

BEFORE THE  
DEPARTMENT OF MANAGED HEALTH CARE  
STATE OF CALIFORNIA

In the Matter of the Application for an Award  
of Advocacy and Witness Fees of:

California Pan-Ethnic Health Network, a  
California corporation,

Applicant.

**DMHC Decision 10-06-04 June 29, 2010**  
Application Received Date: March 16, 2010

Proceeding Control Nos. 2002-0018, 2005-0203  
and 2008-1579  
For 28 CCR § 1300.67.2.2  
(Re: Timely Access )

**DECISION GRANTING AWARD OF ADVOCACY AND WITNESS FEES  
TO CALIFORNIA PAN-ETHNIC HEALTH NETWORK FOR  
SUBSTANTIAL CONTRIBUTION TO  
PROCEEDING CONTROL NOS. 2002-0018, 2005-0203 AND 2008-1579**

**1. SUMMARY**

This decision awards California Pan-Ethnic Health Network, a California corporation (“CPEHN” or “APPLICANT”), Advocacy and Witness Fees for its substantial contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 of the Department of Managed Health Care (“Department”) regarding Timely Access (“proposed regulation”), which became final as set forth at 28 CCR §1300.67.2.2 (“regulation”).

**2. BACKGROUND OF CONSUMER PARTICIPATION PROGRAM**

The Consumer Participation Program (“Program”), enacted in Health and Safety Code § 1348.9 (“Statute”), required the Director (“Director”) of the Department to adopt regulations to establish the Program to allow for the award of reasonable advocacy and witness fees to any person or organization that (1) demonstrates that the person or organization represents the interests of consumers and (2) has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the Director if the order or decision has the potential to impact a significant number of enrollees.

The Statute requires the regulations adopted by the Director to include specifications for: (1) eligibility of participation, (2) rates of compensation, and (3) procedures for seeking compensation. The Statute specified that the regulations shall require that the person or organization demonstrates a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

Pursuant to the Statute, the Program regulations were adopted as section 1010 of Title 28 of the California Code of Regulations (the "Regulations"). The Regulations specified:

- a. Definitions for the Program, including: "Advocacy Fee," "Compensation," "Market Rate," "Represents the Interests of Consumers," "Substantial Contribution," and "Witness Fees." (§ 1010, subsection (b)).
- b. Procedure for a Request for Finding of Eligibility to Participate and Seek Compensation. (§ 1010, subsection (c)).
- c. Procedure for Petition to Participate. (§ 1010, subsection (d)).
- d. Procedure for Applying for an Award of Fees. (§ 1010, subsection (e)).

### **3. REQUIREMENTS FOR AWARDS OF ADVOCACY AND WITNESS FEES**

#### **3.1. PROCEDURAL REQUIREMENTS**

All of the following procedures must be followed and criteria satisfied for a person or organization that represents the interests of consumers to obtain a compensation award:

- a. To become a "Participant," the person or organization must satisfy the requirements of either or both of the following by:
  - (1) Submitting to the Director a Request for Finding of Eligibility to Participate and Seek Compensation in accordance with 28 CCR § 1010(c), at any time independent of the pendency of a proceeding in which the person seeks to participate, or by having such a finding in effect by having a prior finding of eligibility in effect for the two-year period specified in 28 CCR § 1010(c)(3).
  - (2) Submitting to the Director a Petition to Participate in accordance with 28 CCR § 1010(d), no later than the end of the public comment period or the date of the first public hearing in the proceeding in which the proposed Participant seeks to become involved, whichever is later (for orders or decisions, the request must be submitted within ten working days after the order or decision becomes final).
- b. The Participant must submit an "application for an award of advocacy and witness fees" in accordance with 28 CCR § 1010(e), within 60 days after the issuance of a final regulation, order or decision in the proceeding.

c. The Participant must have made a Substantial Contribution to the proceeding. (Health & Saf. Code § 1348.9(a); 28 CCR § 1010(b)(8)).

d. The claimed fees and costs must be reasonable (Health & Saf. Code § 1348.9(a)) and not exceed market rates as defined in 28 CCR § 1010.

### **3.2. APPLICANT'S APPLICATION FOR FINDING OF ELIGIBILITY TO PARTICIPATE**

On March 2, 2004, APPLICANT submitted its Request for Finding of Eligibility to Participate and Seek Compensation with the Department, giving notice that it represents the interests of consumers and of its intent to claim compensation.

On August 27, 2004, the Director ruled that APPLICANT was eligible to participate and to seek an award of compensation.

On October 6, 2006, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

On October 19, 2006, APPLICANT's Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation was approved.

On November 25, 2008, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

By letter dated December 14, 2009, APPLICANT was given notice of ruling and finding that APPLICANT was eligible to participate and seek an award of compensation in the CPP, as of the date of the finding.

### **3.3. APPLICANT'S PETITION TO PARTICIPATE IN THE TIMELY ACCESS PROCEEDING**

On October 8, 2004, APPLICANT submitted its Petition to Participate (Petition) with the Department in the Timely Access rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be \$3,500.00. In its Petition, APPLICANT stated that, with respect to Timely Access issues that:

“Access to care is essential to communities of color. Because of the racial and ethnic health disparities that plague the state, it is imperative that DMHC consider the needs of communities of color when advancing all new regulations. CPEHN, as per our organizational description, has been an advocate for communities of color in terms of statewide health policy for over ten years, in addition to advising DMHC on issues related to multicultural health since DMHC's inception in 2000. We therefore believe we are ideally suited to advice DMHC on these matters.”

On November 5, 2004, the Director approved APPLICANT's Petition to Participate in the Timely Access rulemaking proceeding.

On July 19, 2007, APPLICANT submitted its Petition to Participate (Petition) in the Timely Access rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be \$10,000.00. In its Petition, APPLICANT stated the following with respect to Timely Access issues:

“CPEHN provides a valuable perspective on how timely access regulations will impact communities of color and interact with language access regulations.

CPEHN has a long history of working with the DMHC since its founding. Our expertise is related to communities of color, health disparities, and language access. We were extremely involved in the creation of language access regulations. Our participation on these regulations is essential.”

On July 24, 2007, APPLICANT's Petition to Participate was granted as re-approval of participation in the Timely Access rulemaking proceeding, and the Petition was treated as an amendment of APPLICANT's prior Petition in order to provide an amended estimate of fees to be sought (in accordance with 28 CCR § 1010(d)(5)).

On August 20, 2008, APPLICANT submitted its Petition to Participate (Petition) in the Timely Access rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be \$25,000.00. In its Petition, APPLICANT stated the following with respect to Timely Access issues:

“CPEHN's participation is essential because communities of color require objectifiable standards for timely access that are easy to understand and track. We must ensure there is not discrimination in terms of wait times for timely access. And additional consideration must be given to the fact that communities of color are disproportionately likely to suffer from chronic conditions, wait until potentially too late to contact a provider for help, are less likely to complain about overly long wait times, and also might have a more difficult time getting transportation to medical appointments. Only by having organizations representing communities of color at the table can we ensure that these issues are fully addressed.

CPEHN has a long history of working with DMHC and CDI in the development of regulations related to language access. We also have provided testimony at numerous legislative and administrative hearings. We have been invited, for example, by the chairs of both Assembly and Senate Health Committees to provide testimony on health care reform, chronic disease, and health disparities.”

On October 21, 2008, APPLICANT's Petition to Participate was granted as re-approval of participation in the Timely Access rulemaking proceeding, and the Petition was treated as an

amendment of APPLICANT's prior Petition in order to provide an amended estimate of fees to be sought (in accordance with 28 CCR § 1010(d)(5)).

