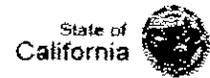


**DMHC Note: Documents that were accessible by clicking on “View” are displayed after the Applicant’s certification of the Application.**



## Application for an Award of Advocacy and Witness Fees

**Entity Name:** Legal Services of Northern California  
**Proceeding:** 2002-0018 General Access/ 2005-0203 Timely Access  
**Date Submitted:** 2/2/2010 9:14:37 AM  
**Submitted By:** Ann Rubinsein  
**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?

\$42,697.09

- 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.

The Hotline's involvement made a substantial contribution to timely access regulation proceedings. The Hotline has been involved in timely access rulemakings since they began; Hotline staff have consistently commented on timely access regulations and participated in stakeholder groups since 2004. With each iteration of the regulations, the Hotline staff researched other states laws on Timely Access, and current law in California on timely access and other related matters. The Hotline participated in conference calls with other advocates to prepare responses to proposed regulations. The Hotline staff also read through our own client cases that dealt with timely access problems to fully understand where and how problems were occurring and how the proposed regulations would address the problems faced by Hotline callers. The Department published the initial Access to Needed Health Care Services proposed regulation in 2004 and opened a public comment period. The Hotline submitted written comments on the proposed regulation to the Department on November 8, 2004. The Hotline's comments advocated for specified waiting time for triage for urgent care appointment. The final regulations do specify the waiting time for telephone triage appointments. The Hotline also requested that the regulations incorporate health plans' obligation to provide access to language assistance and culturally appropriate services. The final regulations do include language access. These first comments advocated for setting a global physician-patient ratio limit in addition to the physician-enrollee ratio standard. The Hotline also suggested that the regulations require health plans to have a documented system for monitoring and evaluating provider compliance with the standards. The comments pointed out how the monitoring called for in the regulations was not sufficient. The Hotline based its comments on data gathered from consumers who contacted the Hotline for assistance with Timely Access. In 2005, the Department released a second version of the Access to Needed Health Care Services regulations. The Hotline submitted a second set of written comments to the Department on April 22, 2005. The Hotline's comments reiterated the issues above as well as advocating for requiring plans to submit a copy of their monitoring systems. These comments also stressed the importance of compliance and ensuring that the Department monitors compliance. Again, the Hotline based its comments on the experience of consumers who had contacted the Hotline for assistance with a timely access problem. The Department withdrew this rulemaking action on April 29, 2005. On June 17, 2005 the Hotline's managing attorney and staff attorney

participated in a stakeholder meeting with the Department to discuss the future of timely access regulations. In January of 2007, the Department released the initial version of the Timely Access to Health Care Services regulation and opened a public comment period which ended on March 5, 2007. The Hotline carefully compared the new version to the implementing statute and to the first and second versions, researched mental health parity laws, and reviewed Hotline data for new information to include in comments to the Department. The Hotline submitted written comments to the Department on March 5, 2007. These comments focused on the inadequate standards proposed for mental health, dental health, and durable medical equipment wait times. The Hotline provided client stories to illustrate why stricter standards were necessary. The final version of the regulations contains stricter time standards than were proposed in the January 2007 version. The Hotline also suggested replacing vague language such as "reasonable time" and "shortest time appropriate" with specific standards. The comments also asked for changes in compliance monitoring and survey methods. A Hotline staff attorney testified at the public hearing in Sacramento on March 5, 2007. In July of 2007, the Department released a second version of the Timely Access to Health Care Services regulation and opened a public comment period which ended on September 21, 2007. The Hotline submitted comments on September 21, 2007 asking for shorter wait times for dental and mental health appointments. The Hotline also requested that it be specified that the need for an interpreter is not a patient caused delay. A section was included in the final regulation that does specify this in asserting that interpreter services shall be coordinated with scheduled appointments. The Hotline also requested that telephone access time standards apply to all plans and providers regardless of how they answer their calls. This was included in the final regulations. The Hotline again read through many of its own client cases that dealt with timely access problems to get an idea of where and how problems were occurring and how the proposed regulations would address the problems faced by Hotline callers. A Hotline staff attorney testified at the public hearing in Sacramento on September 18, 2007. In December 2007, the Department released a third version of the Timely Access to Health Care Services regulations and opened up a brief public comment period. The Hotline submitted comments opposing these new regulations. We opposed the lack of specific timely access standards and the fact that this new rendition was not significantly related to the last. We also objected to the fact that specialty plans were entirely left out of these regulations. The Hotline again looked to our clients' experiences to inform our comments and researched requirements for notice and comment periods, language access and out-of-network access. The Office of Administrative Law disapproved these regulations on February 27, 2008. The final regulations did go back to specific time standards and to including specialty plans. From June to September 2008 the Department engaged stakeholders in a lengthy process to shape the future of the timely access regulations. The Hotline participated in all steps of this process including collaborating on written product with the Western Center on Law and Poverty and Health Access and attending and commenting at the stakeholder meetings. In January 2009, the Department released the initial version of the Timely Access to Non-Emergency Health Care Services regulations. The Hotline submitted comments on February 23, 2009. The Hotline read through the prior versions of the timely access regulations to compare to the newer version. Our comments focused on wait time for dental care, compliance monitoring, and enrollee education. A Hotline staff attorney testified at the public hearing in Sacramento. On June 10 2009 the Department put out a second version of the Timely Access to Non-Emergency Health Care Services regulations with a comment period to end on June 25, 2009. The Hotline submitted comments regarding changes to triage sections, and advocating for changes to the out-of-network policies as well as asking for timely access standards to be included in the plans' evidences of coverage. The Hotline reviewed, but did not comment on the regulations released in July as the changes therein did not appear to affect consumers. The Hotline signed on to the Western Center on Law and Poverty's comments on the final round of comments in October 2009. Through these activities, the Hotline made a substantial contribution to the Timely Access regulations. The Hotline presented relevant issues, evidence and arguments that were seriously considered by the Department which we believe resulted in more relevant, credible and non-frivolous information being available to the Director. Therefore, the Hotline is requesting an award of advocacy and witness fees in the amount of \$42,697.09.

Document Name	Date Uploaded	Uploaded By	
Health Rights Hotline Fee Request	2/2/2010 8:54:34 AM	Ann Rubinsein	<a href="#">View</a>
HRH Timely Access comments 6-2009	2/2/2010 8:58:47 AM	Ann Rubinsein	<a href="#">View</a>

HRH Timely Access comments 2-2009	2/2/2010 9:01:04 AM	Ann Rubinsein	<a href="#">View</a>
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HRH Timely Access comments 9-2007	2/2/2010 9:06:49 AM	Ann Rubinsein	<a href="#">View</a>
HRH Timely Access Comments 3-2007	2/2/2010 9:09:47 AM	Ann Rubinsein	<a href="#">View</a>
HRH Timely Access comments 2004	2/2/2010 9:11:36 AM	Ann Rubinsein	<a href="#">View</a>
HRH Timely Access comments 2005	2/2/2010 9:13:07 AM	Ann Rubinsein	<a href="#">View</a>

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	
Health Rights Hotline Timely Access to Care time records	2/2/2010 8:56:12 AM	Ann Rubinsein	<a href="#">View</a>

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 Sacramento (City), CA (State), on February 02, 2010.

Enter Name: Ann Rubinstein



**H E A L T H   R I G H T S   H O T L I N E**  
**I N D E P E N D E N T   A S S I S T A N C E   F O R   H E A L T H   C A R E   C O N S U M E R S**

February 2, 2010

Consumer Participation Program  
Department of Managed Health Care  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814

**RE:   Application for an Award of Advocacy and Witness Fees**  
**2008-1579- Timely Access to Non-Emergency Health Care Services**

To Whom It May Concern:

The Health Rights Hotline (Hotline), a program of Legal Services of Northern California, is submitting this request to the Department of Managed Health Care (Department) for an Award of Advocacy and Witness Fees in the amount of \$42,697.09 for providing a substantial contribution to the Timely Access regulations. In this application for an award of fees the Hotline is including our activity in three related rulemaking actions: Access to Needed Health Care Services, Control # 2002-0018; Timely Access to Health Care Services, Control # 2005-0203, and Timely Access to Non-Emergency Health Care Services, Control # 2008-1579.

The Hotline's involvement made a substantial contribution to timely access regulation proceedings. The Hotline has been involved in timely access rulemakings since they began; Hotline staff have consistently commented on timely access regulations and participated in stakeholder groups since 2004. With each iteration of the regulations, the Hotline staff researched other states laws on Timely Access, and current law in California on timely access and other related matters. The Hotline participated in conference calls with other advocates to prepare responses to proposed regulations. The Hotline staff also read through our own client cases that dealt with timely access problems to fully understand where and how problems were occurring and how the proposed regulations would address the problems faced by Hotline callers.

The Department published the initial Access to Needed Health Care Services proposed regulation in 2004 and opened a public comment period. The Hotline submitted written comments on the proposed regulation to the Department on November 8, 2004. The Hotline's comments advocated for specified waiting time for triage for urgent care appointment. The final regulations do specify the waiting time for telephone triage appointments. The Hotline also requested that the regulations incorporate health plans' obligation to provide access to language assistance and culturally appropriate services. The final regulations do include language access. These first comments advocated for setting a global physician-patient ratio limit in addition to the physician-enrollee ratio standard. The Hotline also suggested that the regulations require health plans to have a documented system for monitoring and evaluating provider compliance with the standards. The comments pointed out how the monitoring called for in the regulations was not sufficient. The Hotline based its comments on data gathered from consumers who contacted the Hotline for assistance with Timely Access.

**Health Rights Hotline**  
**Request for an Award of Advocacy and Witness Fees**  
**2008-1579- Timely Access to Non-Emergency Health Care Services**  
**Page 2 of 5**

In 2005, the Department released a second version of the Access to Needed Health Care Services regulations. The Hotline submitted a second set of written comments to the Department on April 22, 2005. The Hotline's comments reiterated the issues above as well as advocating for requiring plans to submit a copy of their monitoring systems. These comments also stressed the importance of compliance and ensuring that the Department monitors compliance. Again, the Hotline based its comments on the experience of consumers who had contacted the Hotline for assistance with a timely access problem. The Department withdrew this rulemaking action on April 29, 2005. On June 17, 2005 the Hotline's managing attorney and staff attorney participated in a stakeholder meeting with the Department to discuss the future of timely access regulations.

In January of 2007, the Department released the initial version of the Timely Access to Health Care Services regulation and opened a public comment period which ended on March 5, 2007. The Hotline carefully compared the new version to the implementing statute and to the first and second versions, researched mental health parity laws, and reviewed Hotline data for new information to include in comments to the Department. The Hotline submitted written comments to the Department on March 5, 2007. These comments focused on the inadequate standards proposed for mental health, dental health, and durable medical equipment wait times. The Hotline provided client stories to illustrate why stricter standards were necessary. The final version of the regulations contains stricter time standards than were proposed in the January 2007 version. The Hotline also suggested replacing vague language such as "reasonable time" and "shortest time appropriate" with specific standards. The comments also asked for changes in compliance monitoring and survey methods. A Hotline staff attorney testified at the public hearing in Sacramento on March 5, 2007.

In July of 2007, the Department released a second version of the Timely Access to Health Care Services regulation and opened a public comment period which ended on September 21, 2007. The Hotline submitted comments on September 21, 2007 asking for shorter wait times for dental and mental health appointments. The Hotline also requested that it be specified that the need for an interpreter is not a patient caused delay. A section was included in the final regulation that does specify this in asserting that interpreter services shall be coordinated with scheduled appointments. The Hotline also requested that telephone access time standards apply to all plans and providers regardless of how they answer their calls. This was included in the final regulations. The Hotline again read through many of its own client cases that dealt with timely access problems to get an idea of where and how problems were occurring and how the proposed regulations would address the problems faced by Hotline callers. A Hotline staff attorney testified at the public hearing in Sacramento on September 18, 2007.

