any target level, the plan shall adopt a corrective action plan to improve performance. The scope of the plan's corrective action shall be relative to the improvement needed to achieve an acceptable level of performance. The plan shall further monitor the effectiveness of its corrective action plan. This section is not intended to prevent a plan from adopting a more stringent standard for initiating a corrective action plan than the ten percent relative decrease stated above.

(b) For each of the plan's contracting provider organization that participate in the California Consumer Assessment Survey 2003, the plan shall monitor the provider organization's annual reported performance for each rating aspect of the category, Timely Care and Service. The plan shall use any applicable findings that impact plan performance to inform any plan corrective action plan required by subsection (a)(2).

(c) The Department shall assess the plan's compliance with the requirements in this section.

NOTE: AUTHORITY CITED: SECTION 1351, HEALTH AND SAFETY CODE; SECTIONS 1342, 1367, AND 1367.03, HEALTH AND SAFETY CODE (AB 2179, CH. 797, STATS. 2002).



CPEHN

California Pan-Ethnic Health Network

September 25, 2006

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Re: Comments to proposed regulation: **2004-0115 Language Assistance Programs**

Dear Director Lucinda Ehnes...

Thank you for the opportunity to comment on the new regulations related to language assistance programs. We are pleased that there is now a requirement for all health plans to provide interpreters and translated materials to their enrollees. Providing culturally and linguistically appropriate services is vital to ensuring access to quality health care services.

The California Pan-Ethnic Health Network, CPEHN, sponsored SB 853, which is the statute now being implemented by the Department of Managed Health Care. Because of these new regulations, health plans will be held accountable for providing services to all their diverse members. This is a model for the rest of the country.

CPEHN was established in 1992 and incorporated as a 501c(3) nonprofit organization in 1998 in response to the need for a representative community-driven voice in health policy. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color. CPEHN organizes multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care. We bring together diverse communities and policymakers to share ideas and build effective advocacy efforts to improve the health of California.

We support strong regulations to require health plans to do their share in ensuring access to health care for diverse communities. We also are extremely pleased that many of our comments from the last comment period were addressed. We are particularly pleased with the new language that clarifies that language data is to be collected from each enrollee. We also are extremely supportive of the new language that requires plans to collect information on race and ethnicity, which now complies with the need for DMHC to clarify the statutory requirement that plans collect a demographic profile on their enrollees. We do however believe that there is no reason to treat primary language data any differently from race and

ethnicity. Therefore, we believe that race and ethnicity should be collected in the same manner from each enrollee. The current draft is vague as to whether plans must in fact collect information on race and ethnicity from EACH enrollee. This should be clarified. Race, ethnicity, and primary language (written and spoken) should be collected on each enrollee. Ideally, plans would benefit, as would advocates and regulators, from DMHC spelling out the exact categorizations for race and ethnicity that should be collected by health plans. We can assist in this regard. The categories should allow for detailed analysis of subpopulations, and be reported to policymakers to ensure health plans are addressing the health needs of their enrollees. The regulations should also clearly state that plans need a process developed for sharing this demographic information with their providers. The regulations should also explicitly clarify that this information must be collected from all new enrollees on an ongoing basis as well as existing enrollees.

We strongly language in this latest draft that requires plans to notify enrollees in multiple languages of the availability of interpreter services. We also support language requiring health plans to shoulder their fair share of the financial responsibility for providing interpreter services. We support the deletion of language in the prior draft that held hospitals to a lower standard for services.

We believe that additional clarity should be given to plans regarding ensuring the quality of interpreters. More explicit requirements should be developed to ensure that in every medical encounter with an LEP individual that a trained interpreter is present. The regulations should specify that face to face interpretation is desirable unless it is unfeasible, as is required in the Healthy Families program. The current language dealing with family and friends does not sufficiently ensure that each plan enrollee receives a quality interpreter. Even if a request is made for the use of family or friend as an interpreter, the plan and provider have an obligation to encourage the use of a qualified interpreter. This should extend to an outright ban on the use of minors as interpreters. A ban is proposed in the Department of Insurance regulations, and is present in the Healthy Families Program Cultural and Linguistic requirements.