### **3.4. APPLICATION FOR AWARD OF ADVOCACY AND WITNESS FEES**

The regulation became final and effective on January 17, 2010. Within 60 days thereafter (on March 16, 2010), APPLICANT timely submitted its Application for an Award of Advocacy and Witness Fees (Application). 28 CCR § 1010(e)(1).

After the Application was publicly noticed, no objections to the Application were received. The application for an award of compensation must include (as required by 28 CCR § 1010(e)(2) and (3)):

“a. A detailed, itemized description of the advocacy and witness services for which the Participant seeks compensation;

b. Legible time and/or billing records, created contemporaneously when the work was performed, which show the date and the exact amount of time spent<sup>1</sup> on each specific task<sup>2</sup>; and

c. A description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding as defined in subpart (b)(8), supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.” 28 CCR § 1010 (e)(2).

With its Application, APPLICANT submitted a billing specifying the dates of services, a description of each specific task or each activity of advocacy and witness service, identification of the person providing each service, the elapsed time (exact amount of time spent) for each service in quarters (15 minutes) of an hour for attorney advocates and in 0.5 hour or 30 minute increments for non-attorney advocates, the hourly rate requested,<sup>3</sup> and the total dollar amount billed for each task. The application did not include billing for attorney advocates. The total fees requested for work performed by APPLICANT is \$11,750.00.

---

<sup>1</sup> “...the phrase ‘exact amount of time spent’ refers either to quarters (15 minutes) of an hour for attorneys, or to thirty (30) minute increments for non-attorney advocates.” 22 CCR § 1010(e)(3).

<sup>2</sup> “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, or other 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, subject matter of the hearing and the names of witnesses who appeared at the hearing, if any.” 28 CCR § 1010(e)(3)a, b, c, and d.

<sup>3</sup> Under the PUC Intervenor Compensation Program, the intervenors submit time logs to support the hours claimed by their professionals. Those logs typically note the dates, the number of hours charged, and the issues and/or activities in which each was engaged. D.06-11-009 (November 9, 2006), p. 26.

The Hearing Officer finds that the Application of APPLICANT substantially complies with the technical requirements of 28 CCR § 1010(e)(2) and (3).

#### **4. PROCEDURAL HISTORY**

The evolution of the Timely Access proceeding consisted of informal stakeholders meetings and three noticed proceedings with three proceeding control numbers identified as follows.

##### **4.1. PROCEEDING CONTROL NO. 2002-0018 – Access to Needed Health Care Services, amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in title 28, California Code of Regulations**

On July 9, 2004, the Department issued a Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and establishing a 45-day comment period from July 9, 2004 to August 23, 2004.

Initially, no public hearing was scheduled on the proposed regulations.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2002-0018, the Department stated that:

“California Health and Safety code sections 1344 and 1346 vest the Director with the power to administer and enforce the provisions of the Act.

California Health and Safety Code section 1344 mandates that the Director have the ability to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of the Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director’s discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. In addition, the Director may honor requests from interested parties for interpretive opinions.

California Health and Safety Code section 1346 vests in the Director the power to administer and enforce the Act, including but not limited to recommending and proposing the enactment of any legislation necessary to protect and promote the interests of plans, subscribers, enrollees, and the public.

Health and Safety Code section 1367.03 requires the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. The Director proposes amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in Title 28, California Code of Regulations to effectuate section 1367.03 by setting forth minimum standards with which health care service plans (plans) shall comply to ensure that enrollees have timely access to needed health care services.

The proposed regulations set access to care standards concerning the availability of primary care physicians, specialty care physicians, hospital care,

and other specified health care services to ensure that enrollees have timely access to care.

Amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 shall benefit enrollees because it will ensure that plans provide health care services within reasonable proximity of the business or residence of the enrollee including accessible emergency health care services. The regulation clarifies that all services offered by the plan be accessible without delays detrimental to the health of the enrollees and set timelines for routine non-urgent care, urgent care and preventive care. This will ensure that plan enrollees will receive needed health care services within a reasonable timeframe, while not be overburdening the plans or providers.”

A Public Hearing on the proposed regulation was scheduled for, noticed, and held on August 16, 2004.

On August 17, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 30 days to September 22, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on September 13, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On September 15, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 45 days to November 8, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on October 20, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On April 1, 2005, the Department issued a notice of a second public comment period for 15 days ending April 22, 2005, regarding the proposed regulation modified as a result of comments received in the prior comment period.

By letter dated April 19, 2005, the Department gave notice of intention to withdraw the proposed regulations from the proceeding and to propose a revised version of the regulations pursuant to a new rulemaking proceeding. A formal Notice of Decision Not To Proceed was published on April 29, 2005.

#### **4.2. PROCEEDING CONTROL NO. 2005-0203 -- Timely Access To Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations**

Beginning in October of 2006, the Department invited parties who would be the subject of the proposed regulation to public discussions (“stakeholder meetings”) in order to increase public participation and improve the quality of the proposed regulation. Gov’t Code § 11346.45.

Stakeholder meetings were held during October and November of 2006.

On January 12, 2007, the Department issued a Notice of Proposed Rulemaking and Notice of Public Hearing proposing to adopt 28 CCR section 1300.67.2.2, establishing a 52-day written comment period from January 12, 2007 through March 5, 2007, and scheduling a Public Hearing to be held on March 5, 2007. The scheduled Public Hearing was held on March 5, 2007.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2005-0203, the Department stated that:

“The Department proposes to adopt section 1300.67.2.2 pursuant to California Health and Safety Code section 1367.03, which specifically authorizes the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. Section 1367.03 directs the Department to develop indicators of and standards for timeliness of access to care.

AB 2179 (2002) added section 1367.03 of the Health and Safety Code, expressly instructing the Department to develop and adopt regulations to assure timely access to health care. The statute also contained specific requirements for the content of the regulations, including requirements that the regulations establish indicators of timeliness of access to care, adopt standards for timely access to health care services, and specify the manner in which health care service plans are to report annually to the Department on compliance with the standards. Accordingly, the regulation establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance.

The statute requires the adoption of “time elapsed” standards specifying the time elapsed between the time an enrollee seeks health care and obtains care. The statute also authorizes the Department to adopt standards other than time elapsed but requires the Department to demonstrate why such standard other than time elapsed is “more appropriate.” Proposed section 1300.67.2.2 adopts time elapsed standards and proposes a “same-day access” standard which is demonstrated to be “more appropriate” than time elapsed standards because timeliness of access under the same-day access standard exceeds timeliness of access under all of the time elapsed standards of the proposed regulation.

In Section 1 of AB 2179, the Legislature found and declared ‘that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of

adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population.”

On July 16, 2007, the Department issued a Notice of a Second Public Comment Period for 45 days from July 16, 2007 through August 30, 2007, and Notice of Second Public Hearing for August 13, 2007. By notice dated August 8, 2007, the Department rescheduled the Second Public Hearing to September 18, 2007, and extended the Second Public Comment Period for 21 days ending September 21, 2007. The rescheduled Public Hearing was held on September 18, 2007.

On December 10, 2007, the Department issued a Notice of a Third Public Comment Period for 16 days from December 10, 2007 through December 26, 2007.

On January 11, 2008, the Department submitted the proposed regulation to the Office of Administrative Law (“OAL”) for review in accordance with the Administrative Procedure Act (“APA”). On February 27, 2008, the OAL disapproved the proposed regulation, and issued a Decision of Disapproval of Regulatory Action dated March 5, 2008.

