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RE: Comments on the Department of Managed Health Care (DMHC)'s Proposed Regulation of Health Care Services Plans Regarding Language Assistance Programs: Proposed Adoption of Section 1300.67.04 and Deletion of Subsection (f) of Section 1300.67.8 - Control No. **2004-0115 Language Assistance Programs**

Dear Director Lucinda Ehnes:

On behalf of the Health Consumer Alliance, the National Health Law Program (NHeLP) and the Western Center on Law and Poverty (WCLP), are submitting these comments in response to the Department of Managed Health Care's publication of its proposed regulations on December 23, 2005. The Health Consumer Alliance (HCA) is a partnership of consumer assistance programs operated by community-based legal services organizations in twelve counties whose mission is to help low-income people obtain essential health care. NHeLP, as the lead agency of HCA, is a national, public interest law firm whose mission is to provide legal expertise to advocates, providers, and policy makers to promote and protect health care coverage and access for low-income and vulnerable individuals served by publicly-funded health programs, with a special focus on limited-English proficient (LEP) populations. WCLP, as the support center for HCA, advances and enforces the rights of low-income Californians in health, housing and public assistance by working statewide for systemic change and seeks to improve the lives of low-income people through litigation, education, legal support to social and legal services providers, legislation and policy advocacy. We appreciate the opportunity to provide comments during the formal comment period for DMHC's proposed regulations on managed care plans' language assistance programs.

WCLP was one of the sponsors of SB 853 to ensure that health plans provide culturally and linguistically accessible services to their members. NHeLP has been working with the Department of Managed Health Care (DMHC) over the last several years to ensure that culturally and linguistically competent services are provided to immigrant and LEP populations, and specifically for the last six months on these regulations. Moreover, we monitored the passage of SB 853, as well as conferred with other advocates on various versions of the regulations proposed by the DMHC.

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We commend DMHC for publishing these critically important regulations that establish a floor for managed care plans to ensure that all health plan enrollees receive the necessary language assistance that they are entitled to. We strongly support the requirement that all health plans must provide interpreters for any LEP member free of charge at all points of contact, which includes all network provider sites. We also support the requirement that vital documents and vital information must be translated into threshold languages as defined in the statute.

However, there are several areas where the regulations do not conform to the statutory requirements and/or do not provide enough clarity regarding the language assistance requirements. Therefore, we have many recommendations to the proposed regulations that we believe are necessary to fulfill the intent of the statute and/or would help clarify the standards and requirements. We will begin with some general comments, then present more specific recommendations in the order which they appear in the regulation and not necessarily in the order of importance.

General Observations

The proposed regulations do not provide sufficient guidance to the health plans in terms of uniform criteria and standards, and allow each plan too much flexibility in developing its own standards. The lack of standards in the proposed regulations will make monitoring and enforcement difficult. For example, the regulations simply require the plans to submit a description of the methods which they use to assess the threshold languages. This may result in plans using different methods to determine the threshold languages for which vital materials must be translated so that two plans in the same county may translate materials in different languages though both serve the same area. The regulations should provide more guidance on the method and data that the plans must use to determine the threshold languages, and/or define the methodology for the plans on how to calculate the threshold languages.

Moreover, the regulations only require the plans to describe their internal policies and procedure but contain no mechanism to ensure that culturally and linguistically services are actually provided to plan members. The current regulations also do not provide clear requirements or standards for the four elements of the language assistance program, especially with regard to the standards for enrollee assessment, providing language assistance services, and compliance monitoring, as required by the statute. Thus, DMHC is only monitoring the policies and procedures of the plans and not the actual provision of services or providing clear guidelines for the plans to follow to establish and maintain their language assistance programs.

Another serious drawback with the proposed regulations is the weak reporting requirements for the health plans and the lack of an explicit, separate monitoring of health plan compliance with the regulations. We would strongly support the use of a matrix tracking the regulations, similar to a matrix proposed by DMHC earlier, which would establish a more standardized approach for plan filings. We believe that using a monitoring tool such as the matrix will provide guidance for the plans on the specific requirements for which DMHC expects the plans to comply. Current plan filings and audits for other purposes would not provide the necessary audit tool that DMHC must have in order to measure and evaluate plan compliance with the proposed regulations. (*See* CA. Code of Regulations §1300.67.04(e) for amended regulatory language).

I. Deemed Compliance and Exemptions

A. Medi-Cal and Non-Medi-Cal Lines of Business

The statute, Health & Safety Code § 1367.04(h), and its proposed regulations apply to all health care service plans. The only lines of business which may meet another standard are Medi-Cal lines of business, which are regulated by the Department of Health Services (DHS), but only if three conditions are met: 1) the plan must meet the same or similar standards as the Medi-Cal program, either by contract or state law; 2) the standards must provide as much or greater access to cultural and linguistic services as the standards established by this section for an equal or higher number of enrollees and therefore meet or exceed the minimum standards established in this section; and 3) the Department must determine that the plan is in compliance with the Medi-Cal program standards. The proposed regulations as written incorrectly allow those health plans with both Medi-Cal and non-Medi-Cal lines of business to adopt the Medi-Cal cultural and linguistic standards for their non-Medi-Cal or commercial lines of business. There is no authority in the statute to permit this type of “deemed compliance.” The current regulations are also unclear regarding DMHC monitoring of those plans and does not explain if, and how, it will monitor them. Therefore, because the statute does not allow any plan to be exempt from auditing by DMHC, except Medi-Cal plans, and even in that case, only if it meets the above three criteria, including DMHC’s determination that the health plan is being appropriately audited by DHS, the regulations must be changed. The language clearly states that only Medi-Cal plans have the option to be found in compliance by the Department of Health Services and therefore all other health plans with non-Medi-Cal enrollees must comply with the standards established by this section, which is explicitly stated in Health & Safety Code § 1367.04(h)(3).