In December 2007, the Department released a third version of the Timely Access to Health Care Services regulations and opened up a brief public comment period. The Hotline submitted comments opposing these new regulations. We opposed the lack of specific timely access standards and the fact that this new rendition was not significantly related to the last. We also objected to the fact that specialty plans were entirely left out of these regulations. The Hotline again looked to our clients' experiences to inform our comments and researched requirements for notice and comment periods, language access and out-of-network access. The Office of Administrative Law disapproved these

**Health Rights Hotline**  
**Request for an Award of Advocacy and Witness Fees**  
**2008-1579- Timely Access to Non-Emergency Health Care Services**  
**Page 3 of 5**

regulations on February 27, 2008. The final regulations did go back to specific time standards and to including specialty plans.

From June to September 2008 the Department engaged stakeholders in a lengthy process to shape the future of the timely access regulations. The Hotline participated in all steps of this process including collaborating on written product with the Western Center on Law and Poverty and Health Access and attending and commenting at the stakeholder meetings.

In January 2009, the Department released the initial version of the Timely Access to Non-Emergency Health Care Services regulations. The Hotline submitted comments on February 23, 2009. The Hotline read through the prior versions of the timely access regulations to compare to the newer version. Our comments focused on wait time for dental care, compliance monitoring, and enrollee education. A Hotline staff attorney testified at the public hearing in Sacramento.

On June 10 2009 the Department put out a second version of the Timely Access to Non-Emergency Health Care Services regulations with a comment period to end on June 25, 2009. The Hotline submitted comments regarding changes to triage sections, and advocating for changes to the out-of-network policies as well as asking for timely access standards to be included in the plans' evidences of coverage.

The Hotline reviewed, but did not comment on the regulations released in July as the changes therein did not appear to affect consumers. The Hotline signed on to the Western Center on Law and Poverty's comments on the final round of comments in October 2009.

Through these activities, the Hotline made a substantial contribution to the Timely Access regulations. The Hotline presented relevant issues, evidence and arguments that were seriously considered by the Department which we believe resulted in more relevant, credible and non-frivolous information being available to the Director. Therefore, the Hotline is requesting an award of advocacy and witness fees in the amount of \$42,697.09.

Below are detailed time records of the specific activities undertaken by the Hotline including the activity, other parties involved in the proceeding, subject matter and work description, date of activity, time spent, billed amount and hourly rate for the staff involved in each activity.

The Hotline determined market rate for each staff member based on position, experience, and the number of years of experience for each staff member for whom fees are claimed. In developing the rates, the Hotline relied on both fees awarded in the past to the Hotline and to other organizations and the Public Utilities Commission (PUC) rates for the relevant years and experience.

Shelley Rouillard, the Hotline's Program Director from 1997 to 2007, had more than 25 years of experience in health and human services advocacy at the time that she participated in the timely access rulemaking procedure. The Hotline has submitted in the past in depth information on Ms. Rouillard's experience. The Hotline believes it is reasonable to request reimbursement at the rate of \$325 per hour for the work that Ms. Rouillard did on the timely access rulemaking in 2004. For the work Ms.

**Health Rights Hotline**  
**Request for an Award of Advocacy and Witness Fees**  
**2008-1579- Timely Access to Non-Emergency Health Care Services**  
**Page 4 of 5**

Rouillard did in 2006 and 2007 the Hotline believes it is reasonable to charge \$350 an hour<sup>1</sup>. These rates are based on PUC rates that the Department has relied on in the past. In 2006 the range of PUC fees awarded to non-attorney experts of all levels of experience was \$115-370 and in 2007 the range awarded to experts with more than 13 years of experience was \$150-380. We could not find information for 2004 but worked backwards based on the differences between the 2006, 2007, and 2008 fees to arrive at the reasonable rate of \$325 per hour for 2004.

Elizabeth Landsberg, the Hotline's Supervising Attorney from 2000 to 2005, had been an attorney for six years when she submitted comments in 2004 and seven in 2005. She has supervised advice and counseling provided through hotlines on a variety of issues. Before joining the Hotline, she worked at a women's rights public interest organization and as a law clerk to a Federal District Judge. She earned her law degree at the University of California, Berkeley School of Law (Boalt Hall). As Ms. Landsberg had six years of experience in 2004, seven in 2005 and was in a supervisory role the Hotline believes it is reasonable to charge \$260 an hour for her services in 2004 and \$270 an hour for her services in 2005. While we do not have information for the PUC rates at that time we worked backwards from the rates awarded in subsequent years for attorneys with 5-7 years of experience. Attorneys with 5-7 years of experience were awarded fees of \$260-\$280 in 2006, \$270-\$290 in 2007, and \$280-\$300 in 2008. Given these rates and Ms. Landsberg's experience we believe it is reasonable to charge \$260 in 2004 and \$270 in 2005.

Pramela Reddi was the Hotline's Staff Attorney/Policy Analyst from 2003 to 2005. She had been an attorney for two years when she submitted comments in 2004. She has a background in health care issues, having served as a graduate student assistant for the Office of Statewide Health Planning and Development and as a law clerk in the Summer Honors Program of the California Office of the Attorney General, Tobacco Litigation and Enforcement Section. She earned her JD at the University of California, Davis School of Law. The Hotline believes it is reasonable to charge \$170 for her services in 2004 based on her experience and the PUC rates for attorneys of 0-2 years that were awarded in 2006, 2007, and 2008.

Vanessa Franco followed Ms. Reddi as Staff Attorney/Policy Analyst in 2005. She has a background in public interest advocacy and publishing and earned her JD at Duke University School of Law. In 2005 Ms. Franco was not yet admitted to the California bar. The Hotline requested and was awarded a rate of \$150 for work Ms. Franco performed on the Block Transfer Regulations in 2005 when she was a legal graduate. Based on that passed award the Hotline believes it is reasonable to request an hourly rate of \$150 for work Ms. Franco performed in 2005. Ms. Franco continued her work on the regulations in 2006, by which time she was a licensed California attorney. In 2006 the range of fees the PUC paid for attorneys with 0-2 years of experience was \$140-\$195. The Hotline believes it is reasonable to request a rate of \$195 per hour for work Ms. Franco performed in 2006.

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<sup>1</sup> While these amounts are more than the Hotline has requested for Ms. Rouillard in the past we believe that they are reasonable because of her experience, the PUC rates, and awards the Department has made to non-attorneys with similar experience at Health Access. Based on similar evaluations of PUC rates and subsequent awards we have lowered the fees requested for work done by Elizabeth Landsberg and Pramela Reddi.

**Health Rights Hotline**  
**Request for an Award of Advocacy and Witness Fees**  
**2008-1579- Timely Access to Non-Emergency Health Care Services**  
**Page 5 of 5**

Ann Rubinstein, the Hotline's Staff Attorney/ Policy Analyst since 2006, earned her JD at the University of California, Berkeley School of law (Boalt Hall) in 2006 and was admitted to the California Bar in December 2006. The PUC's adopted hourly intervener rate range for 2007 for attorneys with 0-2 years experience is \$145-\$200 and for 2008 for attorneys with 0-2 years experience it is \$150-\$205. Based on these PUC rates, which the Department has relied heavily on in past opinion's granting awards of advocacy and witness fees, as well as the rates the Department has awarded the Hotline in the past, the Hotline believes it is reasonable to request reimbursement at the rate of \$200 for work Ms. Rubinstein performed in 2007, and \$205 for work she performed in 2008. Furthermore these were the amounts the department awarded for Ms. Rubinstein's work on the Unfair Billing Practices in 2007 and 2008. The PUC's adopted hourly intervener rate range for 2008 for attorneys with 3-4 years of experience is \$200-\$235. In 2009 Ms. Rubinstein was an attorney with 3 years of experience. The Hotline did not have information on rates awarded in 2009. The PUC generally allows a 3% COLA each year. We added 3% to the rate awarded to attorneys with 3-4 years of experience in 2008, resulting in the rate of \$242. The Hotline believes it is reasonable to charge a rate of \$242 an hour for work Ms. Rubinstein performed in 2009.

Julie Aguilar Rogado was the Hotline's Managing Attorney from 2007 to 2008. She earned her law degree at UCLA and was admitted to the State Bar in 1999. Ms. Aguilar Rogado has spent her entire legal career since law school at Legal Services of Northern California; the majority of her years have been spent in supervisory and managerial positions. Ms. Aguilar Rogado had 8 years of experience when she worked on the timely access regulations in 2007. The PUC rates awarded in 2007 for attorneys with 8-12 years of experience ranged from \$290-\$345. The Hotline believes it is reasonable to charge \$345 for work Ms. Aguilar performed in 2007. In 2009 when Ms. Aguilar Rogado again worked on the regulations she had 10 years of experience. The Hotline does not have information on what rates were paid in 2009. The rates paid for attorneys with 8-12 years of experience in 2008 were \$300-\$355. The PUC generally allows a 3% COLA each year. \$365 is 3% more than \$355. The Hotline believes it is reasonable to charge a rate of \$365 an hour for work Ms. Aguilar Rogado performed in 2009.

Thank you for your consideration of our request.

Sincerely,

Ann Rubinstein  
Staff Attorney

Attachment



HEALTH RIGHTS HOTLINE  
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

June 25, 2009

Department of Managed Health Care  
Attn: Emilie Alvarez, Regulations Coordinator  
Office of Legal Services  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814  
Via e-mail: regulations@dmhc.ca.gov

**RE: Timely Access to Non-Emergency Health Care Services Regulation;  
Control No. 2008-1579**

Dear Director Ehnes,

The Health Rights Hotline (Hotline) is submitting comments on the Department of Managed Health Care's (Department) proposed regulations Timely Access to Non-Emergency Health Care Services § 1300.67.2.2. The Hotline is a program of Legal Services of Northern California and provides information and assistance to health care consumers in El Dorado, Placer, Sacramento, and Yolo counties. The Hotline helps consumers better understand their health care rights and access health care services.

We have restricted our comments to the changes that were made to the most recent version of timely access regulations. Our comments regarding past versions, where our recommended changes were not made, still stand, including the fact that 48 hours is too long to wait for an urgent care appointment.

*Out of Network*

We are pleased that the proposed regulations now include wording to ensure that if a plan does not have sufficient network adequacy to provide an enrollee with a timely specialty appointment the plan has the obligation to arrange for, at no additional cost to the enrollee, an out of network provider. This should not just apply to specialty care but also to primary care when an enrollee cannot secure a timely appointment with either their primary care provider or another general practitioner in the health plan. A written plan detailing this process should still be measured under the Quality Assurance Process.

*Triage*

Triage wait times have been changed from 10 minutes to 30 minutes. A 30 minute wait is too long to be safe or effective. Patients call triage and screening services to determine if their ailment is something that requires immediate emergency room care, or if it will not kill or inflict major harm on them to wait for an appointment. In 30 minutes someone who is unsure if they are experiencing an emergency or an urgent need for health care services could suffer dire consequences if they are in fact experiencing an emergency.

Someone only experiencing an urgent need could, out of fear, decide that they cannot wait the 30 minutes and unnecessarily utilize emergency room resources costing the plan more or leading the plan to deny the services and unreasonably costing the beneficiary. The maximum acceptable triage wait time should be 10 minutes.

Section (c)(8)(D) adds that when providers are unable to meet the triage requirements the health plan must provide services that meet the triage requirement. This will allow small doctors' offices that do not have the capabilities to meet the requirements on their own to still be a part of the plan and utilize the plans greater resources. According to Section (a)(2) dental plans no longer have to comply with phone triage and screening rules. This will create a problem for dental beneficiaries trying to access dental care who are not sure when or if they need to come in to the dental office or if they should go to the emergency room instead. We understand that dental providers often have solo or small practices that do not have the capabilities to provide the timely triage and screening services required of the health providers. To remedy this, section (c)(8)(D) should also apply to dental providers and plans. When a dental provider cannot provide the triage and screening service the dental plan should step in and fill that roll for dental enrollees.

#### *Evidence of Coverage*

The Department is doing a great disservice to beneficiaries and eviscerating the effectiveness of timely access standards by removing the requirement for plans to include timely access standards in their evidence of coverage (EOC). The standards will mean nothing if enrollees do not know they have the right to access care in a timely manner including the definition of timely manner. Placing the standards in a newsletter or other enrollee communication is useful but it is not a sufficient replacement for printing the standards in the EOC. Newsletters and mailings are often not read and generally not saved by consumers. The EOC is usually saved by enrollees and used as a reference when an enrollee does need to access health care. The EOC is the one place that contains everything an enrollee needs to know about their rights and responsibilities under the plan; not including timely access standards would be missing an essential component of their rights under the plan.