#### **4.3. PROCEEDING CONTROL NO. 2008-1579 – Timely Access to Non-Emergency Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations**

In June and September of 2008, the Department invited parties who would be the subject of the proposed regulation to public discussions (“stakeholder meetings”) in order to further increase public participation and improve the quality of the proposed regulation. Gov’t Code § 11346.45.

On January 9, 2009, the Department issued a Notice of Proposed Rulemaking Action proposing to adopt 28 CCR section 1300.67.2.2, and establishing a 45-day comment period from January 9, 2009 to February 23, 2009.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2008-1579, the Department stated that:

“The Department proposes to adopt section 1300.67.2.2 to establish standards and requirements for timely access as required by section 1367.03.

AB 2179 (2002) added section 1367.03 of the Health and Safety Code, directing the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. In Section 1 of AB 2179 the Legislature found and declared ‘that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population.’

Section 1367.03 contains a number of requirements regarding the development and content of the regulations, including specified factors to be considered by

the Department in developing the regulations, requirements for contracts between plans and providers, and annual plan reporting requirements. The proposed regulations have been developed in accordance with the legislative directive set forth in Section 1367.03.

These proposed regulations adopt a balanced approach, to achieve workability and provide for operational flexibility, by establishing both performance standards and prescriptive time-elapsd standards; reasonable mechanisms to preserve the relevance of the clinical judgment of providers, provisions to encourage best practices for enhanced accessibility and a mechanism for enrollees to obtain assistance in determining the relative urgency of their need [for] an appointment. These proposed regulations also strike a reasonable balance with meaningful performance standards for quality assurance monitoring by plans and their delegated provider groups.”

Initially, no public hearing was scheduled on the proposed regulations. However, by letter dated January 28, 2009, a representative of the California Medical Association requested that a public hearing be held.

On January 30, 2009, the Department issued an Amended Notice of Rulemaking Action and Public Hearing Agenda. The Public Hearing was scheduled for, and held on, February 23, 2009.

On June 10, 2009, the Department issued a Notice of Second Comment Period and modified Proposed Text for 15 days from June 10, 2009 through June 25, 2009.

On July 23, 2009, the Department issued a Notice of Third Comment Period and modified Proposed Text for 15 days from July 23, 2009 through August 7, 2009.

On September 28, 2009, the Department issued a Notice of Fourth Comment Period and modified Proposed Text for 15 days from September 28, 2009 through October 13, 2009.

On or about November 3, 2009, the Department issued an Updated Informative Digest for Timely Access to Non-Emergency Health Care Services (2008-1579) as follows:

“As required by section 11346.9 of the Government Code, the Director of the Department of Managed Health Care (Director) sets forth below the updates to the Informative Digest for this rulemaking action proposing the addition of section 1300.67.2.2 to title 28, California Code of Regulations (Regulations).

### **Authority and Reference**

Pursuant to Health and Safety Code section 1341.9, the Department of Managed Health Care Department) is vested with all duties, powers, purposes, responsibilities, and jurisdiction as they pertain to health care service plans (plans) and the health care service plan business.

Health and Safety Code section 1344 grants the Director authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out

the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).

Health and Safety Code section 1367.03, added to the Knox-Keene Act pursuant to AB 2179, (stats 2002, c. 797) requires the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner by developing indicators of timeliness of access to care and developing standards for timeliness of access.

Health and Safety Code section 1367 establishes significant standards for the delivery and quality of health care services by health plans, including broad requirements for delivering care in a timely manner as appropriate for each enrollee's health care needs, and consistent with good professional practice. Subsection (d) of section 1367 requires that plans 'shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.' Prior to the enactment of AB 2179, subsection (e)(1) of section 1367 required that 'All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.' AB 2179 amended subsection (e)(1) to require, 'All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.' (Underline added to reflect the new language added by AB 2179.)

AB 2179 made another notable amendment to section 1367, by adding the following clarification regarding the ultimate obligation of health plans to comply with the standards and requirements of Section 1367. 'The obligation of the plan to comply with this 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.'

Health and Safety Code section 1367.01, regarding health plan utilization review processes, and Civil Code section 3428, establishing a cause of action for ordinary negligence for a health plan's breach of the duty of ordinary care in performing utilization review, are important provisions relevant to the development of these regulations.

### **Necessity**

Adoption of Section 1300.67.2.2 remains necessary to implement, clarify, and make specific the requirements of Health and Safety Code section 1367.03 (Section 1367.03) as described in the initial Notice of Rulemaking Action published on January 9, 2009. As explained in the Department's Notice of Rulemaking Action and the Initial Statement of Reasons, Section 1367.03 expressly instructs the Department to develop and adopt regulations 'to ensure that enrollees have access to needed health care services in a timely manner' and directed the Department to develop indicators of timeliness of access to

care including three indicators specified in subsection (a)(1)-(3) of Section 1367.03. Subsection (b) of Section 1367.03 further directs the Department to consider specified factors in developing standards for timeliness of access to care. Subsection (c) of Section 1367.03 permits the Department to adopt standards other than the time-elapsd from the time an enrollee first seeks care and obtains it, if the Department demonstrates why that standard is more appropriate.

AB 2179 also required the California Department of Insurance (CDI) to adopt regulations, although the legislature described a different approach for the CDI than it outlined for the Department. The Department has consulted with CDI regarding the development of these regulations, consistent with Section 1342.4, to assess the potential for consistency in developing the respective regulations.<sup>4</sup>

The course of this rulemaking action has been highly complex and controversial, with interested and affected persons very polarized in their views about the best approach to establish standards for timeliness of access to health care services. The extreme complexity and serious polarization of the interested persons participating in the development of this regulation resulted in the submission of many different alternatives by the interested persons. The alternatives proposed to and considered by the Department are captured in the public comments collected during four public comment periods, and in the Department's responses to each of the public comments.

The final revised regulation text remains true to the legislative intent and mandate reflected in Section 1367.03, while accomplishing the difficult task delegated to the Department by the Legislature, that is, to balance the competing concerns among affected persons, to accomplish sensible, workable and meaningful regulations designed to ensure timely access to care for enrollees. The necessity for the provisions in the final revised text and for the changes made to the text that was initially published, is explained in the Final Statement of Reasons.

The final revised regulation text reflects substantial changes that are sufficiently related to the original text and within the scope of the Notice of Rulemaking Action. Accordingly, consistent with APA requirements, the Department made the revised text available for public comment. A reasonable member of the directly affected public could have determined from the Notice that these changes to the regulation could have resulted.”

---

<sup>4</sup> The CDI added geographic accessibility standards (distance metrics) to its existing regulations. The geographic access standards added by the CDI for primary care physicians and hospitals are consistent with the Department's geographic access standards for those categories of services. The CDI also added geographic access standards for specialist physicians and mental health care providers. These regulations do not modify existing Knox-Keene geographic access standards, which do not include standards for specialist physicians and mental health care providers. The Department's approach, as required by Section 1367.03, is directed to address the waiting times for services. Sections 1300.51(d)(Exhibit H), 1300.67.2 and 1300.67.2.1, title 28, California Code of Regulations. Additional consistency between CDI regulations and DMHC regulations may be found in physician-to-enrollee ratio requirements: 1 full time

On November 3, 2009, the final regulation package was submitted to the Office of Administrative Law (OAL). The regulation was approved by OAL<sup>5</sup> and filed with the Secretary of State on December 18, 2009. The regulation was effective on January 17, 2010.<sup>6</sup>

## 5. SUBSTANTIAL CONTRIBUTION

Health and Safety Code section 1348.9, subdivision (a) provides that:

“[T]he director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation...”  
(Emphasis added).