We strongly support the deletion of references to deemed compliance regarding plans with a Medi-Cal line of business. We reiterate prior comments that the regulations misinterpret the statute's intent as it relates to the Medi-Cal program. The statute intends for DMHC to establish a process to determine if their regulations provide more access to a greater number of enrollees than do the current Medi-Cal requirements, and if they do, then Medi-Cal enrollees should have access to those higher standards. The current draft simply exempts Medi-Cal outright, without any process for comparing the relative requirements.

We thank the Department for the work they have done so far on this issue, and look forward to continuing to advise you on future drafts.

Sincerely,

Martin Martinez, MPP
Policy Director



California Pan-Ethnic Health Network

March 5, 2007

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

Dear Director Lucinda Ehnes

Thank you for the opportunity to comment on the new regulations related to timely access to care. The California Pan-Ethnic Health Network, CPEHN, organizes multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color.

We support strong regulations to require health plans to fulfill their duty to provide timely access to health care services. We would like to suggest changes to the regulation to ensure timely access for communities of color.

The regulations should specify that the following compliance monitoring tools be done in multiple languages to comply with language access requirements: enrollment satisfaction survey, including CAHPS, 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.

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). 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, 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 its application for the LEP patient because the potential delay posed by obtaining language

assistance services, such as an interpreter, is greater, and there are no set 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 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).

We thank the Department for the work they have done so far on this issue, and look forward to continuing to advise you in the future.

Sincerely,

Martin Martinez, MPP
Policy Director



California Pan-Ethnic Health Network

September 21, 2007

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

Dear Director Lucinda Ehnes:

Thank you for the opportunity to comment on the new regulations related to timely access to care. The California Pan-Ethnic Health Network, CPEHN, organizes multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color.

We support strong regulations to require health plans to fulfill their duty to provide timely access to health care services. We are disappointed that DMHC has not clarified wait times for interpreter services. We feel this matter has taken on greater urgency, as comments made at the public hearing on timely access regulations make us very worried that health plans and providers will force enrollees to choose between language services and timely access. Communities of color and limited English proficient (LEP) persons do not have to choose which rights they are entitled to. All Californians must benefit from both these laws.

In light of the provider comments it is imperative that DMHC clarify in this regulation that these wait times apply to the provision of interpreter services as well. However, it would be reasonable for DMHC to clarify that enrollees should have to wait no more than 15 additional minutes for an interpreter. We would remind you that the language access statute, SB 853, requires DMHC to develop standards for the timeliness of oral interpretation services (1367.04b1D4). It has been our understanding that the vagueness in the language access regulation on this regard was to be clarified in the timely access regulations.

While we feel strongly that the regulations must be changed to clarify that LEP enrollees have equal access to timely care, an undue delay, or starting from scratch, as some providers have called for, is unacceptable. These regulations are over 3 years late and further delays only cause more harm for consumers.

We would like to suggest the following additional changes to the timely access regulation to ensure appropriate access for communities of color.

- The regulations address how plans must ensure timely telephone access, but again, do not require plans to address how they would handle telephone access in a timely manner for LEP enrollees.
- The regulations specify how a plan can handle offering patients appointments with alternate providers in situations in which wait time is too long. The regulations specify that plans must address ensuring that the alternate provider is geographically accessible and appropriate for the enrollee's condition; however, the regulations do not specify that the plan must address ensuring the alternate provider's language proficiency.
- We are pleased that DMHC is requiring plans to use surveys of enrollees as a means of gauging compliance with the standards outlined in these regulations. However, the regulations do not specify that these surveys must be translated. How else can we ensure that the needs of all communities are being addressed equally by health plans if all satisfaction surveys are conducted in English? According to the language access statute, satisfaction surveys are to be a way of gauging compliance with the language access regulations, so it is appropriate to consider these surveys to be vital documents that require translation into at a minimum the threshold languages:

"1367.07. Within one year after a health care service plan's assessment pursuant to subdivision (b) of Section 1367.06, the health care service plan shall report to the department, in a format specified by the department, regarding internal policies and procedures related to cultural appropriateness in each of the following contexts:

.....

(d) Evaluation of the health care service plan's programs and services with respect to the plan's enrollee population, using processes such as an analysis of complaints and **satisfaction survey** results."