We urge you to finalize these regulations quickly so health plan enrollees can start receiving and enforcing their right to timely access to needed health care.

Sincerely,

Ann Rubinstein  
Staff Attorney



H E A L T H R I G H T S H O T L I N E  
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

February 23, 2009

Department of Managed Health Care  
Attn: Emilie Alvarez, Regulations Coordinator  
Office of Legal Services  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814  
Via e-mail: regulations@dmhc.ca.gov

**RE: Timely Access to Non-Emergency Health Care Services Regulation; Control  
No. 2008-1579**

Dear Director Ehnes,

The Health Rights Hotline (Hotline) is submitting comments on the Department of Managed Health Care's proposed regulations Timely Access to Non-Emergency Health Care Services § 1300.67.2.2. The Hotline is a program of Legal Services of Northern California and provides information and assistance to health care consumers in El Dorado, Placer, Sacramento, and Yolo counties. The Hotline helps consumers better understand their health care rights and how to access health care services.

The Hotline appreciates that the Department of Managed Health Care (Department) has released another version of proposed regulations on timely access. Timely access barriers are a recurring issue for our clients. Eight percent of the calls we receive are regarding timely access to health care. The sooner these regulations are finalized the sooner clients will have clarity on when they should be able to access care and will be able to remedy problems with access to care. Since 2002, when the legislation calling for these regulations was passed, the Hotline has served more than 1,100 consumers with timely access to health care problems. If adopted, these regulations will potentially result in fewer consumer problems regarding timely access. When we do receive calls regarding timely access, we will be better able to remedy our clients' problems with enforceable standards on timely access to care, unlike in the following circumstance:

*"John" is a man in his late fifties who has health insurance through his employer. John was scheduled for gall bladder surgery but his doctors found cancer. They said he needed to see an oncologist for diagnostic testing and placed him on a liquid diet until he saw an oncologist. John waited almost two months for an appointment with an oncologist. During that time he unfortunately had to go to the emergency room, but regardless of the severity of his illness, the doctors and plan would not schedule the oncologist appointment any sooner.*

The Hotline would like to see the following changes made that will go farther to ensure that enrollees like John do receive timely access to needed health care.

### **Standards for Timely Access to Care**

We commend the Department for choosing time-elapsed standards to measure timely access to care. Time-elapsed standards are the only measure that clearly complies with the enacting legislation. Time-elapsed standards ensure that patients, providers, and plans all have the same comprehensible information.

### Interpreter Services

We are very pleased that the Department has added specific requirements for interpreter services in these regulations, and that they work in conjunction with § 1367.04. Many of our clients who have limited English proficiency are denied prompt care at the doctor's office because of lack of interpreters. In the worst situations clients receive inappropriate care because they cannot wait for an interpreter, which can lead to disastrous consequences. We recommend that the following language be inserted to clarify that interpreter requirements do not extend the time-elapse standards.

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 **and that complies with this section including (C)(5)**. This subsection does not modify the requirements established in section 1300.67.04, or approved by the Department pursuant to section 1300.67.04 for a plan's language assistance program.

### Plan Responsibility

To ensure that providers not only have the ability to comply with the time-elapsed standards but actually do comply we would like to see the following language added:

In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes, **and that it does offer appointments within the timeframes**.

### Urgent Care

The Department has increased the urgent care time-elapsed standard from past versions of the regulations. The standard was previously twenty-four hours. A wait time that exceeds twenty-four hours is unacceptable for people in urgent need of medical care. The proposed forty-eight hour standard will put patients at risk and increase the likelihood their conditions will worsen without treatment and force them to access care from an emergency department. Those who wait

the proposed forty-eight hours when it is medically inappropriate to do so will experience protracted pain and exacerbated medical conditions. Some medical conditions, when not treated in a timely manner, can lead to a lifetime of poorer health and increased medical costs to the health plan and the enrollee. Patients who go to the emergency room will cost the plan more for that visit and further congest our already overflowing emergency rooms. Emergency room visits for urgent care could also lead to expensive and draining billing problems for enrollees if the plan refuses to pay because the medical problem was not an emergency. All urgent care, including dental, mental and ancillary health, should be available within twenty-four hours.

### Dental Care

We are very pleased to see that the Department aligned the mental health standards with the physical health standards, and set out dental standards, although as stated above urgent dental and mental health care appointments should be offered in twenty-four hours. At the Hotline dental issues are one of the most common problems for our callers, and a large number of those calls are from clients who are not receiving timely access to appointments and care. Dental health is an integral part of overall health; these standards are just as important as the standards set out in section (c)(5). To that end the language after the first clause of (c)(6)(A) should be strengthened to mirror the language in section (c)(5)(G). We recommend the following:

Urgent appointments within the dental plan network shall be offered within ~~72~~ **24** hours of the time of request for appointment. ~~when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice~~ **The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the person providing triage and screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and documented in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.**

### Telephone Access

We are pleased that enrollees will not have to wait more than ten minutes to speak with a knowledgeable and competent representative. Having reliable available phone access will decrease emergency room visits and increase the likelihood that enrollees will receive appropriate and timely care.

## **Quality Assurance Processes**

### Provider Networks

To ensure that enrollees always have access to timely care, no matter what the circumstance of the provider network, the Department should add that when a nearby provider or provider in a neighboring service area is not available for a timely appointment, an enrollee may receive out of network care. The plan should have the responsibility of finding the timely out of network care for the enrollee. Out of network care provided due to lack of accessible in network providers should cost the enrollee no more than in network care and the plan should deal directly with that provider to get the services paid for.

### Compliance Monitoring

The only way to truly monitor plans to ensure they are providing timely access is to do secret shopper calls. Plans should be required to conduct anonymous as well as non-anonymous telephone surveys. Anonymous surveys provide accurate information as to what times are being offered to enrollees. In non-anonymous surveys, the providers know the times with which they should be complying and have an incentive to answer that appointments are available within those times. Anonymous surveys would remove that incentive to bend the truth. All plans should be monitored and report on the results in the same way to make the results easily understandable by consumers.

## **Enrollee Disclosure and Education**

The proposed regulations specify that in the Evidence of Coverage there will be details on timely access requirements, triage and screening services, and how to get assistance in cases of non-compliance. This published information will ensure that clients can have access to that information and have more knowledge of what they should be receiving. Enrollees will now know if their health plan and doctor are offering appropriate appointment times. The regulations also include that enrollees' plan cards will have the telephone number to access triage and screening services. That information is essential as many people do not read their evidence of coverage and do not have access to the information in their EOC when they need urgent care. The regulations should specify that this information in both the evidence of coverage and on the plan ID card will be provided in the enrollee's preferred language.

## **Alternative Standards**

Time-elapsd standards are the only ones that will truly provide timely access to care, and they are the only standards that fully comply with the implementing legislation. We do not support the Department allowing plans to develop alternate plans.

If alternate plans are permitted, they should be monitored in the same way as regular plans are monitored as feasible.

**Conclusion**

The Hotline commends the Department's efforts to ensure that consumers have the ability to access health care in a timely manner. We appreciate the opportunity to submit these comments.

Sincerely,

Ann Rubinstein  
Staff Attorney



H E A L T H R I G H T S H O T L I N E  
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

December 26, 2007

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**RE: Timely Access to Health Care Services Regulation; Control No. 2005-0203**

Dear Director Ehnes,

The Health Rights Hotline (Hotline) provides services to health care consumers in Placer, El Dorado, Yolo, and Sacramento Counties. We serve these consumers in a variety of ways including assisting them in receiving timely appointments and referrals. From this experience we know that relying on a health plan to come up with their own timely standards, adhere to them, and reveal them to clients is not reasonable.

Currently Health and Safety Code § 1383.15(c) requires that plans have timelines filed with the Department detailing how they process requests for second opinions. "Sarah", a current Hotline client, has been attempting to get a surgery performed by her Medi-Cal HMO for well over a year. The plan keeps denying her for different medical reasons and Sarah requested a second opinion. This second opinion is still pending even though during the past few weeks the Hotline has repeatedly contacted the plan to request a speedy resolution. The Hotline contacted the Department to find out what the HMO's timeline for second opinions is; the Department said the Hotline would have to contact the plan for that information. The Hotline contacted the plan who said they did not have that information on hand and suggested that the Hotline ask Sarah as it might be in her evidence of coverage. Sarah does not know the timeline and is still awaiting the result of her request for a second opinion. Sarah's situation illustrates that even when plans are required to have public timelines they do not routinely share them with beneficiaries. The Department's new proposed timely access regulations would keep things just as they are currently, with the health plans in control of when beneficiaries get care and beneficiaries suffering the consequences.

### **Timeliness Standards**

The Department had proposed detailed timeliness standards in the past two rounds of proposed regulations. While the Hotline did not fully support each and every time standard, overall we were very pleased with the proposed regulations as they would have brought clarity and rapidity to beneficiaries' pursuit of needed health care. The new regulations do not provide this. They keep things as they are now. The Department has taken §1367.03, which requires them to adopt regulations "to ensure that enrollees have access to needed health care services in a timely manner" and passed that responsibility on to the plans.

## Health Rights Hotline Comments on Proposed Regulations

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The Department's actions do not fulfill the requirements of §1367.03. They have only placed the onus of the regulations on the plans. The proposed regulations do not ensure that enrollees will receive timely access to health care; they simply require the plans to create their own standards based on vague professional standards which do not currently provide timely access. On top of that the Department has so weakened their proposed monitoring of compliance of these self-made regulations that there will be no valid way to show if the plans are adhering to their own standards.

The statute clearly placed the responsibility of developing timely access standards upon the Department. The Department cannot pass that responsibility on to the health plans. Furthermore, the Department is much better situated to create these standards than the health plans. The Department has done years of research on what these standards should be. The Department should take that knowledge and add to it the "professionally recognized standards of practice" and the "involvement from actively practicing health care providers," that they suggest plans use. Using all three resources the Department should create the comprehensive timely access standards that §1367.03 requires. This will yield stronger, less biased and more consistent standards than what the plans will have the resources or desire to create. Moreover, any standards the Department implements will have the added benefit of being vetted in the public comments process.

The result of health plan authorized standards will have a number of negative consequences. Beneficiaries who switch from one plan to another will encounter differing standards of care along the way. Beneficiaries who switch plans may not remember if they can get urgent care from their new plan in 24 or 48 hours, and when they are experiencing a need for urgent care they will not have the luxury of looking it up in their evidence of coverage. We urge the Department to go back to a system of specific timely access standards based on urgency and specialty, as well as to return to an effective version of compliance monitoring, so the regulations are in compliance with §1367.03 and so consumers actually receive timely access to care.

### **Statutory Requirements**

The proposed regulations are drastically changed from the last two rounds. No person could logically have expected this iteration to arise from the previous versions of timely access regulations. This can be seen in the fact that nearly all 20 pages of the second round were cut out and the 7 pages of this new regulation are almost entirely brand new. These major and significant changes were not "sufficiently related to the original text so that the public was adequately placed on notice that the changes could result from the originally proposed regulatory action" as the notice of the third comment period claims, and as Gov. Code § 11346.8 (c) requires. The department must publish a new notice with a 45 day comment period.

### **Specialty Plans**

## Health Rights Hotline Comments on Proposed Regulations

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The proposed regulations do not apply to dental, vision, chiropractic, acupuncture, or EAP plans. While the Hotline recognizes that the care these specific medical plans offer differs from the care full service health plans provide, we also know that when this specific medical care is needed, it is required in as timely a manner as any other health care service. Prompt dental attention is just as important as prompt medical attention. A child with an infected tooth needs timely care as much as a child with any other kind of infection. Under this proposed system, where only plans that use hospitals are covered, the beneficiary's right to timely care only arises once dental health becomes problematic enough to require a hospital setting. This is not only physically harmful to the beneficiary, it is fiscally irresponsible. We urge the department to apply the regulations to dental, vision, chiropractic, acupuncture, and EAP plans and services.