The definition of “Substantial Contribution” provides the criteria for evaluating whether the consumer participant has made a substantial contribution.<sup>7</sup> 28 CCR § 1010(b)(8) defines

“Substantial Contribution” as follows:

“‘Substantial Contribution’ means that the Participant significantly assisted the Department in its deliberations by presenting relevant issues, evidence, or arguments which were helpful, and seriously considered, and the Participant’s involvement resulted in more relevant, credible, and non-frivolous information being available to the Director.”

---

equivalent primary care physician for every 2000 enrollees; and 1 full time equivalent physician for every 1,200 enrollees.

<sup>5</sup> Office of Administrative Law, Notice of Approval of Regulatory Action, OAL File No. 2009-1103-04 S, December 18, 2009.

<sup>6</sup> *Id.*

<sup>7</sup> Further guidance is provided in PUC Decisions awarding intervenor compensation – for example:

“In evaluating whether ... [an intervenor] made a substantial contribution to a proceeding, we look at several things. First, did the ALJ or Commission adopt one or more of the factual or legal contentions, or specific policy or procedural recommendations put forward by the ... [intervenor]? ... Second, if the ... [intervenor’s] contentions or recommendations paralleled those of another party, did the ... [intervenor’s] participation materially supplement, complement, or contribute to the presentation of the other party or to the development of a fuller record that assisted the Commission in making its decision? ... [T]he assessment of whether the ... [intervenor] made a substantial contribution requires the exercise of judgment.

“In assessing whether the ... [intervenor] meets this standard, the Commission typically reviews the record, ... and compares it to the findings, conclusions, and orders in the decision to which the ... [intervenor] asserts it contributed. It is then a matter of judgment as to whether the ... [intervenor’s] presentation substantially assisted the Commission. [citing D.98-04-059, 79 CPUC2d 628, 653 (1998)].

Should the Commission not adopt any of the ... [intervenor’s] recommendations, compensation may be awarded if, in the judgment of the Commission, the ... [intervenor’s] participation substantially contributed to the decision or order. For example, if ... [an intervenor] provided a unique perspective that enriched the Commission’s deliberations and the record, the Commission could find that the ... [intervenor] made a substantial contribution.” PUC Decision D.06-11-031 (November 30, 2006), PP. 5 - 6; similarly, D.06-11-009 (November 9, 2006), pp. 7 - 8.

## 5.1 APPLICATION MUST INCLUDE DESCRIPTION OF CONTRIBUTION

The application for an award of compensation must include “a description of the ways in which the Participant’s involvement made a Substantial Contribution to the proceeding<sup>8</sup> ..., supported by specific citations to the record, Participant’s testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.” 28 CCR § 1010(e)(2)c.

## 5.2. APPLICANT’S DESCRIPTION OF ITS CONTRIBUTION

APPLICANT submitted the following information, documents and testimony in support of its position regarding the proposed adoption of the proposed regulation and regulation changes:

“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-elapsed standards for accessing services, so consumers are concretely aware of

---

<sup>8</sup> Decisions under the PUC’s Intervenor Compensation Program go further and require intervenors to assign a reasonable dollar value to the benefits of the intervenor’s participation.

“D.98-04-059 directed ...[intervenors] to demonstrate productivity by assigning a reasonable dollar value to the benefits of their participation to ratepayers. The costs of ...[an intervenor’s] participation should bear a reasonable relationship to the benefits realized through their participation. This showing assists us in determining the overall reasonableness of the request.” D.06-11-031 (November 30, 2006), p. 11; D.06-11-009 (November 9, 2006), pp. 31 - 32.

what their rights to care are. We are pleased to see these provisions reflected in the final regulation.”

APPLICANT submitted the following documents in support of its description of Substantial Contribution:

CPEHN supporting document dated 8-26-2004.  
CPEHN supporting document dated 10-8-2004  
CPEHN supporting document dated 9-25-2006  
CPEHN supporting document dated 3-5-2007  
CPEHN supporting document dated 9-21-2007  
CPEHN supporting document dated 12-26-2007  
CPEHN supporting document dated 11-19-2008  
CPEHN supporting document dated 2-23-2009  
CPEHN supporting document dated 6-25-2009  
CPEHN supporting document dated 8-7-2009

### **5.3 PROCEDURAL VERIFICATION OF SUBSTANTIAL CONTRIBUTION**

#### Proceeding Control No. 2002-0018

By letter dated August 26, 2004, APPLICANT presented written comments on the proposed regulation. The comments primarily recommended 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. The submission contained approximately 13 comments, including recommended changes to the proposed regulation in the form of bold additions and strike out edits. APPLICANT stated in summary:

(1) It was recommended that 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.

(2) Language should be added to clarify that, in regard to accessibility of services, plans must assume that enrollees do not have access to vehicles and must rely on public transportation. Primary care access within 30 minutes or 15 miles should be clarified to specify “by public transportation.”

(3) Language regarding the ratio of enrollees to staff should be clarified to add “interpreter services” along with medical services and preventive services.

(4) Language should be added to clarify that the location of facilities providing inpatient and other health care services 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.

(5) Regarding the requirement that each plan have a documented system for monitoring and evaluating accessibility of care, waiting time for the provision of interpreters should be included, as well as the language capabilities of providers and accessibility of providers by public transportation.

(6) 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.

(7) Language should be added to assure that the plan's health education program 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.

(8) Clarification should be added to assure that all timely access timelines must take into account the travel and accessibility by public transportation, and the need to arrange interpreter services.

(9) The standard regarding specialty care being geographically accessible should include "accessible by public transportation."

(10) Plan monitoring of providers to assess whether waiting time to speak to a qualified professional trained to screen or triage should include assessing whether the wait time to access interpreter services is adequate to assure timely access.

(11) Regarding corrective action when plan monitoring identifies patterns of non-compliance with access standards, language should be added to clarify the addition of action to ensure availability of interpreter services.

(12) Regarding the plan's annual report of the plan's compliance with access standards, the plan's report should include sufficient detail to allow the Department to determine if all enrollees regardless of income, race, ethnicity, and primary language, are receiving timely services.

(13) Annual assessment of enrollee satisfaction with accessibility of services should be conducted in each language in which CAHPS translations are available for each covered population. In addition, the HMO Report Card should include linguistic services in the other languages portion of the Report Card.

By letter dated October 8, 2004, APPLICANT presented written comments on the proposed regulation. The comments primarily reiterated prior recommendations 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. The submission contained approximately 13 comments, including recommended changes to the proposed regulation in the form of bold additions and strike out edits. APPLICANT stated in summary:

(1) CHAPS should be utilized in all languages for which translations are available.

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

(2) It was reiterated that language should be added to clarify that, in regard to accessibility of services, plans must assume that enrollees do not have access to vehicles and must rely on public transportation. Primary care access within 30 minutes or 15 miles should be clarified to specify "by public transportation."

(3) It was reiterated that language regarding the ratio of enrollees to staff should be clarified to add "interpreter services" along with medical services and preventive services.

(4) It was reiterated that language should be added to clarify that the location of facilities providing inpatient and other health care services 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.

(5) In calculating the 15 mile or 30 minute 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.

(6) Regarding the requirement that each plan have a documented system for monitoring and evaluating accessibility of care, waiting time for the provision of interpreters should be included, as well as the language capabilities of providers and accessibility of providers by public transportation.