- The regulations specify how plans must ensure statistical validity of their surveys, including addressing sample size and valid demographics. However, the regulations do not specify that plans must ensure sufficient diversity in terms of demographic characteristics such as language, race, ethnicity, gender, and income. Plans must ensure their samples reflect not just an appropriate size globally, but are sufficient to look at the quality and timeliness of care received by subgroups in all communities.

- Along these same lines, we believe that plans should not be held in compliance with these regulations if their surveys or other monitoring techniques reveal significant disparities in access by race or language, even if they are meeting the requirements for their overall populations.
- We are pleased that plans will be required to conduct secret shopper calls to providers' offices in certain situations to gauge compliance with plans' contract providers, but again, it is essential that a portion of these calls be conducted in languages other than English.

We thank the Department for the work they have done so far on this issue, and look forward to continuing to advise you in the future.

Sincerely,

Martin Martinez, MPP
Policy Director



California Pan-Ethnic Health Network

December 26, 2007

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

Dear Director Lucinda Ehnes:

Thank you for the opportunity to comment on the regulations related to timely access to care. The California Pan-Ethnic Health Network, CPEHN, organizes multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color.

We support strong regulations to require health plans to fulfill their duty to provide timely access to health care services. We are disappointed that DMHC has removed time elapsed standards from the proposed regulations. The appropriate place to debate and determine standards is the regulatory process. The current proposed language does not provide health plans or consumers with sufficient information to develop standards. The wide discretion DMHC is claiming in approving standards does not allow stakeholders sufficient input into this process. The difficult give and take with stakeholders over the past few years will not vanish without specific standards, but will move underground, into backdoor conversations without public oversight.

We strongly disagree that access for interpreters was addressed in (c)(2)(G)(v) in Rule 1300.67.04. The wording in the language access regulation is vague and does not provide plans with a clear time elapsed standard for the provision of interpreters.

In CPEHN's previous comments we urged DMHC to ensure that enforcement of these timely access regulations must include assessing how these requirements impact communities of color and limited English proficient communities, which are subject to vast health disparities. We strongly support the requirement that plans conduct satisfaction surveys of their enrollees to determine compliance with the

regulations. However, there is no requirement that plans translate surveys into other languages, or ensure adequate sample sizes of communities of color. These two issues are not addressed anywhere in the language access regulations. A response to these points was not made in the comments chart DMHC provided us, and we are eager to see this important issue addressed. Plans must not only ensure overall compliance but also ensure that specific communities are not bearing the brunt of excessive wait times.

We thank the Department for the work they have done so far on this issue, and look forward to continuing to advise you in the future.

Sincerely,

Martin Martinez, MPP
Policy Director

Marty Martinez

Subject: FW: Timely Access Regulations: Informal comment period extended through 11/21/08
From: Marty Martinez [mailto:mmartinez@cpehn.org]
Sent: Wednesday, November 19, 2008 6:29 PM
To: ealvarez@dmhc.ca.gov
Cc: 'Chammout, Suzanne'; mmartinez@cpehn.org
Subject: RE: Timely Access Regulations: Informal comment period extended through 11/21/08

Thank you for the opportunity to comment on the timely access regulations. My comments may be expanded later as I talk with the other advocates, but for the issues I have most championed in the past, my comments are as follows:

"(c) (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."

The above is great, my only concern is that it doesn't apply to accessing an interpreter at the initial point of contact. I'd like to see it strengthened by adding that procedures must be in place to ensure that the provision of language services should not produce additional wait times.

And then here:

"(d) (3) (B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at subsection (c)."

This is good as well, but I think it is important that the needs of vulnerable populations be addressed, as they are the least likely to complain. The survey should be translated into the top languages in the state (or at a minimum the plan's threshold languages), and the survey should oversample vulnerable populations, such as persons with limited English proficiency and communities of color. (Plans will know what their top language speakers are and their racial breakdown due to the SB 853 data collection.)

Thank you!

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California Pan-Ethnic Health Network

February 23, 2009

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Department of Managed Health Care
Office of Legal Services
980 9th Street, Suite 500
Sacramento CA 95814
regulations@dmhc.ca.gov
Fax: (916) 322-3968

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

Dear Director Lucinda Ehnes:

Thank you for the opportunity to comment on the new regulations related to timely access to care. The California Pan-Ethnic Health Network, CPEHN, organizes multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color.