### **Office Waiting Times**

There should be guidelines for office waiting times. We often speak with clients who have waited hours in offices for care even when they had made appointments in advance. For many people long office wait times mean not getting care at all because they must return to work or caregivers for their children. LEP beneficiaries often have to wait long times in waiting rooms while interpreters are acquired. These regulations should specify that LEP beneficiaries cannot be provided a different standard of care than people who are English proficient. The Department should include office waiting times as an indicator of timeliness.

### **Interpretation**

There is no mention in these regulations of time guideline for acquiring an interpreter. The Department should expressly state that time to acquire interpreters, or serve LEP beneficiaries equally in any way, must be included in the plans' time standards. Not including this would discriminate against LEP beneficiaries, and violate §1367.04.

### **Out-of-Network Providers**

Currently the proposed regulations state in §(c)(4) that when a medical group cannot provide timely access, the beneficiary will be referred to another in-network provider. To ensure that beneficiaries always have access to timely care, even when their plans provider network is insufficient, the section should state that if another in-network provider is not available in a timely manner, the beneficiary will be referred to an out-of-network provider and the plan will pay for the treatment from that out-of-network provider.

Sincerely,

Ann Rubinstein  
Staff Attorney



HEALTH RIGHTS HOTLINE  
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

September 21, 2007

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**RE: Timely Access to Health Care Services Regulation; Control No. 2005-0203**

Dear Director Ehnes,

The Health Rights Hotline (Hotline) is an independent program that provides free information and assistance to health care consumers in El Dorado, Placer, Sacramento, and Yolo counties. Since its inception in 1997, the Hotline has served more than 26,000 consumers. In 2006, approximately 8 percent of issues reported by Hotline callers related to delays in obtaining needed health care services.

The Hotline appreciates this opportunity to comment on proposed regulations to ensure timely access to health care. The Hotline is pleased to see that Durable Medical Equipment providers were added to the list of ancillary and other providers in this iteration of the proposed regulations, and that the compliance and monitoring sections have been strengthened. Below are specific comments on the regulations and related case stories from the Hotline's direct experience assisting health care consumers. Please note that the names of Hotline clients have been changed to protect their identities.

### **Appointment Waiting Times**

The Hotline appreciates that the Department of Managed Health Care (Department) kept most of the specific wait times for primary and specialty care appointments in the new proposed regulations. Having reliable timely access to health care will have a large impact on the health of our clients, who now often have to wait weeks or months to receive primary or specialty care. For example,

*Trish is a woman in a Medi-Cal HMO. She had GI surgery two years ago but things went wrong. After the surgery she required another surgery to have her pelvic wall rebuilt, which was supposed to be done promptly. She received a referral for this follow-up surgery months after the GI surgery and was not able to get the actual surgery until over a year after the referral; she got through that time by taking antidepressants and painkillers. Trish was outraged with the delays in getting referrals and treatment, but Trish did not know what she could have done to speed things up or how she could now*

*file a complaint. The Hotline advised her that in the future she could seek assistance from her health plan, her medical group, and the HMO helpline. The Hotline advised Trish about who she could file a complaint with, but Trish seemed more interested in pursuing follow-up care than in filing a complaint.*

The specified times in the proposed regulations would ensure that in the future people in Trish's situation will not be forced to wait too long for health care. There are two areas where the Hotline would like to see the wait times shortened.

#### Dental Waiting Times

The Hotline was disappointed to see that the Department did not change the wait times for dental care. The wait times for dental appointments are far too long; this is highlighted by the large discrepancy between dental wait times and wait times for other specialty care. Dental care is an integral part of overall health care; making people wait so long for dental appointments will hurt not just their oral health but their overall health. Urgent dental care needs to be provided within 24 hours. 36 business days is too long to wait for routine dental care, in that amount of time routine care could change to urgent care. Similarly, 180 calendar days is too long to wait for preventative care. For those consumers receiving regular dental check ups, 180 days makes sense as a standard, but if a new patient who has not had dental care in many years makes an appointment they should be able to access preventative care much sooner. The Hotline suggests standards of 14 days for routine care and 60 days for preventive care.

#### Mental Health Waiting Times

The Hotline was similarly disappointed to see that the Mental Health appointment wait times were not shortened in this iteration of the proposed regulations. Urgent care for mental health needs to be accessible within 24 hours. 48 hours is too long for someone with an urgent mental health need to have to wait.

#### Telemedicine

The Hotline is pleased that the Department is embracing telemedicine as a way to ensure that beneficiaries living in rural areas can achieve meaningful timely access to health care. The Hotline is concerned that the way the regulations are currently written telemedicine could supplant in-person appointments. Electronic communication and telemedicine should only be used under certain circumstances; such as when an in-person appointment is not available in a proximate area and the medical issue is one that does not need to be closely examined. A consumer should be able to turn down a telemedicine appointment in favor of an in-person appointment and still have the in-person appointment offered in a timely manner.

### Enrollee Delay

The Hotline agrees with the Department that delay caused by the enrollee should not be included in the appointment waiting time. It is important to specify that needing an interpreter or other necessary accommodation would not be considered delay caused by the enrollee. The time to find an interpreter or make other needed accommodations should be included in the waiting times in this section and all other sections of the Timely Access regulations. Enrollees with language or other barriers often spend large amounts of time waiting for appointments or in doctors' offices. For example:

*Helena, a Russian speaking woman called the Hotline because she wanted to change her Denti-Cal HMO. She felt that she had received poor care. Her dentist did not extract teeth that needed to be extracted, she ended up going to another dentist and paying out of pocket to have the teeth extracted. Helena does not speak English and requires an interpreter at appointments. The doctor's office often canceled her appointments. When she came to scheduled appointments they made her wait. Helena has high blood pressure and once she was made to wait so long she passed out in the dentist's office. The Hotline gave Helena information on how to change HMOs, the Hotline also informed Helena of her right to make a complaint. Helena was not interested in filing a complaint because she wanted to focus on getting a new HMO and then getting a dental appointment, furthermore the complaint forms were not available in Russian.*

Including time to secure an interpreter is necessary to ensure that the Timely Access regulations do not conflict with the Language Assistance regulations. This section should read:

§1300.67.2.2 (b)(2) Appointment waiting time means the time from the initial request for health care services (by an enrollee or provider to a provider, provider's office, or to the plan) to the time offered for the appointment for services (or the provision of a report to referring provider), inclusive of: (A) time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers; (B) triage time, if triage is provided; (C) time for arranging for an interpreter to be at the appointment in cases where an interpreter is requested; and (D) time for arranging for other necessary accommodations related to an enrollee's impairment.

### **Telephone Access**

Telephone access to a qualified professional within 15 minutes during office hours is an excellent standard. The Hotline is concerned that this standard has an exception in the circumstance that a professional is not immediately available. This exception should be deleted; otherwise the standard can be completely circumvented because providers' offices could just ensure that professionals are never available from their phone intake stations. If the standard is retained, the

regulation should specify a time within which the professional will return the call, such as thirty minutes. Thirty minutes would give the professional a reasonable amount of time to come back and make the call and is not too much time if the consumer is experiencing an urgent or emergency situation and needs clarification about what to do. As the regulation is now, a consumer calling during office hours when a provider is not available has less assurance of someone calling back in a timely manner than a consumer who calls after office hours.

If providers have an answering machine, there should be a specific time in the regulation in which they have to return the call. Currently the regulation states that a call must be returned in a time “consistent with good professional practice.” §1300.67.2.2 (C)(3)(A)(ii)(II). That language is too vague; a time should be specified to bring it in line with the rest of the regulations. The message should specify how much time it will take for the provider to return the call or how the consumer can contact an available qualified professional.

There should be a requirement that providers and plans have an after hours access system, whether it be a machine or answering service, otherwise they will be able to circumvent this section of the regulations all together by making themselves completely inaccessible after hours.

Some plans do not allow separate access to their providers. Consumers in those plans must call the plan to reach their provider. Those plans should have to follow the after-office hours’ guidelines that providers must adhere to.

### **Office Waiting Times**

What were previously standards here have been reduced to guidelines. Cal. Health & Safety Code §1367.03 is entitled “Development of standards for timely access to health care services.” §1367.03 is located within Article 5 of the Knox-Keene Act, which is entitled “Standards.” Standards are specifically called for. Reducing a section that should be a standard to a guideline, seems to render that section unenforceable. The regulations discuss what the Department must do to evaluate compliance with standards but there is nothing about compliance with guidelines. *See* §1367.03(f)-(j). This new wording will prevent enforcement of the office waiting times, in conflict with the regulation. In all sections where the word “guideline” is used it should be deleted and replaced with “standard.” For example the section regarding office waiting times should begin:

§1300.67.2.2 (c)(3)(B)(iii)(4) Quality Assurance Standards for office waiting times: All plans shall establish quality assurance standards for office waiting times. Except for delay caused by exigent or unforeseen circumstances (for example, a provider called to handle an urgent or emergency patient condition), a general office waiting time standard shall be:

### **Monitoring**

Plans should be required to conduct anonymous as well as non-anonymous telephone surveys. Anonymous surveys provide accurate information as to what times are being offered to enrollees. In non-anonymous surveys, the providers know the times with which they should be complying and have an incentive to answer that appointments are available within those times. Anonymous surveys would remove that incentive to bend the truth. Furthermore non-anonymous surveys may not reveal the whole story of when appointments are available. Appointments for certain types of procedures or consumers may be available far earlier than for other types of procedures or consumers. For example:

*Johnny is an infant who is new to his Medi-Cal HMO. He had an urgent need to see his Primary Care Physician. Johnny's grandmother told the PCP's office that Johnny had a spreading rash and swelling and that Johnny would not stop crying. The PCP's office told Johnny's Grandmother that they could not see him because the first available appointment they had for new patients was not for over a month. They went on to say that if Johnny was an established client they could see him that day but as he was new he would have to wait over a month.*

At the March 5, 2007 Timely Access hearing, plans voiced concerns about the logistics of the secret shopper calls and the amount of time it would take. Since anonymous calls are more effective than non-anonymous calls, if time to do the surveys is a concern, we would urge the department to adopt the secret shopper surveys in lieu of the non-anonymous surveys. As for the anonymous calls jamming up the books and taking appointments away from real patients, the anonymous appointment could be cancelled soon after the call or even at the end of the call where the appointment is made. Audits of providers' records should be conducted along with anonymous surveys.

The Hotline appreciates that the Department took the time to translate plan and provider compliance into measurable percentages; this is a sensible way to determine when a plan is out of compliance. We do think consumer complaints should be taken seriously, especially as a way to find egregious instances of non-compliance, but they should not be used as a measure of the plans compliance. Adding 5 percent to a plan's score for not having consumer complaints is not an accurate measurement. Consumer complaints are not a good measure of how compliant a plan is with the Timely Access regulations. Many consumers will not know of their right to complain, or will not have the time to complain after waiting too long to talk to someone or to schedule an appointment. Helena and Trish's stories above illustrate further reasons why consumers may not file complaints. The number of consumers who complain will be a very small percentage of the number of consumers who actually experience problems. If the Department continues to use this system we urge them to take several steps to ensure that beneficiaries know specifically when they should be getting access to appointments and how they can go about complaining. These

steps should include all EOCs listing the specific times in which consumers must be able to access appointments and telephone and office wait times. These times should also be posted in all providers' offices and played on provider and plan recordings during telephone wait times.

The regulation outlines special steps that preferred provider organizations need to take. These steps should be in addition to compliance with the rest of the regulations, not the only requirement for PPO compliance. Otherwise people who enroll with PPOs will not receive their health care in the same timely manner as those in HMOs.

The Hotline is pleased to see that there is an option for plans to coordinate on the Enrollee Satisfaction survey and to use standardized questions jointly prepared by multiple plans and approved by the department. Standard questions will provide a more meaningful comparison between the plans. The Hotline would urge the Department to have all the plans use standardized, jointly prepared questions and cut out the option of creating their own individual questions. Individually prepared questions will make plans less comparable. Even if the plan can show that they are meeting all the timely access requirements it will not allow the data to be aggregated with data from all the plans. The statute expressly states that health plan reported data will allow "consumers to compare the performance of plans." Cal. Health & Safety Code §1367.03(f)(2). Unless the plans use standardized questions the data collected will not meet this requirement.