(7) It was reiterated that 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.

(8) It was reiterated that language should be added to assure that the plan's health education program 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.

(9) In regard to access to non-emergency appointments, all timelines must take into account the travel time and accessibility by public transportation and the need to arrange interpreter services.

(10) Clarification should be added to specify that specialty care appointments are to be accessible by public transportation.

(11) Clarification should be added to include within plan monitoring of providers the requirement for assessing whether the wait time to access interpreter services is adequate.

(12) The plan's annual report should include sufficient detail to allow the Department to determine if all enrollees regardless of income, race, ethnicity, and primary language, are receiving timely services.

(13) It was reiterated that the annual assessment of enrollee satisfaction with accessibility of services should be conducted in each language in which CAHPS translations are available for each covered population. In addition, the HMO Report Card should include linguistic services in the other languages portion of the Report Card.

By letter dated September 25, 2006, APPLICANT presented written comments on the proposed regulation, signed by the Policy Director of APPLICANT. That submission contained approximately four comments. APPLICANT stated in summary:

(1) The revised proposed regulation requires collection of race and ethnicity data from enrollees. However, primary language (written and spoken) should also be collected from each enrollee.

(2) The proposed regulation should require that plans have a process developed for sharing the demographic information (race, ethnicity, and primary language) with the plan's providers.

(3) Additional clarity should be given to plans regarding ensuring the quality of interpreters, so that in every medical encounter with an LEP individual a trained interpreter is present. The regulation should specify that face-to-face interpretation is desirable unless it is unfeasible. In regard to family and friends acting as interpreters, the plan and providers should have an obligation to encourage use of a qualified interpreter. There should be an outright ban on using minors as interpreters.

(4) The references to deemed compliance regarding plans with a Medi-Cal line of business should be deleted. Medi-Cal plans should not be exempt outright, without any process for comparing the relative requirements. Medi-Cal enrollees should benefit from the higher timely access standards of the regulation.

Proceeding Control No. 2005-0203

By letter dated March 5, 2007, APPLICANT presented written comments on the proposed regulation, signed by the Policy Director of APPLICANT. The comment letter contained approximately seven comments. APPLICANT's comments suggested changes to ensure timely access for communities of color. APPLICANT stated in summary:

(1) The regulation 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 regulation); and anonymous (secret shopper) telephone audits of providers' offices.

(2) The regulation should incorporate language access requirements in the appointment and telephone standards, so that a sick LEP consumer may receive timely access. The final timely access regulation should contain a reference to the Language Assistance Program regulation.

(3) The timely access standards should 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.

(4) Standards should be added for (1) timely delivery of language assistance services for emergency, urgent and routine health care services and (2) coordination of interpretation services with appointment scheduling. This would ensure that these two indicators would be included in compliance monitoring of the plans.

(5) Language should be added to clarify 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.

(6) It was urged that qualified interpreters be used in the quality assurance standards for timely telephone access.

(7) There is no reference to time requirements regarding the translation of materials into other languages upon request. It was recommended that the statutory time requirements be included 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 should be able to request the document be translated, and translation must be completed within 21 days. The regulation should specify that 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 the translation.

By letter dated September 21, 2007, APPLICANT presented written comments on the proposed regulation, signed by the Policy Director of APPLICANT. That submission contained approximately eight comments. APPLICANT stated in summary:

(1) Disappointment was expressed because of lack of clarification of wait times for interpreter services. Concern was expressed that without such clarification health plans and providers may force enrollees to choose between language services and timely access. It would be reasonable to clarify that enrollees should have to wait no more than 15 additional minutes for an interpreter.

(2) “Starting from scratch” with the regulation is unacceptable. The timely access regulations are over three years late, and further delays will only cause more harm for consumers.

(3) The regulation should require plans to address how they would handle telephone access in a timely manner for LEP enrollees.

(4) The regulation should specify that the plan must ensure that alternate providers have language proficiency in situations where the wait time is too long and an alternate provider must be assigned.

(5) The regulation should specify that surveys used to gauge compliance with timely access standards must be translated into the threshold languages, at a minimum.

(6) The regulation should ensure statistical validity of plan surveys by ensuring sufficient diversity in terms of demographic characteristics such as language, race, ethnicity, gender, and income, so as to look at the quality and timeliness of care received by subgroups in all communities.

(7) Plans should not be held in compliance with the timely access regulation 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.

(8) It is essential that a portion of the now required secret shopper calls in providers’ offices be in languages other than English.

By letter dated December 26, 2007, APPLICANT presented written comments on the proposed regulation, signed by the Policy Director of APPLICANT. The comment letter contained approximately three comments. APPLICANT stated in summary:

(1) Disappointment was expressed because the time-elapsd standards had been removed from the proposed regulation. The newly proposed language does not provide health plans or consumers with sufficient information to develop standards. Stakeholders do not have sufficient input into the newly proposed language.

(2) Strong disagreement was expressed regarding the view that access for interpreters was

addressed in the language assistance regulation, which is vague and does not provide plans with a clear time-elapsed standard for the provision of interpreters.

(3) The regulation should ensure that enforcement of the timely access regulations include assessing how the timely access requirements impact communities of color and LEP communities. Plans should be required to translate consumer satisfaction surveys into other languages and ensure adequate sample sizes of communities of color. Plans must not only ensure overall compliance but also ensure that specific communities are not bearing the brunt of excessive wait times.

In August and September of 2008, APPLICANT's Policy Director reviewed relevant materials from the Department and other stakeholders, prepared issues for discussion in the in-person stakeholder process meetings, and participated in the in-person stakeholder process meetings in Sacramento with Department staff and representatives of other stakeholders, including two meetings in September.

APPLICANT's participation in the informal stakeholder process included comments provided by e-mail dated November 19, 2008. That submission contained approximately two comments. APPLICANT stated in summary:

(1) Regarding the requirement to coordinate interpreter services with scheduled appointments to assure provision of interpreter services at the time of appointment, concern was expressed that it doesn't apply to accessing an interpreter at the initial point of contact. The requirement should be strengthened by adding that procedures must be in place to ensure that provision of language services does not produce additional wait times.

(2) Regarding the annual enrollee experience survey, it 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.

Proceeding Control No. 2008-1579

By letter dated February 23, 2009, APPLICANT presented written comments on the proposed regulation, signed by the Policy Director of APPLICANT. The comment letter contained approximately two comments. APPLICANT stated in summary:

(1) The regulation should spell out that if a plan does not translate enrollee experience surveys into at least their threshold languages, then the plan would be out of compliance.

(2) In conducting enrollee surveys, plans must ensure adequate sample sizes for all major racial, ethnic, and language communities served by the health plan

By e-mail dated June 25, 2009, APPLICANT presented two written comments on the proposed regulation. APPLICANT stated in summary:

(1) Disappointment was expressed that language was not added clarifying that enrollee experience surveys need to be translated into at least threshold languages.

(2) Objection was made to the change that allows patients to wait up to 30 minutes to speak with a trained person to be screened and triaged. Ten to 15 minutes is a more acceptable wait time.

By e-mail dated August 7, 2009, APPLICANT presented two written comments on the proposed regulation. APPLICANT stated in summary:

(1) Disappointment was reiterated that language was not adopted clarifying that enrollee experience surveys need to be translated into at least threshold languages.

(2) Objection was reiterated to the change that allows patients to wait up to 30 minutes to speak with a trained person to be screened and triaged. Ten to 15 minutes is a more acceptable wait time.