We support strong regulations to require health plans to fulfill their duty to provide timely access to health care services. We support concrete, time-elapsd standards based on type of service needed and degree of medical urgency.

We strongly support language at (c)(4) that requires interpreters to be provided in a timely manner consistent with that required for all other care. Timely access to linguistically appropriate care can lead to improved quality of care as well as decreases in health care costs associated with treatment of patients in emergency rooms.

We also strongly support language at (d)(3)(B) that requires an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology. It is important that enrollee experience be used as a guide to help ensure plan compliance with timely access standards. We believe the regulations as written require these surveys be conducted in a manner that helps ensure compliance to the entirety of these regulations, including access to interpreters. It is therefore our understanding that if a plan does not translate these

surveys into at least their SB 853 threshold languages they would be out of compliance. It would be helpful, however, if this were spelled out clearly.

It is also important to clarify that in conducting these surveys, plans must ensure adequate sample sizes for all major racial, ethnic, and language communities served by the health plan. Again, we do believe the current language would require these thing—especially related to language—but additional clarity is important.

We are very pleased to see such significant improvement in the regulations. We are hopeful that our role in providing prior comments and participating in the stakeholder roundtable process has been valuable in producing such improved draft regulations. We thank the Department for the work they have done so far on this issue, and look forward to continuing to advise you and work on implementation of these regulations in the future.

Sincerely,

Martin Martinez, MPP
Policy Director

Marty Martinez

From: Marty Martinez [mmartinez@cpehn.org]

Sent: Thursday, June 25, 2009 5:18 PM

To: mmartinez@cpehn.org; regulations@dmhc.ca.gov

Subject: Comments to proposed regulation: Timely Access to Non-Emergency Health Care Services

Thank you for the opportunity to once again comment on the Timely Access regulations. We thank you for continuing to have strong language ensuring that interpreters be arranged for in advance. We strongly support this provision. We are disappointed, however, that comments we have made earlier--clarifying that enrollee experience surveys need to be translated into at least threshold languages--was not adopted.

We also object to the change that now allows patients to wait to speak with a trained persons to be screened and triaged within 30 minutes. We believe 10 to 15 minutes is a more acceptable wait time.

Thank you for receiving these comments.

Sincerely,

Martin Martinez, MPP
Policy Director
California Pan-Ethnic Health Network
654 Thirteenth St.
Oakland, CA 94612
(510)832-1160
fax: (510) 832-1175
mmartinez@cpehn.org

Register now for CPEHN's conference, "Voices for Change: Connecting the Dots Between Prevention & Care" – go to www.cpehn.org for more information.

Marty Martinez

From: Marty Martinez [mmartinez@cpehn.org]

Sent: Friday, August 07, 2009 4:27 PM

To: mmartinez@cpehn.org; regulations@dmhc.ca.gov

Subject: Comments to proposed regulation: Timely Access to Non-Emergency Health Care Services

Thank you for the opportunity to once again comment on the Timely Access regulations. We do not have comments to any of the specific changes made during this round of comments. Therefore, I am merely reiterating comments we made earlier. Thank you for your continued hard work on these regulations.

We thank you for continuing to have strong language ensuring that interpreters be arranged for in advance. We strongly support this provision. We are disappointed, however, that comments we have made earlier--clarifying that enrollee experience surveys need to be translated into at least threshold languages--was not adopted.

We also object to the change that now allows patients to wait to speak with a trained persons to be screened and triaged within 30 minutes. We believe 10 to 15 minutes is a more acceptable wait time.

Thank you for receiving these comments.

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Martin Martinez, MPP

c/o CPEHN

654 13 Street, Oakland, CA 94612 mmartinez@cpehn.org

Summary of qualifications

Wide experience with all the elements of policy advocacy, including successfully sponsoring legislation, building coalitions, educating grassroots communities, researching and developing policy briefs, and coordinating media relations. I have staged press conferences, been interviewed in print and on television, and participated in radio debate. I am also experienced with many aspects of non-profit work: providing direct services, outreach to hard-to-reach communities, fundraising, and program development and management. I have served on several community boards, at times as a founding member of an organization, and have participated in the hiring and supervision of staff and several strategic planning processes. I am accustomed to tight deadlines, coordinating large coalitions, managing multiple projects, and planning logistics for large events. I have expertise on many issues related to health policy, civil rights, and other issues of concern to diverse communities.