**Conclusion**

The Hotline applauds the Department's efforts to ensure that consumers have the ability to access health care in a timely manner. We appreciate the opportunity to submit these comments.

Sincerely,

Ann Rubinstein  
Staff Attorney



H E A L T H R I G H T S H O T L I N E  
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

March 5, 2007

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

Dear Director Ehnes,

The Health Rights Hotline (Hotline) is an independent program that provides free information and assistance to health care consumers in El Dorado, Placer, Sacramento, and Yolo counties. Since its inception in 1997, the Hotline has helped consumers better understand their health care rights and access health care services. Since its inception in 1997, the Hotline has served more than 25,000 consumers. In 2006, approximately 8% of issues reported by Hotline callers related to delays in obtaining needed health care services.

The Hotline appreciates this opportunity to comment on proposed regulations to ensure timely access to health care. The Hotline appreciates the amount of time and effort the Department of Managed Health Care (Department) has put into these essential regulations. The timely access regulations will help to ensure meaningful access to health care for health care consumers. The Hotline is pleased to see that the proposed regulation includes more specific times and standards than previous drafts. Below are specific comments on the regulations and related case stories from the Hotline's direct experience assisting health care consumers. Please note that the names of Hotline clients have been changed to protect their identities.

(a)(3) Delegation and Responsibility. The Hotline supports the Department continuing to hold plans responsible for timely access compliance even when plans delegate their responsibilities to provider groups or specialized plans. We hear from clients who are caught in the middle between plans and medical groups, neither of which want to take responsibility for the access problem the patient is experiencing. We believe these regulations will help prevent that from happening in the future.

(a)(3)(B) This section is difficult to understand. It is not clear what the Department is attempting to convey in this section. Further, "contacting" health care provider should be changed to "contracting" health care provider.

(b)(1)(A) Appointment Waiting Time. The Hotline is very pleased to see that the time for obtaining authorization and completing other plan requirements is included in the calculation of

overall appointment wait time. We often get calls from consumers who have waited too long for care because an authorization has yet to come through, or due to other administrative issues. Waiting for referrals has taken months for some callers.

*Carol is in her fifties and in a dental plan. She had all of her upper teeth pulled in September. In November she called the Hotline because she had not received dentures. Carol reported that the dentist and the plan kept having miscommunications. The dentist would send information to the plan that the plan would say was wrong but not tell the dentist what he needed to send so that the dentures would be approved. The Hotline called the plan and found out what was needed to approve the dentures. The Hotline informed the dentist's office what they needed to submit. The dentures were approved the next day. However, due to a lengthy process of ordering, making, and fitting dentures which the plan said there was no way to speed up, it took several more months for Carol to actually receive her dentures. She skipped Thanksgiving, Christmas, and New Year's celebrations with her family because she was so embarrassed by her lack of teeth. Carol did not receive dentures until late January, five months after her teeth were pulled. Carol felt that her nutrition suffered during those five because she could not eat vegetables. Carol also suffered emotional and mental health problems during those five months without teeth.*

(b)(1)(B)The Hotline understands that specialists do not have control over enrollee delays or the time it takes to relay test results to specialists. There should be a way to assure that test results do not delay care by an unreasonable length of time. In addition to standard waiting times for a specialist appointment and the standards in (c)(2)(D)(i) regarding ancillary and other provider accessibility, there should be standards specifying time within which routine tests must be performed and standards for the time in which the test results must be sent to the ordering provider. This will help assure that testing done outside of the specialist's control will still occur within a reasonable time.

(b)(2) Office Waiting Time. An extended wait time in the examination room is a reality some patients experience at the doctor's office. The Hotline is pleased to see the department recognize this reality and specifically include wait time in an exam room in calculating the overall wait time.

(c)(2)(A) Primary Care Accessibility. The Hotline applauds the Department for making urgent primary care accessible within 24 hours.

(c)(2)(C) Mental Health Care Accessibility. The Mental Health Care access standards are insufficient when compared with the primary care and specialty care standards. The option to have either in person or electronic communication appointments is not reasonable. Electronic

communication is not an adequate way to meet an urgent mental health care need. A provider needs to actually see a patient to assess his or her current mental state and needs. A mental health patient in the midst of a psychotic break may not be able to accurately describe their symptoms to a provider via phone or e-mail. Two days (48 hours) is too long to wait for any urgent appointment. A 24 hour wait for an in-person appointment would be sufficient but electronic communication is insufficient.

Under the proposed regulation, there must be an initial evaluation within 10 business days for routine mental health but the actual appointment can be scheduled an additional 14 days after the evaluation. In other words, a patient could go 24 or more days while waiting for an actual appointment. This is much longer than the 10 days for routine primary care appointments and 14 days for routine specialty care appointments. Twenty-four days is not a reasonable amount of time to wait for routine mental health care. Mental health care should not be more difficult to obtain than standard medical care for those who reach out for help.

(c)(2)(D) Ancillary and Other Provider Accessibility. The Hotline supports specific standards set out for ancillary and other provider access. However, durable medical equipment (DME) suppliers also should be specifically identified in this section. For persons needing DME, living without the equipment for even a short amount of time could have a dramatically negative effect on their quality of life and ability to function. Someone who cannot get a working wheelchair within a reasonable time will likely be prevented from going about their daily activities, including working. For example,

*Colleen is a middle aged woman with disabilities. She belongs to an HMO through her employer. Colleen has been experiencing difficulties obtaining a wheelchair that meets her needs. She waited a year for approval for a new wheel chair. Once approved, she received a wheelchair from her DME supplier but it was not the one she ordered. It was too big for Colleen and too heavy for her van. Because the chair could not go on the van lift, she could not get to work. Colleen informed her DME supplier that her wheelchair was not properly fitted for her and was too heavy for her car lift. The DME supplier said they would resolve the problem but after a year she still had the wrong chair. The Hotline made a conference call to the DME supplier and spoke with a supervisor. In two weeks, the DME supplier measured Colleen for a new chair which was supposed to be delivered in a few weeks. Colleen called the Hotline two months later because she had still not received her chair.*

(c)(2)(E)(ii)(sic<sup>1</sup>) Hospital Accessibility. Using “the shortest time appropriate” is too vague a standard by which to measure timeliness of routine hospital care. We would prefer to see a specific measurement standard that the Department can use in its compliance monitoring.

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<sup>1</sup> (c)(2)(E)(ii) should be (c)(2)(E)(iii).

(c)(2)(F) Specialized Plan Accessibility. The Hotline is pleased to see that waiting times for specialized plans is detailed. We support most of the wait times, including 24 hours for urgent chiropractic care.

Waiting times for dental care, however, noticeably depart from the other standards. Routine dental care within 42 days is unacceptable. A month and a half is too long to wait for routine care of any sort; other specialties must provide routine care in 14 days and dental care should not be an exception. In 42 days untreated routine dental care can become urgent dental care. Similarly 180 days is too long for preventive dental care. A person should not have to wait 6 months to have their first cleaning when they have signed up with a new dentist. The Hotline suggests standards of 14 days for routine dental care and 60 days for preventive dental care.

The Hotline has seen many egregious examples of consumers in dental HMOs who have gone without needed dental care for long periods of time. For example,

*Abby is a woman in her thirties, enrolled in a dental HMO. Abby had a root canal done in October but a crown was not placed on the tooth at that time. The dental office stated the earliest appointment they could give her to put a crown on was four weeks away. She was instructed to subsist on soup and other soft foods for that month. Abby was in pain while waiting for her crown, the dental office offered her pain medication but could not get her in for the crown earlier than one month. Abby asked the Hotline if there was any law that protected her from having to wait so long, the Hotline informed Abby that she could file a complaint with her dental plan and with the HMO Help Center.*

(c)(3) Quality Assurance for Timely Telephone Access. Under the proposed regulation neither the plan nor the provider has to keep records to show compliance with telephone access standards. Rather, the regulation simply states that the plan keep records of any enrollee or provider complaints regarding telephone wait time. Relying on people to take the initiative to complain is an unacceptable standard. Someone who is sick and has waited a long time for access to a health care provider may not have the time or energy to lodge a complaint, and may not even know of their right to do so. Most of the Hotline callers know very little about their rights to complain or where they can make a formal complaint. Complaints should be one measure the Department uses to monitor plan's quality assurance standards and used in conjunction with another monitoring system to assure timely telephone access.

(c)(3)(H) The regulation proposes that when a provider's office uses an answering machine, the office must return the call "within a reasonable time." To be consistent with the rest of the regulation, and to ensure that all enrollees have timely access to necessary care regardless of the callback system their provider uses, this section should provide a more concrete standard. We

support the Western Center on Law and Poverty's amendment to this section regarding how to contact a qualified professional for triage when the provider's office uses a recorded message to answer telephone calls.

*Cynthia and her three children are in a Medi-Cal HMO. She has been trying to get the children in to see their primary care physician. Every time she calls to make an appointment, the office is closed, and no one calls her back. Cynthia had been dealing with this problem for too long and was fed up. The Hotline did a conference call with Cynthia to her HMO and assisted her in finding a new primary care physician for the children.*

(c)(3)(I) The Hotline supports the time standards for providers calling to request prior authorization.

(c)(5)(6)(7) In these sections the term "quality improvement standards" should be changed to "quality assurance standards," to be consistent with sections (3) and (4).

(c)(5) Appointment Changes or Cancellations. The Hotline has concerns about the wording in this section that allows a provider to cancel or change an appointment without prior notice to address exigent scheduling needs. While we understand that there may be situations where a provider is called to an emergency, the regulation should limit how many times an appointment can be cancelled. Some Hotline clients have had appointments cancelled several times in a row. These appointments are not always rescheduled within the month. Others have come to their appointment only to be told that the appointment has been cancelled. Consumers should be notified at least 48 hours in advance of a cancelled appointment and a new appointment should be scheduled at that time.

*Mee is a Hmong-speaking child who is enrolled in a Denti-Cal HMO and needs dental care. Mee's father made appointments for her twice and both times the appointments were cancelled when she showed up to get care. The day before the first appointment, Mee's father called the office and confirmed the appointment. Yet when Mee came in for care, the dentist refused to see her claiming that she did not have an appointment. Mee's father made another appointment. When she came in for that appointment Mee waited several hours in the waiting room and then she was denied care because the dentist had too many patients. Mee's father asked the Hotline how he could go about changing plans, he had already changed providers several times within the plan and each provider presented access problems. The Hotline gave him information on how to change plans.*

(c)(6) Follow-up or Standing Appointments. "Good professional practice" is too broad of an exception for follow up or standing appointments. The regulation should have a more concrete

standard. We encourage the Department to create specific standards to ensure clients receive timely access to follow-up care.

(c)(7) Enrollee Requests for Specific Specialists. The Hotline supports informing both the enrollee and the referring provider when there is a delay in obtaining an appointment with a specific, desired specialist. Currently, the referring provider may not be informed of these developments when they occur. A provider may assume there has been a successful referral when, in fact, the enrollee is waiting for needed care beyond the required standards. Section (c)(9) offering appointments with alternate providers, should also include a reference to informing a referring provider when appointments with alternate providers are offered.

(d) Alternative Standards; Material Modifications. The Hotline is pleased to see that plans must demonstrate that any alternative standards are more appropriate than the standards in the regulations. The Hotline supports the list of facts and circumstances that justify using alternative standards.

(d)(1)(B) The Hotline suggests changing “Provider shortage” to “Provider availability.” While the plan may have, on paper, what appears to be an adequate provider network based on Knox Keene standards, as a practical matter, a patient may not be able to get an appointment for a long period of time because the provider practice is very busy. This would not necessarily indicate a provider “shortage,” but rather a lack of provider “availability.” In these cases, the plan should make arrangements for a patient to see an appropriate provider outside the medical group or health plan network within the required timeframe. To help ensure that access to a provider is true access, the Hotline supports the Western Center on Law and Poverty’s comments that there be a global cap on the number of patients for whom one physician is responsible.