#### **5.4. FINDING OF SUBSTANTIAL CONTRIBUTION**

The Hearing Officer finds that participation by APPLICANT: (1) significantly assisted the Department in its deliberations by presenting relevant issues, evidence, and arguments that were helpful and seriously considered, and (2) resulted in more relevant, credible, and non-frivolous information being available to the Director to make her decision regarding the proposed adoption of 28 CCR §1300.67.2.2 than would have been available to the Director had APPLICANT not participated.

The Hearing Officer hereby determines that by its participation APPLICANT made a substantial contribution on behalf of consumers to the proceedings, to the Department in its deliberations, and as a whole, to the adoption of 28 CCR §1300.67.2.2.

The Hearing Officer finds that APPLICANT has made a Substantial Contribution, pursuant to 28 CCR § 1010(b)(8), to the timely access rulemaking proceeding.

#### **6. REASONABLENESS OF HOURS AND COSTS AND MARKET RATE**

Health and Safety Code section 1348.9 allows the Director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation.

## 6.1. FEES AND COSTS REQUESTED

APPLICANT billed the following time, hourly rates, and fees for its representatives.

Staff / Title	Hours	Rates	Fees
Policy Director			
- Work in 2004	8.0	\$250.00	\$2,000.00
- Work in 2006	3.0	\$250.00	\$750.00
- Work in 2007	9.0	\$250.00	\$2,250.00
- Work in 2008	21.0	\$250.00	\$5,250.00
- Work in 2009	6.0	\$250.00	\$1,500.00
<b>TOTAL FEES</b>	<b>→</b>		<b>\$11,750.00</b>

APPLICANT did not claim or bill for any expenses or recoverable costs.

## 6.2. CONSIDERATIONS USED IN PUC'S INTERVENOR COMPENSATION PROGRAM

Reference to the intervenor compensation program of the California Public Utilities Commission ("PUC") seems appropriate because it is similar to the Department's Consumer Participation Program<sup>9</sup> and has an extensive history of awarding intervenor compensation and updating hourly rates used in computing awards of compensation to intervenors who make substantial contributions to PUC decisions.

In each proceeding before the PUC in which intervenors participate, the PUC issues a written opinion setting forth the decision regarding award of intervenor compensation. Therefore, the many PUC written decisions granting intervenor compensation provide a valuable source of guidelines to determine reasonableness and market value. Some of the common threads of the PUC decisions are summarized as follows.

In considering an intervenor organization's request for compensation, the PUC opinions:

a. Separately consider and approve the individual hourly rate of compensation for each of the intervenor's experts and advocates.<sup>10</sup>

b. Have awarded the same rate for an individual expert that was approved in a prior proceeding in the same year,<sup>11</sup> and have declined to approve a requested increase in hourly rate for an expert over the rate approved in a prior proceeding in the same year.<sup>12</sup>

<sup>9</sup> The Legislative history behind the Department's Consumer Participation Program specifically referred to the PUC's program.

"The Legislature finds and declares that consumer participation programs at the Public Utilities Commission and the Department of Insurance have been a cost-effective and successful means of encouraging consumer protection, expertise, and participation...." Stats 2002 C. 792 § 1 (SB 1092).

<sup>10</sup> PUC Decision (D.) 06-11-031 (November 30, 2006).

<sup>11</sup> D.06-11-031 (November 30, 2006).

<sup>12</sup> D.06-11-032 (November 30, 2006), pp. 10 – 11.

c. Have awarded increases of three percent (3%) rounded to the nearest \$5 over the prior year when increase in hourly rates is requested by the intervenor organization or where the hourly rate for an individual expert or advocate was approved in the prior year and an increase is considered warranted for the current year.<sup>13</sup> The PUC has consistently rejected requests for increase over 3%.<sup>14</sup>

d. Have stated that documentation of claimed hours by presenting a daily breakdown of hours accompanied by a brief description of each activity, reasonably supported the claim for total hours.<sup>15</sup>

e. Have approved compensation for travel time at one-half the normal hourly rate.<sup>16</sup>

f. Have approved compensation for preparation of the intervenor organization's compensation request or compensation claim at one-half the normal hourly rate.<sup>17</sup> However, administrative costs are considered non-compensable overheads, and therefore, the PUC has disallowed time charged by an intervenor's office manager for gathering expense data for the compensation claim.<sup>18</sup>

g. Have approved compensation for efforts that made a substantial contribution even where the PUC did not wholly adopt the intervenor's recommendations.<sup>19</sup>

h. Have approved payment of itemized direct expenses where the request shows "the miscellaneous expenses to be commensurate with the work performed," including costs for photocopying, FAX, Lexis research, postage, courier, overnight delivery, travel, and parking.<sup>20</sup>

i. Have reminded intervenors of the requirements for records and claim support, and that PUC staff may audit the records – for example:

"We remind all intervenors that Commission staff may audit their records related to the award and that intervenors must make and retain adequate accounting and other documentation to support all claims for intervenor compensation. [Intervenor's]... records should identify specific issues for which it requested compensation, the actual time spent by each employee or consultant, the applicable hourly rate, fees paid to consultants, and any other costs for which compensation was claimed."<sup>21</sup>

j. Have disallowed time where the "hours seem excessive" or the "proposal is not

---

<sup>13</sup> D.06-11-031 (November 30, 2006), p. 11.

<sup>14</sup> D.06-11-031 (November 30, 2006), p. 11.

<sup>15</sup> D.06-11-031 (November 30, 2006), p. 10.

<sup>16</sup> D.06-11-031 (November 30, 2006); D.06-11-032 (November 30, 2006), p. 8, fn. 4.

<sup>17</sup> D.06-11-031 (November 30, 2006), p. 9, fn. 2; D.06-11-032 (November 30, 2006), p. 8, fn. 4.

<sup>18</sup> D.06-11-009 (November 9, 2006), p. 27.

<sup>19</sup> D.06-11-031 (November 30, 2006), p. 10.

<sup>20</sup> D.06-11-031 (November 30, 2006), p. 12; D.06-11-032 (November 30, 2006), pp. 14 – 15; D.06-11-009 (November 9, 2006), p. 32.

<sup>21</sup> D.06-11-031 (November 30, 2006), pp. 14 -15.

persuasive,”<sup>22</sup> and have changed or disallowed compensation amounts requested for the following reasons:<sup>23</sup> “Excessive hourly rate; arithmetic errors; failure to discount comp prep time [and travel time]; hours claimed after decision issued; ... administrative time not compensable; unproductive effort.”

### **6.3. REASONABLENESS OF TIME BILLED**

We must assess whether the hours claimed for the consumers’ efforts that resulted in substantial contributions to the proceedings are reasonable by determining to what degree the hours and costs (if any costs are claimed) are related to the work performed and necessary for the substantial contribution.<sup>24</sup>

a. Billed Activities. APPLICANT billed for 13 activities summarized as follows:

(1) Analysis of the text of the proposed regulation, and preparation of written comments dated August 26, 2004, for a total of 5.0 hours.

(2) Analysis of revised text of the proposed regulation against the backdrop of existing law, best practices research, and client experience, and preparation of written comments dated October 8, 2004, for a total of 3.0 hours.

(3) Analysis of revised text of the proposed regulation, and preparation of written comments dated September 25, 2006, for a total of 3.0 hours.

(4) Analysis of revised text of the proposed regulation, and preparation of written comments dated March 5, 2007, for a total of 3.0 hours.

(5) Analysis of revised text of the proposed regulation, and preparation of written comments dated September 21, 2007, for a total of 3.0 hours.