Education

- Masters of Public Policy, 1996 - Goldman School of Public Policy (GSPP), **University of California at Berkeley**. Earned full Woodrow Wilson Fellowship.
- Bachelor of Arts, 1993 - **Swarthmore College**, PA.
- Summer Fellowship Program, 1992 - Woodrow Wilson School of Public Policy and International Affairs, **Princeton University**, NJ.

Professional experience

Policy Director, 2001-present - California Pan-Ethnic Health Network (CPEHN). Oakland, CA. Statewide multicultural health policy organization.

- Responsible for setting the overall policy agenda of the organization and managing the Policy Advocacy Program. Issues areas include: cultural and linguistic access, racial and ethnic health disparities, obesity in communities of color, the need for more and better data and research, access to care, and the Medi-Cal Managed Care and Healthy Families Program.
- Performed direct advocacy work at the state level, both with administrative agencies and with the legislature.
- Served on numerous governmental and policy advisory bodies, including: the Department of Health Services Council on Multicultural Health; the Office of the Patient Advocate Cultural and Linguistic Work Group; the Medi-Cal Managed Care Advisory Group; the Department of Consumer Affairs Task Force for Cultural and Linguistically Competent Physicians and Dentists; the Medi-Cal Roundtable.
- Assisted Executive Director in program and fund development, drafting proposals and managing grant objectives.
- Supported the Board of Directors, organized the Public Policy Advisory Committee and network of multicultural health organizations.
- Coordinated CPEHN's sponsorship of legislation.
- Organized for or against statewide propositions. Was a leader in the defeat of Proposition 54 in 2003.
- Monitored and advocated for budget items through the legislative and administrative process.
- Coordinated community forums, drafted policy briefs and reports, and directed media relations.

Policy Coordinator, 1996-2001 - AIDS Project East Bay (APEB). Oakland, CA. At the time the largest AIDS services organization in the East Bay, providing services to over 1,000 clients with HIV, and prevention messages that reached over 20,000 persons annually.

- Monitored and advocated on HIV and health issues through entire legislative and budget processes, and through administrative agencies. With partners, secured \$8 million in state funds for HIV prevention in communities of color, expanded needle exchange programs, and advocated for legislation to establish unique identifier systems to track HIV cases.
- Assembled statewide coalitions to advance priorities and testified before legislative committees.
- Coordinated large-scale "Lobby Day" events that involved transporting several hundred individuals from around the state to advocate in Sacramento.
- Taught advocacy 'classes.' Trained individuals how to advocate and tell their stories to policymakers.
- As a member of APEB's development committee, researched grants and wrote proposals. Essentially raised my own salary from grant sources for over three years. Participated in many fundraising trainings.
- Produced the APEB newsletter.
- Over years of employment, would supplement FTE hours providing direct services, such as housing case management, HIV testing and counseling, prevention and outreach work.

Internships

- Analyst, University of California, Office of the President, Office of Financial Support. 1995.
- News Reporter, Asbury Park Press, large-circulation NJ newspaper. Periodic 1988-91.
- Researcher, AIDS Law Project of Pennsylvania. 1991.
- Constituent Services Intern, Office of New Jersey State Senate President John F. Russo. 1989.

Community activities

- California Public Health Association North (CPHA-N). 2002-present. Legislative Chair for the Governing Council of this Northern California affiliate of the American Public Health Association.
- California Health Interpretation Association (CHIA). 2003-present. Board member of this organization dedicated to building the interpretation profession.
- The Lambda Letters Project (LLP). 1998-present. Provide legislative analyses for this statewide grassroots network, which generates hundreds of letters a month from community members to their legislators.
- The California HIV Advocacy Coalition (CHAC). 1998-2001. Co-founding steering committee member of statewide coalition of HIV and health care advocates.
- Equality California. 1998-2001. Co-founding regionally-elected board member of the largest CA organization lobbying for gay, lesbian and transgender rights.
- Volunteer for numerous political campaigns.

References -- Available upon request.