(d)(2)(D) This section should be rephrased to make it clearer that the plan needs to provide a method for educating enrollees about their rights to timely access. We suggest the following language:

(D) The specific steps the plan will take to provide timely access to enrollees within the affected service area including **the process the plan will use to educate enrollees about their right to timely access to care and the steps an enrollee can take when timely access standards have not been met.**

(e) Compliance Monitoring. The Hotline is pleased to see the new requirement of a “valid and reliable methodology.” We also support surveying persons who were disenrolled from the plan. In the last sentence of the paragraph, “contacting” should be “contracting.”

(e)(2) We believe that the most effective way to monitor the plans is through auditing provider records and secret shopper telephone surveys. We recommend that the Department strike sections

(B) and (D), thereby requiring the plans to utilize the methodologies in (A) and (C) which are more likely to accurately reflect the compliance of the provider's office. Non-anonymous phone calls and provider surveys may not elicit accurate information on the actual wait times within a plan.

(f) Plan's Enrollee Satisfaction Survey. The Hotline urges the Department to add language to require plans to conduct enrollee satisfaction surveys in the threshold languages as required under the language assistance program regulation (§1300.67.04). The Department should add language to all sections where language access is a factor. For example, the length of time to get an interpreter should be included in calculating overall waiting times.

(h) (2) Compliance and Implementation. The Hotline is pleased to see that the regulation requires the plans to file descriptions of their educational programs in their Evidence of Coverage and disclosure forms. This will ensure that beneficiaries have access to information about their rights and what to do when they must wait longer than is acceptable.

(k) No New Cause of Action. The Hotline suggests that the Department clarify that while these regulations do not add any new cause of action they are also not taking away any existing causes of actions or rights.

(l)(2) Alternative Monitoring and Reporting Requirements. This section should be removed. Monitoring from one year to the next is critical to assure compliance. Without yearly monitoring plans that had performed well one year could fall out of standards in the unmonitored year, but the Department would not be aware of this problem until the following year after many enrollees had been deprived of their right to timely access and had perhaps suffered serious health consequences.

## **Conclusion**

The Hotline applauds the Department's efforts to ensure that consumers have the ability to access health care in a timely manner when they truly need it. We appreciate the opportunity to submit these comments.

Sincerely,

Ann Rubinstein  
Staff Attorney



H E A L T H R I G H T S H O T L I N E  
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

November 8, 2004

Office of Legal Services  
Department of Managed Health Care  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814  
*Via e-mail: [regulations@dmhc.ca.gov](mailto:regulations@dmhc.ca.gov)*

**RE: Comments on Proposed Regulation  
2002-0018 Access to Needed Health Care Services**

To Whom It May Concern:

On behalf of the Health Rights Hotline, I am submitting comments on the proposed Access to Needed Health Care Services regulations. The Hotline is an independent program that provides information and assistance to health care consumers in El Dorado, Placer, Sacramento, and Yolo counties. Since its inception in 1997, the Hotline has helped consumers understand their health insurance benefits and access services.

Timely access to health care services is an important issue for consumers. In 2003, nineteen percent of the HMO enrollees who contacted the Hotline experienced access to care problems due to provider availability and difficulty scheduling appointments. Implementation of regulatory standards for timely access to health care services will help to overcome access barriers and ensure patients get the care they need.

**Section 1300.67.2(d) – Physician-enrollee ratio**

The proposed regulation would set a standard for physician-enrollee ratio. Under this standard the ratio would apply to a physician and the number of enrollees per contracted health plan. Effectively, the physician's overall patient ratio could be much higher than the standard depending on the number of plans with which the physician is contracted.

We suggest that the regulation set a global physician-patient ratio limit in addition to the physician-enrollee ratio standard. The physician-enrollee ratio requires a health plan to demonstrate it has an adequate number of contracted physicians for its enrollees. In addition, the global ratio would require the health plan to demonstrate that its contracted physicians do not have excessively large panels of patients due to contracts with multiple health plans. The global physician-patient ratio would limit the number of patients for whom each contracting physician is responsible.

We suggest the regulation require health plans to monitor the total number of patients

**Comments on Proposed Regulation**  
**2002-0018 Access to Needed Health Care Services**  
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under the care of their contracted physicians. This is particularly feasible for primary care physicians who have panels of assigned patients. Primary care physicians typically are provided by health plans periodic lists of their assigned patients. These lists indicate the number of patients assigned to each physician. A global limit on the number of patients under the care of each physician in addition to the physician-enrollee ratio will help to ensure timely access to health care services.

**Sections 1300.67.2(h)(1) and 1300.67.2.2(d), (e), and (f) – Monitoring and documentation of compliance with appointment standards**

We support the appointment standards set forth in subsection 1300.67.2.2(a). We also support the regulations requiring health plans to have a documented system for monitoring and evaluating provider compliance with the standards. Though subsection 1300.67.2.2(d) requires health plans to “adopt reasonable and effective mechanisms using valid methodology to monitor on a periodic basis provider compliance with the access standards,” we suggest the regulations incorporate more oversight on the method of monitoring.

We suggest the regulations require health plans to submit their proposed monitoring protocol to the Department before the first year in which they are required to file an annual report pursuant to subsection 1300.67.2.2(f). This would allow the Department to prospectively determine whether the monitoring protocol includes “reasonable and effective mechanisms using valid methodology.” This would still allow health plans the flexibility to develop their own monitoring protocol. Without effective and reliable monitoring methods, assessing compliance by the health plans and providers with the appointment standards set forth in the regulations will be difficult.

Additionally, we oppose health plans using survey results from the current Consumer Assessment of Health Plans Study (CAHPS<sup>®</sup>) to demonstrate compliance. CAHPS is designed to evaluate patients’ general satisfaction with providers and access. Two of the survey questions address appointments but they do not address the specific time periods in which appointments were offered. Thus the survey results, either positive or negative, would not indicate whether specific appointment standards were met. While the regulations do not state that plans may use the CAHPS to monitor and demonstrate compliance, health plans may choose to do so if there is no indication that the CAHPS is not a sufficient tool for demonstrating compliance with the appointment standards. We suggest the regulations state that the CAHPS surveys are not sufficient to demonstrate compliance with the appointment standards. Rather, the monitoring protocol should assess whether patients were offered appointments within the standard times.

**Section 1300.67.2.2(d) – Waiting time for triage for urgent care appointment**

The proposed regulation does not set a specific standard for an enrollee’s waiting time to

**Comments on Proposed Regulation**  
**2002-0018 Access to Needed Health Care Services**  
**Page 3 of 3**

speak to a qualified professional for urgent care appointment triage. Subsection 1300.67.2.2(a)(1)(B) does establish that after determining the necessity for urgent care an appointment must be offered within 24 hours. For this time frame to be meaningful, the enrollee must have timely access to telephone triage.

We suggest the regulation include a specific waiting time limit to ensure timely access to urgent care appointments. As some triage systems require the patient to leave a telephone message in order for a qualified professional to contact the patient, the patient should have an expectation as to when she will receive a call-back. We suggest the outer limit for waiting time be 4 hours. Moreover, this will prevent enrollees from accessing care through hospital emergency departments due to lack of timely telephone access to their provider's office.

**Language assistance and culturally appropriate services**

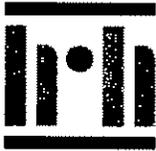
Senate Bill 853 (2003) amended the California Health and Safety Code to require commercial health plans to provide language assistance and culturally appropriate services to their enrollees. The statutes describe the requirement, which will be further developed through regulations, to engage in: linguistic needs assessments; translation of documents; interpreter services; culturally sensitive recruitment, retention and education of staff; and evaluation of the health plan's programs and services. The change in law recognizes that California communities are ethnically and linguistically diverse. Census data from 2000 indicate nearly forty percent of Californians speak a language other than English at home and over half the population is non-white.

We suggest the current regulations incorporate health plans' obligation to provide access to language assistance and culturally appropriate services. Specifically, linguistically and culturally appropriate services are a necessity for timely access to needed health care services. Evaluation of the availability of providers and compliance with appointment standards should consider the linguistic and cultural needs of the enrollees. Giving an appointment within the prescribed time without an interpreter would be insufficient for a limited English proficient patient. These regulations should reference sections 1367.04 and 1367.07 of the Health and Safety Code with regard to monitoring and evaluating accessibility of care.

Thank you for your consideration of these comments based on the experience of the Health Rights Hotline. If you have questions I can be reached at (916) 551-2147.

Sincerely,

Pramela Reddi  
Staff Attorney



H E A L T H R I G H T S H O T L I N E  
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

22 April 2005

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

Via facsimile: 916-322-3968

**RE: Comments on Proposed Regulation  
2002-0018 Access to Needed Health Care Services**

To Whom It May Concern:

These comments on the proposed Access to Needed Health Care Services regulations are on behalf of the Health Rights Hotline. The Hotline is an independent program that assists health care consumers in El Dorado, Placer, Sacramento, and Yolo counties. Since its inception in 1997, the Hotline has helped consumers understand their health insurance benefits and access services.

As we stated in our letter commenting on the last version of these regulations, the Hotline hears from numerous health care consumers who have problems accessing timely care. These regulations establishing standards for access to care will assist these consumers in getting appropriate care timely and will aid us in assisting consumers in getting care.

**Section 1300.67.2(d) – Physician-Enrollee Ratio**

We are concerned that the Department has eliminated the requirement that plans, in contracting with provider groups, must have one full-time equivalent provider to each 1,200 enrollees. While the Department has importantly retained the required ratio of one primary care physician for each 2,000 enrollees the broader ratio should also be maintained to establish some reasonable benchmark on the total number of providers needed for a set number of enrollees. We encourage the Department to reinstate the 1,200 enrollee to one provider ratio requirement.

The Hotline also reiterates our previous concern that as written the ratio applies per contracted health plan as opposed to imposing a global physician-patient ratio. A global ratio is the only effective way of ensuring that providers do not contract with multiple health plans and cumulatively have more patients assigned to them than they can effectively and timely serve.

**Section 1300.67.2(h) and 1300.67.2(f), (i) – Monitoring and Evaluation**

The Hotline commends the Department for adding to those accessibility elements the health plans must monitor “which providers’ practices are closed to new patients.” 1300.67.2(h)(1). We hear from numerous managed care consumers whose health plans referred them to providers who are no longer taking new patients. This is a frustrating experience for consumers which wastes their time and requires needless effort and phone calls. Knowing how many of its contracted providers are accepting new patients is critical to a plan’s ability to accurately assess the accessibility of its providers and give appropriate referrals to its members.

The regulations have been further strengthened by laying out the specific activities that should be included in plans’ accessibility monitoring and by including a range of activities to accurately monitor accessibility. This combination of patient surveys, review of grievances, and planned as well as unplanned audits should allow a plan to effectively gauge its compliance with the accessibility standards.

While these specific requirements regarding a monitoring system are well-designed to monitor compliance with the accessibility standards the Hotline still believes that the Department should require plans to submit their proposed monitoring protocol ahead of time. Currently, the regulations only require that health plans submit annual reports regarding their monitoring and compliance but the Department will have no prior notice if a plan’s monitoring system is not adequate. Since the regulations already require that plans have a documented such monitoring systems, submitting a copy of the monitoring systems would not be unduly burdensome.

**Section 1300.67.2.2 (d) – Triage Systems**

The revised proposed regulations still do not set a specific time frame by which a provider is expected to return an enrollee’s message requesting an urgent appointment – a significant and troubling omission. Simply requiring that the provider “attempt to contact the enrollee in a timely manner appropriate for the enrollee’s health care needs consistent with good professional practice,” section 1300.67.2.2 (d)(2), is insufficient to ensure timely access to care. The whole point of a triage system is to determine which requests for appointments are indeed likely urgent. If a consumer cannot speak to a qualified provider for screening or triage she cannot know if her need for care is urgent or not. In our experience, many consumers rightly rely on such triage systems for advice prior to going to an urgent care clinic or emergency room. Without timely access to triage advice consumers may needlessly utilize these expensive options. For these reasons, the Hotline urges the Department to adopt a specific waiting time standard for triage as it has done for different levels of appointment. Again, the Hotline suggests that the regulation state that the waiting time for triage not exceed four hours.