(6) Analysis of revised text of the proposed regulation, and preparation of written comments dated December 26, 2007, for a total of 3.0 hours.

(7) Development of key issues for participation in stakeholder process and review of other stakeholder materials on August 7, 2008, for a total of 3.0 hours.

(8) Participation in stakeholder process meeting on September 3, 2008, for a total of 8.0 hours.

(9) Participation in stakeholder process meeting on September 4, 2008, for a total of 8.0 hours.

(10) Analysis of revised text of the proposed regulation, and preparation of written

---

<sup>22</sup> D.06-11-032 (November 30, 2006), pp. 9 - 10.

<sup>23</sup> D.06-11-009 (November 9, 2006), Appendix p. 1.

<sup>24</sup> See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 9; D.06-11-009 (November 9, 2006), p. 26.

comments dated November 19, 2008, for a total of 2.0 hours.

(11) Analysis of revised text of the proposed regulation, and preparation of written comments dated February 23, 2009, for a total of 3.0 hours.

(12) Analysis of revised text of the proposed regulation, and preparation of written comments dated June 25, 2009, for a total of 2.0 hours.

(13) Analysis of revised text of the proposed regulation, and preparation of written comments dated August 7, 2009, for a total of 1.0 hours.

b. Adjustments. The time billed appears reasonable.

c. Finding. The Hearing Officer hereby finds that the time billed is related to the work performed, necessary for the substantial contributions made, and reasonable for the advocacy and witness services performed and work product produced.

#### **6.4. MARKET RATE**

Public interest attorneys are entitled to request the prevailing market rates of private attorneys of comparable skill, qualifications and experience. (*Serrano v. Unruh* (“*Serrano IV*”) (1982) 32 Cal.3d 621.). APPLICANT is entitled to be compensated for Advocacy Fees and Witness Fees at hourly rates that reflect Market Rate for services. Advocacy Fees and Witness Fees cannot exceed Market Rate, as defined in the Regulation. 28 CCR §§ 1010(b)(1), (3) and (10). “Market Rate” is defined at 28 CCR section 1010(b)(3) as follows:

“‘Market Rate’ means, with respect to advocacy and witness fees, 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 for attorney advocates, non-attorney advocates, or experts with similar experience, skill and ability.”

#### **6.5. HOURLY RATES THAT REFLECT “MARKET RATE”**

The Hearing Officer finds that hourly rates for services provided in a statewide proceeding or proceeding of a state agency having statewide jurisdiction and effect (such as proceedings of the PUC, see *infra*) are essentially equivalent to “comparable services in the private sector in the Los Angeles and San Francisco Bay Areas,” as required by 28 CCR § 1010, subsection (b)(3).

Accordingly, we must take into consideration whether the claimed fees and costs (if any) are comparable to the market rates paid to experts and advocates having comparable training and experience and offering similar services.<sup>25</sup> In order to determine Market Rate, we must look to available data inside and outside the Department.

---

<sup>25</sup> See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 10.

## 6.6. APPLICANT'S JUSTIFICATION FOR RATES BILLED

In support of the hourly fee rates requested, APPLICANT did not submit any justification other than the experience and biographical information regarding the persons providing services.

## 6.7. HOURLY RATE DETERMINATIONS UNDER THE PUC PROGRAM

Until PUC Decision R.04-10-010 in 2004, the PUC “set hourly rates piecemeal”<sup>26</sup> for intervenors – i.e., “... for each proceeding, each intervenor, and indeed each appearance by a particular representative of an intervenor, ...[the PUC] might revisit the reasonableness of that representative’s hourly rate.”<sup>27</sup> The PUC recognized the need for coordination by establishing, through periodic rulemakings, the rates to be paid to all intervenors’ representatives for work done in specified time periods.<sup>28</sup> The first such rulemaking was R.04-10-010, D.05-11-031, which set certain guidelines, recognized that hourly rates had stabilized, and determined that the PUC would not authorize a general increase to intervenor hourly rates for work performed in 2005.<sup>29</sup>

In an Interim Opinion on Updating Hourly Rates,<sup>30</sup> the PUC adopted a three percent (3%) cost-of-living adjustment (COLA) for work performed in calendar year 2006, adopted an additional 3% COLA for work performed in 2007, and established effective with 2007 work three rate ranges for non-attorney experts based on levels of experience, similar to the five levels already established for attorneys.<sup>31</sup> The three levels for non-attorney experts are: 0-6 years; 7-12 years; and 13-plus years. In so doing, the PUC found that:

“...basing expert rates on levels of experience, similar to the levels established for attorneys, will better ensure that an expert’s given rate is within the market rates paid to persons of comparable training and experience. However, in no event should the rate requested by an intervenor exceed the rate billed to that intervenor by any outside consultant it hires, even if the consultant’s billed rate is below the floor for a given experience level. ...[I]ntervenors must disclose the credentials of their representatives in order to justify the requested rates.”<sup>32</sup> (Emphasis added).

The following table shows the PUC’s adopted ranges for work performed by intervenor representatives in 2006, 2007, 2008 and 2009. The rate ranges for attorneys and non-attorney experts are based on levels of applicable experience.

---

<sup>26</sup> PUC Order Instituting Rulemaking R.06-08-019 (August 24, 2006), p. 2.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at pp. 2-3.

<sup>30</sup> D.07-01-009 (January 11, 2007) (part of Rulemaking R.06-08-019).

<sup>31</sup> *Id.* at pp. 1, 3-4.

<sup>32</sup> *Id.* at p. 5.

## Hourly Intervenor Rate Ranges for 2006, 2007, 2008<sup>33</sup> and 2009

(2006 rates = rates adopted in D.05-11-031 + 3%, rounded to nearest \$5)

(2007 rates = rates adopted for 2006 in D.07-01-009 + 3%, rounded to nearest \$5)

(2008 rates = rates adopted for 2007 + 3%, rounded to nearest \$5)

(2009 rates = 2008 rates adopted for 2009 in Resolution ALJ-235)

Years of Experience	2006 Range	2007 Range	2008 and 2009 <sup>34</sup> Range
<b>Attorneys:</b>			
0 - 2	\$140 - \$195	\$145 - \$200	\$150 - \$205
3 - 4	\$190 - \$225	\$195 - \$230	\$200 - \$235
5 - 7	\$260 - \$280	\$270 - \$290	\$280 - \$300
8 - 12	\$280 - \$335	\$290 - \$345	\$300 - \$355
13+	\$280 - \$505	\$290 - \$520	\$300 - \$535
<b>Experts:</b>			
0 - 6		\$120 - \$180	\$125 - \$185
7 - 12		\$150 - \$260	\$155 - \$270
13+		\$150 - \$380	\$155 - \$390
All years	\$115 - \$370		

Note: The rates intervenors request for the use of outside consultants may not exceed the rates billed to the intervenors by the consultants, even if the consultants' rates are below the floor for any given experience level.

The PUC decided to continue to update hourly rates annually on a calendar year basis.<sup>35</sup> The PUC based its 3% COLA adjustments on the Social Security Administration's COLA, which is released annually in late fall, and reliance thereon would be consistent with a calendar year adjustment of hourly rates.<sup>36</sup>

In 2008, the PUC found it reasonable to adopt another 3% COLA for intervenor rates for work performed in 2008.<sup>37</sup> That increase is primarily based on various federal inflation indexes, such as the Social Security Administration's COLA and Bureau of Labor Statistics data for consumer prices and wages.<sup>38</sup> In its 2008 Decision and for future reference, the PUC found that a

<sup>33</sup> D.08-04-010 (April 10, 2008) (part of Rulemaking 06-08-019) at p. 5.

<sup>34</sup> For work performed in 2009, the PUC ordered that intervenors are not authorized an hourly rate COLA, and hourly rate ranges adopted for 2008 remain in effect. Resolution ALJ-235 (March 12, 2009) at pp. 2-4.

<sup>35</sup> D.07-01-009 (January 11, 2007) at p. 9.

<sup>36</sup> *Id.* at pp. 4 and 11.

<sup>37</sup> D.08-04-010 (April 10, 2008) at pp. 4 and 24.

<sup>38</sup> *Id.* In reviewing available data, the PUC found no index that specifically targets rates for services by regulatory professionals (attorneys, engineers, economists, scientists, etc.), and the PUC's "findings are weighted heavily to SSA COLA and similar data." *Id.* at p. 4.

COLA adjustment should be authorized, by future PUC Resolution, for work performed in 2009, and in subsequent years in the absence of a market rate study, to be effective on January 1 of each year.<sup>39</sup> However, a COLA would not necessarily be authorized. By Resolution ALJ-235 (March 12, 2009), the PUC ordered that intervenors are not authorized an hourly rate COLA for work performed in 2009, and hourly rate ranges adopted for 2008 would remain in effect.

#### **6.8. DETERMINATION OF MARKET VALUE HOURLY RATE**

Fees claimed may be adjusted to reflect Market Rate. “The hearing officer shall issue a written decision that ... shall determine the amount of compensation to be paid, which may be all or part of the amount claimed.” 28 CCR § 1010(e)(7). APPLICANT claims advocacy and witness fees for one Policy Director.

For work performed by APPLICANT’s Policy Director, APPLICANT claims Advocacy and Witness Fees at the hourly rate of \$250.00 for 2004, 2006, 2007, 2008 and 2009. APPLICANT submitted justification for the rate claimed by reference to biographical information and the number of years of experience for the staff member for whom fees are claimed. The credentials provided by APPLICANT indicate that at the time of the work for which claim is made, APPLICANT’s Policy Director had: as of 2004, approximately four years of experience as Policy Director of APPLICANT plus an additional five years as Policy Coordinator of AIDS Project East Bay, for a total of nine years as of 2004; and by adding one additional year as Policy Director for each year past 2004, APPLICANT’s Policy Director had approximately 10 years of experience as of 2005, approximately 11 years of experience as of 2006, approximately 12 years of experience as of 2007, approximately 13 years of experience as of 2008, and approximately 14 years of experience as of 2009. APPLICANT’s Policy Director has a BA degree from Swarthmore College in Pennsylvania and a Masters of Public Policy from the University of California, Berkeley, California.

Prior to 2006, the PUC did not establish a rate range of fees. Instead, the PUC set hourly rates piecemeal for each proceeding and each intervenor. In order to determine Market Rate for 2004, the Hearing Officer considered individual rates set by the PUC for 2003 and 2004 and used a form of regression analysis to extrapolate back from adopted PUC rate ranges for 2006. The highest of the individually awarded PUC rates (for 16 years of experience) for 2003 was \$215. However, the \$250.00 rate claimed by APPLICANT for 2004 is less than 94 percent of the highest (\$370) of the rates adopted in PUC’s rate range for non-attorney experts for services in 2006. To extrapolate the highest rate for 2004, the PUC’s highest rate for 2006 (\$370/hour) was reduced by three percent per year (for a total of six percent) to estimate the rate for 2004, illustrated as follows:  $\$370 \times .94 =$

---

<sup>39</sup> D.08-04-010 (April 10, 2008) at pp. 24 -25.

\$347.80, and \$347.80 is higher than the requested rate of \$250. Therefore, it appears that the \$250.00 hourly rate requested for 2004 does not exceed Market Rate as construed and found herein in accordance with the PUC rate ranges.

For 2006 through 2009, the PUC's adopted hourly intervenor rate ranges for non-attorney experts with 9 – 14 years of experience are as follows: for 2006, \$115 - \$370 (without breakdown by years of experience); for 2007, \$150 - \$260; and for 2008 and 2009, \$155 - \$390 for 13 or more years of experience (see ¶ 6.8, *infra*). Therefore, it appears that the \$250.00 hourly rate claimed for 2006, 2007, 2008 and 2009 by APPLICANT does not exceed Market Rate as discussed and found herein. Regarding services provided by APPLICANT's Policy Director, the Hearing Officer finds that the hourly rate of \$250.00 is consistent with Market Rate for the services provided in 2004, 2006, 2007, 2008 and 2009.

Based on the information and documentation provided by APPLICANT, the Hearing Officer did not consider it necessary to audit the records and books of the APPLICANT to verify the basis for the amounts claimed in seeking the award. 28 CCR § 1010(e)(6).

## 7. AWARD

APPLICANT is awarded Advocacy and Witness Fees as follows:

Staff / Title	Hours	Rates	Fees
Policy Director			
-- Work in 2004	8.0	\$250.00	\$2,000.00
-- Work in 2006	3.0	\$250.00	\$750.00
-- Work in 2007	9.0	\$250.00	\$2,250.00
-- Work in 2008	21.0	\$250.00	\$5,250.00
-- Work in 2009	6.0	\$250.00	\$1,500.00
<b>TOTAL FEES</b>	<b>→</b>		<b>\$11,750.00</b>

## 8. ASSIGNMENT OF PROCEEDING

This proceeding was and is assigned to Stephen A. Hansen, Staff Counsel III, as Hearing Officer.

## FINDINGS OF FACT

1. APPLICANT has satisfied all the procedural requirements necessary to claim compensation in this proceeding.
2. APPLICANT made Substantial Contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 as described herein.
3. APPLICANT requested hourly rates for its representatives that, as adjusted herein, are

reasonable when compared to Market Rates for persons with similar training and experience.

4. The total reasonable compensation for APPLICANT is \$11,750.00.

## CONCLUSIONS OF LAW

1. APPLICANT has fulfilled the requirements of Health and Safety Code § 1348.9 and 28 CCR § 1010, which govern awards of advocacy and witness compensation, and is entitled to such compensation incurred in making Substantial Contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

2. APPLICANT should be awarded \$11,750.00 for its contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

## AWARD ORDER

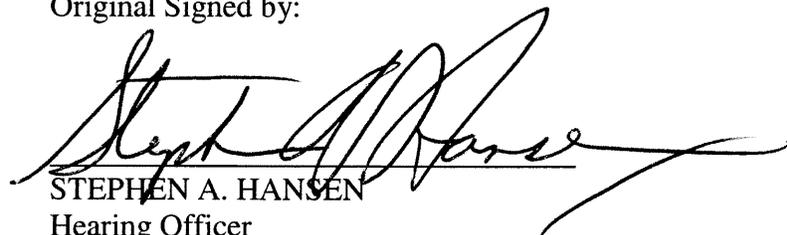
1. California Pan-Ethnic Health Network, a California corporation, is hereby awarded \$11,750.00 as compensation for its Substantial Contribution to the Timely Access regulatory Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and to 28 CCR § 1300.67.2.2.

2. Payment shall be made within thirty (30) days of the effective date of this decision.

3. This decision is effective thirty (30) days after posting of this decision on the Department's website. 28 CCR § 1010(e)(7) and (8).

Dated: June 29, 2010

Original Signed by:



STEPHEN A. HANSEN  
Hearing Officer  
Department of Managed Health Care