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Relying on consumer complaints to monitor the adequacy and accessibility of triage services is insufficient. Many health care consumers do not know of their option to file a complaint with their health plan regarding accessibility problems nor how to do so. Moreover, many ill consumers are not in a position to file a complaint given their conditions. The regulations should both set forth a time frame for triage services and a recordkeeping requirement to ensure that consumers have access to this important component of health care services. Without such recordkeeping neither the health plans nor the Department can effectively monitor compliance with the screening and triage requirements.

**Section 1300.67.2.2 (e) – Compliance**

The Hotline supports the regulation’s expectation that if a plan’s contracting providers cannot offer appointments in keeping with the timeframe standards, that it should arrange for the enrollee to see a non-contracted provider. The regulation also rightly explicitly states that in such circumstances, the enrollee is only responsible for the co-payment that would apply to a visit with a contracting provider. The regulation should specify that this information must be included in the enrollee disclosures required by section 1300.67.2.2 (j). Many health care consumers will not know that if their health plan does not have a contracted provider the plan should arrange for them to see a non-contracted provider for the same co-payment. Including this information in the accessibility information the Department is rightly requiring in health education program materials will help ensure that consumers know the specific avenues they have to get needed health care services.

**Section 1300.67.2.2 (l) – Department Review of Compliance**

The Hotline supports the adoption of specific factors the Department will look to in evaluating plan compliance with the accessibility standards. We suggest that the following factors be added or amended as follows:

- Add as a factor “the extent of non-compliance, e.g. the number of days beyond the timeframe standards specified in the regulation.” A plan whose enrollees have to wait an average of 60 days for specialty care is non-compliant to a greater extent than a plan whose enrollees have to wait an average of 35 days for specialty care.
- Add as a factor “the adequacy of the plan’s monitoring plan.” Plans should be given an incentive to effectively monitor compliance with the standards and rewarded for doing so.
- Add as a factor “any corrective actions the plan took to remedy its non-compliance.” A plan that immediately took effective corrective action to remedy non-compliance should be viewed more favorably than a plan that delayed action or adopted ineffective compliance measures.

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- Factor (3) reads “the adequacy of a plan’s mechanism to make alternative arrangements for enrollees when contracting providers are unable to meet the standards.” This is difficult to follow. Instead it should simply state “the extent to which the plan arranged for enrollees to see non-contracting providers when the contracting providers could not meet the standards.”

**Language Assistance and Culturally Competent Services**

As previously stated, the Hotline suggests these access to care regulations should address health plans’ obligation to provide access to language assistance and culturally appropriate services pursuant to Senate Bill 853 (2003). Access to care is ineffective if Limited English proficient (LEP) consumers are given an appointment with in the required time without an interpreter. An appointment with a specialist is not effective if consumers cannot communicate their symptoms and medical history and cannot understand the provider’s diagnosis and recommended course of treatment. Because linguistic and cultural competency are so critical to effective health care services, these standards should be incorporated in all the Department’s access standards – rather than only as a separate set of standards. These accessibility regulations should reference sections 1367.04 and 1367.07 of the Health and Safety Code. Evaluation of the availability of providers and compliance with appointment standards should consider the linguistic and cultural needs of the enrollees.

Thank you for your consideration of these comments based on the experiences of the health care consumers served by the Health Rights Hotline. If you have questions I can be reached at (916) 551-2182.

Sincerely,

Elizabeth A. Landsberg  
Acting Program Director / Supervising Attorney

Activity	Other Parties Involved in Proceeding	Subject Matter and Work Description	Date of Activity	Staff	Exact Time Spent (hour)	Position	Amount Billed for Task	Hourly Rate
Administrative		Print out notice of proposed rulemaking	7/9/2004	Shelley Rouillard	0.02	Program Manager	\$7.67	\$325.00
Document Review		Read proposed regulations	7/22/2004	Shelley Rouillard	0.25	Program Manager	\$81.25	\$325.00
Legal Research		Review proposed regulations	8/3/2004	Pramela Reddi	0.17	Staff Attorney/Policy Analyst	\$28.90	\$170.00
Meeting	Pramela Reddi	Meet with Pramela to discuss regulations	8/11/2004	Shelley Rouillard	0.25	Program Manager	\$81.25	\$325.00
Meeting	Shelley Rouillard	Meet with Shelley to discuss regulations	8/11/2004	Pramela Reddi	0.25	Staff Attorney/Policy Analyst	\$42.50	\$170.00
Legal Research			8/18/2004	Pramela Reddi	0.25	Staff Attorney/Policy Analyst	\$42.50	\$170.00
Document Review		Review amended notice, check for updates text	10/6/2004	Pramela Reddi	0.25	Staff Attorney/Policy Analyst	\$42.50	\$170.00
Document Review		Reviewed Access Hearing transcript	10/7/2004	Pramela Reddi	0.35	Staff Attorney/Policy Analyst	\$59.50	\$170.00
Administrative		printed report	10/22/2004	Pramela Reddi	0.25	Staff Attorney/Policy Analyst	\$42.50	\$170.00
Administrative	Elaine Paniewski	E-mails with Elaine re: Access meeting	10/25/2004	Pramela Reddi	0.25	Staff Attorney/Policy Analyst	\$42.50	\$170.00
Report Running		Ran report on cases with access problems 00-04	10/26/2004	Pramela Reddi	0.25	Staff Attorney/Policy Analyst	\$42.50	\$170.00
Document Review		Reviewed 8/16/04 Hearing Transcript	10/26/2004	Pramela Reddi	1.25	Staff Attorney/Policy Analyst	\$212.50	\$170.00
Meeting	Pramela Reddi, Elizabeth Landsberg	Meet with Pramela and Elizabeth re proposed regulations and HRH response	11/2/2004	Shelley Rouillard	0.25	Program Manager	\$81.25	\$325.00
Meeting	Pramela Reddi, Shelley Rouillard	discussed draft regs in HRH systemic meeting	11/2/2004	Elizabeth Landsberg	0.25	Supervising Attorney	\$65.00	\$260.00
Meeting	Shelley Rouillard, Elizabeth Landsberg	Met to discuss HRH's response to access regs	11/2/2004	Pramela Reddi	0.25	Staff Attorney/Policy Analyst	\$42.50	\$170.00
Legal Research			11/2/2004	Pramela Reddi	2.25	Staff Attorney/Policy Analyst	\$382.50	\$170.00
Legal Research	Cheri Gisler	Researched issues in in regs, discussed with Denti-Cal	11/5/2004	Pramela Reddi	4.00	Staff Attorney/Policy Analyst	\$680.00	\$170.00
Legal Research		Drafted, Edited, and submitted comment letter	11/8/2004	Pramela Reddi	6.00	Staff Attorney/Policy Analyst	\$1,020.00	\$170.00
Letter		edited draft letter to DMHC commenting on regs.	11/8/2004	Elizabeth Landsberg	0.50	Supervising Attorney	\$130.00	\$260.00
Document Review		Reviewing changes to regs by DMHC	4/21/2005	Elizabeth Landsberg	0.67	Supervising Attorney	\$179.63	\$270.00
Document Review		reviewing revised regs and other background material	4/21/2005	Elizabeth Landsberg	0.70	Supervising Attorney	\$189.00	\$270.00
Letter		Comments on regulations	4/21/2005	Elizabeth Landsberg	2.00	Supervising Attorney	\$540.00	\$270.00
Letter		finishing the letter commenting on regs	4/22/2005	Elizabeth Landsberg	0.49	Supervising Attorney	\$133.28	\$270.00
Administrative		coordinating meeting with DMHC re: regs over last several weeks	6/14/2005	Elizabeth Landsberg	0.50	Supervising Attorney	\$135.00	\$270.00

Document Review		reviewing other advocacy groups' reg comments in preparation for mtg w/Dept	6/14/2005	Elizabeth Landsberg	0.76	Supervising Attorney	\$205.35	\$270.00
Meeting		Meeting	6/17/2005	Vanessa Franco	3.00	Staff Attorney/Policy Analyst	\$450.00	\$150.00
Meeting	Suzanne Chammout	Met with Suzanne Chammout at DMHC re: approach to regs.	6/17/2005	Elizabeth Landsberg	3.00	Supervising Attorney	\$810.00	\$270.00
Document Review		reviewing comments in preparation for meeting with EAL, Beth, and Beth	1/31/2006	Vanessa Franco	0.85	Staff Attorney/Policy Analyst	\$164.88	\$195.00
Meeting	Elizabeth	with Elizabeth Landsberg, Beth Capell, Beth Abbot,	1/31/2006	Vanessa Franco	1.58	Staff Attorney/Policy Analyst	\$308.75	\$195.00
Data Analysis		determining fields for RT to run report for Monday's meeting	2/1/2006	Vanessa Franco	0.26	Staff Attorney/Policy Analyst	\$50.05	\$195.00
Preparation		Preparing issue/action brief for SR for this afternoon's meeting	2/6/2006	Vanessa Franco	0.59	Staff Attorney/Policy Analyst	\$114.62	\$195.00
Meeting	CAHP, Health Access, Physicians Association	with CAHP, Health Care Access, Physicians association	2/6/2006	Vanessa Franco	2.32	Staff Attorney/Policy Analyst	\$451.64	\$195.00
Document Review		reading relevant portions of Knox-Keene Act	2/6/2006	Vanessa Franco	0.52	Staff Attorney/Policy Analyst	\$101.62	\$195.00
Meeting	Shelley Rouillard	with SRL to discuss today's meeting	2/6/2006	Vanessa Franco	0.51	Staff Attorney/Policy Analyst	\$100.26	\$195.00
Data Analysis		finishing memo for SR re client examples of excessive wait times	2/6/2006	Vanessa Franco	0.73	Staff Attorney/Policy Analyst	\$141.75	\$195.00

\$7,203.15

Activity	Other Parties Involved in Proceeding	Subject Matter and Work Description	Date of Activity	Staff	Exact Time Spent (hour)	Position	Amount Billed for Task	Hourly Rate
Intake Call		Reading new Regs	1/31/2007	Ann Rubinstein	1.28	Staff Attorney/Policy Analyst	\$255.44	\$200.00
Letter		Writing memo to SR on new regs	2/2/2007	Ann Rubinstein	2.07	Staff Attorney/Policy Analyst	\$413.17	\$200.00
Document Review		Readin SRs Timely Access File	2/8/2007	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$400.00	\$200.00
Document Review		Reading Vanessa/ Pramela's TA file	2/15/2007	Ann Rubinstein	0.98	Staff Attorney/Policy Analyst	\$196.50	\$200.00
Legal Research		Reading Statute	2/16/2007	Ann Rubinstein	0.54	Staff Attorney/Policy Analyst	\$107.22	\$200.00
Letter		Editing 1st draft of comments per meetin w/ SR	2/20/2007	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$400.00	\$200.00
Legal Research		Mental Health ParityResearch; Indiv cause of action research	2/20/2007	Ann Rubinstein	2.24	Staff Attorney/Policy Analyst	\$448.00	\$200.00
Meeting	Shelley Rouillard	Met w/ Shelley to discuss proposed regs/ comments	2/20/2007	Ann Rubinstein	0.80	Staff Attorney/Policy Analyst	\$160.00	\$200.00
Letter		writing TA comments	2/21/2007	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$200.00	\$200.00
Letter		Editing comments based on mtg	2/23/2007	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$200.00	\$200.00
Letter		Working on Comments	2/26/2007	Ann Rubinstein	1.14	Staff Attorney/Policy Analyst	\$228.00	\$200.00
Legal Research		1367.03	2/27/2007	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$200.00	\$200.00
Letter To		Finalizing TA comments	3/1/2007	Ann Rubinstein	5.34	Staff Attorney/Policy Analyst	\$1,068.00	\$200.00
Preparation	Shelley Rouillard	Writing testimony- preparing for hearing, met with	3/2/2007	Ann Rubinstein	5.86	Staff Attorney/Policy Analyst	\$1,172.00	\$200.00
Letter		Preparing testimony	3/5/2007	Ann Rubinstein	1.50	Staff Attorney/Policy Analyst	\$300.00	\$200.00
Letter To		Finalizing and sending comments	3/5/2007	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$200.00	\$200.00
Presentation		Testifying at hearing, attending hearing	3/5/2007	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$400.00	\$200.00
Document Review		Reading 2nd iteration of regs	8/6/2007	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$200.00	\$200.00
Document Review		Reading and comparing old comments/ regs to new regs	8/7/2007	Ann Rubinstein	3.00	Staff Attorney/Policy Analyst	\$600.00	\$200.00
Document Review		Reading proposed regs	9/4/2007	Ann Rubinstein	1.67	Staff Attorney/Policy Analyst	\$334.00	\$200.00
Legal Research		Reading/ comparing statute, new reg and old regs	9/5/2007	Ann Rubinstein	1.57	Staff Attorney/Policy Analyst	\$314.00	\$200.00
Letter		Writing first draft of comments	9/6/2007	Ann Rubinstein	2.34	Staff Attorney/Policy Analyst	\$468.00	\$200.00
Data Analysis		Reading through cases for relevant stories	9/7/2007	Ann Rubinstein	3.54	Staff Attorney/Policy Analyst	\$708.00	\$200.00
Document Review		Reading old HRH comments, old hearing notes on timely access	9/10/2007	Ann Rubinstein	1.37	Staff Attorney/Policy Analyst	\$274.00	\$200.00
Legal Research		Writing/ Editing comments	9/11/2007	Ann Rubinstein	2.50	Staff Attorney/Policy Analyst	\$500.00	\$200.00
Letter		writing comments/ read wclp's comments/ research recent dental studies	9/12/2007	Ann Rubinstein	1.50	Staff Attorney/Policy Analyst	\$300.00	\$200.00
Letter		writing and prepping testimony, editing comments.	9/13/2007	Ann Rubinstein	4.63	Staff Attorney/Policy Analyst	\$926.00	\$200.00
Presentation		Testifying at hearing, attending hearing	9/18/2007	Ann Rubinstein	6.50	Staff Attorney/Policy Analyst	\$1,300.00	\$200.00

Letter		Editing comments	9/20/2007	Ann Rubinstein	1.08	Staff Attorney/Policy Analyst	\$216.00	\$200.00
Letter		Writing comments- editing several times over	12/26/2007	Ann Rubinstein	3.00	Staff Attorney/Policy Analyst	\$600.00	\$200.00
Legal Research		Researching govt code on notice rules, language access rules, current req timeline, and out-of network rules for ta comments	12/26/2007	Ann Rubinstein	2.50	Staff Attorney/Policy Analyst	\$500.00	\$200.00
Letter		Review and Edit AR's comments to DMHC regs on Timely Access	12/26/2007	Julie Aguilar Rogado	0.30	Managing Attorney	\$103.50	\$345.00
Meeting	DMHC and stakeholders	DMHC TA 1st Stakeholders Meeting	6/30/2008	Ann Rubinstein	4.00	Staff Attorney/Policy Analyst	\$820.00	\$205.00
Document Review		going through dmhc files	7/7/2008	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$410.00	\$205.00
Document Review		Reviewing TA File	7/16/2008	Ann Rubinstein	3.00	Staff Attorney/Policy Analyst	\$615.00	\$205.00
Letter		Beginning TA chart, reviewing old bills	7/17/2008	Ann Rubinstein	4.00	Staff Attorney/Policy Analyst	\$820.00	\$205.00
Letter To		Drafting 1st proposal	7/21/2008	Ann Rubinstein	2.50	Staff Attorney/Policy Analyst	\$512.50	\$205.00
Phone Call - Outgoing	Jen Flory, Elizabeth Landsberg	Conference call with Jen Flory and Elizabeth Landsberg re top proposals draft	7/21/2008	Ann Rubinstein	1.60	Staff Attorney/Policy Analyst	\$328.00	\$205.00
Letter To		Writing up proposal and rationale for issues 3 and 4	7/22/2008	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$410.00	\$205.00
Phone Call - Incoming	Elizabeth Landserg	Call w/ EL re: specifics for issue 7. and prep for and post revisions.	7/23/2008	Ann Rubinstein	1.81	Staff Attorney/Policy Analyst	\$371.62	\$205.00
Conference Call		TA call	7/24/2008	Ann Rubinstein	1.50	Staff Attorney/Policy Analyst	\$307.50	\$205.00
Document Review		Reading other stakeholders plans	7/30/2008	Ann Rubinstein	2.50	Staff Attorney/Policy Analyst	\$512.50	\$205.00
Document Review		Timely Access- reading other groups responses	8/11/2008	Ann Rubinstein	3.25	Staff Attorney/Policy Analyst	\$666.25	\$205.00
Document Review		Preparing reactions to TA comments	8/14/2008	Ann Rubinstein	3.50	Staff Attorney/Policy Analyst	\$717.50	\$205.00
Letter To		Working on Response to other ta proposals	8/15/2008	Ann Rubinstein	2.60	Staff Attorney/Policy Analyst	\$533.00	\$205.00
Letter To		Working on Items 3 and 4 responses	8/18/2008	Ann Rubinstein	0.09	Staff Attorney/Policy Analyst	\$19.36	\$205.00
Letter		TA responses- reading over EL's first edits	8/18/2008	Ann Rubinstein	1.40	Staff Attorney/Policy Analyst	\$287.00	\$205.00
Letter To		Issue three and four responses	8/18/2008	Ann Rubinstein	0.47	Staff Attorney/Policy Analyst	\$96.63	\$205.00
Document Review		editing responses	8/20/2008	Ann Rubinstein	0.48	Staff Attorney/Policy Analyst	\$98.63	\$205.00
Document Review		going over TA stuff for tomorrow	9/2/2008	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$410.00	\$205.00
Meeting	DMHC and stakeholders	Timely Access stakeholder meeting on issue 1	9/3/2008	Ann Rubinstein	5.00	Staff Attorney/Policy Analyst	\$1,025.00	\$205.00
Meeting	DMHC and stakeholders	Informal Stakeholder Meeting	9/4/2008	Ann Rubinstein	2.92	Staff Attorney/Policy Analyst	\$598.60	\$205.00
Document Review		Looking over timely access upcoming issues for the	9/9/2008	Ann Rubinstein	1.16	Staff Attorney/Policy Analyst	\$237.80	\$205.00
Meeting	DMHC and stakeholders	Informal Stakeholders meeting- Issues 3 and 4	9/10/2008	Ann Rubinstein	5.00	Staff Attorney/Policy Analyst	\$1,025.00	\$205.00
Meeting	DMHC and stakeholders	Timely Access Stakeholders meeting- Issues 5,6,7	9/11/2008	Ann Rubinstein	4.00	Staff Attorney/Policy Analyst	\$820.00	\$205.00

Conference Call	Jen Flory, Elizabeth Landsberg	With JF and EL re informal regs	11/4/2008	Ann Rubinstein	0.62	Staff Attorney/Policy Analyst	\$127.44	\$205.00
Document Review		Reading latest version of proposed regs and writing down initial thoughts	1/6/2009	Ann Rubinstein	1.97	Staff Attorney/Policy Analyst	\$476.14	\$242.00
Letter		Writing comments to proposed TA regulations	2/6/2009	Ann Rubinstein	1.53	Staff Attorney/Policy Analyst	\$371.13	\$242.00
Letter		Writing Timely Access Comments	2/20/2009	Ann Rubinstein	4.00	Staff Attorney/Policy Analyst	\$968.00	\$242.00
Document Review		Reading WCLP comments and old HRH comments	2/20/2009	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$242.00	\$242.00
Letter		Editing Timely Access Comments	2/21/2009	Ann Rubinstein	3.00	Staff Attorney/Policy Analyst	\$726.00	\$242.00
Letter		Writing Timely Access Comments	2/21/2009	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$484.00	\$242.00
Letter		edit written comments and testimony draft from ar	2/22/2009	Julie Aguilar Rogado	1.50	Managing Attorney	\$547.50	\$365.00
Letter		Editing Timely Access testimony	2/23/2009	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$242.00	\$242.00
Presentation		Testifying at hearing, attending hearing	2/23/2009	Ann Rubinstein	2.00	Staff Attorney/Policy Analyst	\$484.00	\$242.00
Document Review		Reading 6/09 TA regs	6/16/2009	Ann Rubinstein	1.00	Staff Attorney/Policy Analyst	\$242.00	\$242.00
							\$30,243.94	

Activity	Other Parties Involved in Proceeding	Subject Matter and Work Description	Date of Activity	Staff	Exact Time Spent (hour)	Position	Amount Billed for Task	Hourly Rate
Document Review		Reviewed proposed draft of regs, past comments from HRH and Health Access	2/6/2006	Shelley Rouillard	0.50	Program Manager	\$175.00	\$350.00
Meeting	Vanessa Franco	Met with Vanessa to prepare for meeting with CAHP, CAPG, CMA and consumer advocates	2/6/2006	Shelley Rouillard	0.50	Program Manager	\$175.00	\$350.00
Conference Call	Elizabeth Landsberg, Beth Cappell, Beth	Conf Call w/ EAL, Beth Capell, Beth Abbott re upcoming mtg w/ DMHC	10/17/2006	Shelley Rouillard	0.75	Program Manager	\$262.50	\$350.00
Document Review		Read regulations in preparation for conf call w/advocates	10/17/2006	Shelley Rouillard	0.50	Program Manager	\$175.00	\$350.00
Document Review		Reading case summaries, enacting legislation, prior regulations and comments	10/23/2006	Shelley Rouillard	1.00	Program Manager	\$350.00	\$350.00
Meeting	Elizabeth Landsberg, Beth Cappell, Beth	Meeting with Steve Hansen/DMHC, EAL/WCLP, Beth Capell & Beth Abbott/Health Access, Sarah Mercer/LIF re draft regulations	10/24/2006	Shelley Rouillard	3.00	Program Manager	\$1,050.00	\$350.00
Legal Research		Research waiting times in GMC medical and dental contracts	10/25/2006	Shelley Rouillard	0.50	Program Manager	\$175.00	\$350.00
Letter	Elizabeth Landsberg	E-mail to EAL regarding waiting times in GMC health and dental contracts	10/25/2006	Shelley Rouillard	0.25	Program Manager	\$87.50	\$350.00
Phone Call	Elizabeth Lansberg	To EAL @ WCLP re access standards in Medi-Cal managed care contracts	10/31/2006	Shelley Rouillard	0.25	Program Manager	\$87.50	\$350.00
Letter	Steve Hansen	E-mail to Steve Hansen @DMHC regarding Medi-Cal managed care contract standards	10/31/2006	Shelley Rouillard	0.25	Program Manager	\$87.50	\$350.00
Document Review		Review draft comments to timely access regulation	2/5/2007	Shelley Rouillard	0.25	Program Manager	\$87.50	\$350.00
Document Review		Read proposed regulations	2/20/2007	Shelley Rouillard	1.00	Program Manager	\$350.00	\$350.00
Document Review		Compare proposed regs with Oct 15, 2006 draft	2/20/2007	Shelley Rouillard	0.50	Program Manager	\$175.00	\$350.00
Document Review		Review proposed regs and Ann's comments	2/20/2007	Shelley Rouillard	0.25	Program Manager	\$87.50	\$350.00
Meeting	Ann Rubinstein	Meet with Ann to discuss proposed regs and HRH comments	2/20/2007	Shelley Rouillard	0.75	Program Manager	\$262.50	\$350.00
Letter		Review Ann's draft letter and WCLP draft letter	3/1/2007	Shelley Rouillard	1.50	Program Manager	\$525.00	\$350.00
Meeting	Ann Rubinstein	Meet w/Ann to review and discuss letter	3/2/2007	Shelley Rouillard	1.25	Program Manager	\$437.50	\$350.00
Letter		Finalize letter and testimony for public hearing	3/4/2007	Shelley Rouillard	2.00	Program Manager	\$700.00	\$350.00

\$5,250.00