Even if permitted, the use of “deemed” compliance by non-Medi-Cal lines of business raises several problems. The proposed regulations could allow non-Medi-Cal lines of business to avoid any type of audit or monitoring for compliance. DHS does not audit non-Medi-Cal lines of business and thus, non-Medi-Cal lines of business, including commercial lines, may not be audited at all. Moreover, the Department of Health Services (DHS) only audits its Medi-Cal managed care plans periodically and in a random fashion, and does not share the results of the audits with the general public. It is unclear to consumers and advocates whether the Medi-Cal health plans are actually in compliance with their contract requirements. Furthermore, in order for DMHC to determine whether the plan is in compliance with the Medi-Cal standards, it must audit both the Medi-Cal and the non-Medi-Cal lines of business to ensure that the plans are either meeting the Medi-Cal standards or the minimum standards as set forth in this section. DMHC should not rely on the claims of the health plan or DHS that the plan is using the Medi-Cal standards for language assistance programs for its non-Medi-Cal lines of business when neither the health plan nor DHS has any incentive to actually verify that this is true. Finally, if the standards established by the statute and proposed regulations exceeds those provided to enrollees in the Medi-Cal health plans, all enrollees would be entitled to the increased access provided by the proposed DMHC standards, even Medi-Cal enrollees. DMHC must remove the “deemed compliance” language and include language clarifying that all health care service plans will be audited in some fashion by DMHC. (*See* CA. Code of Regulations §1300.67.04(a) for amended regulatory language).

B. Medicare Part D Prescription Drug Plans

In the current version of the proposed regulations, Medicare enrollees are also incorrectly exempt from these regulations. As stated earlier, the statute does not allow for any health care service plans to be exempt from Health & Safety Code § 1367.04 and its implementing regulations, except for those with contracts with DHS under certain circumstances as explained above. There should not be any exemption for Medicare plans, at least Medicare Part D plans. Part D prescription drug plans were created pursuant to the Medicare Modernization Act of 2003 and should be subject to these regulations, pursuant to AB 1359 (Chan), which explicitly provided DMHC authority to regulate Medicare Part D plans. According to Health & Safety Code § 1350, health service plans, which operate a prescription drug plan, must be licensed by DMHC and subject to the licensure requirements under the Knox-Keene Act. (See CA. Code of Regulations § 1300.67.04(a) for amended regulatory language).

II. Needs Assessment and Data Collection

There are several problems with the proposed regulations with regard to the enrollee assessment and data collection requirements in the statute.

A. Demographic Profile of Enrollees

First, the proposed regulations do not conform to the statutory requirement pursuant to Health and Safety Code § 1367.07 that mandates plans to conduct a demographic profile of its members. The current regulations lack the requirement for plans to collect the race and ethnicity, as well as the primary spoken and written language of each individual enrollee. According to Health & Safety Code § 1367.04(b)(3), plans must develop and update the needs assessment and **demographic profile** of their enrollees. The proposed regulation does not provide any data elements beyond primary language, which should be collected. Both the Medi-Cal and Healthy Families Programs collect the race and ethnicity, as well as primary spoken and written language¹ of their enrollees. Enrollees must be allowed to self-identify their race, ethnicity and their primary oral and written language.

Data regarding race and ethnicity, which can easily be captured on application or re-enrollment forms, must be collected because it provides critical information to ensure: 1) accurate cultural and linguistic assessments of the plan's enrollee population, 2) adequate cultural and linguistic competency trainings are provided to plan staff and network providers, and 3) culturally and linguistically appropriate services are provided to its diverse membership. The Office of Minority Health, U.S. Department of Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services in Health Care (OMH CLAS Standards) recognizes that linguistic needs are only one aspect of cultural competency in health care.² Data collection on race and ethnicity has been recognized as necessary to provide culturally and linguistically appropriate care, as stated in CLAS Standard 10. Moreover, according to the Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in*

¹ Both of the programs collect ethnicity and primary language the application form. On the Medi-Cal form, it asks "What language/dialect do you speak best?" and "What language do you read best?" The application allows the applicant to fill in his/her "Ethnicity (race)(optional)," MC-210 Application at A-1 & A-4., Medi-Cal Program, Department of Health Services (8/01). The Healthy Families application asks "What language do you speak best?" and "What language do you read best?," and the "Ethnic Code" of the children applying. MC-321 HFP Application, Healthy Families Program, Managed Risk Medical Insurance Board (4/05).

² OMH CLAS Standards, *Final Report*, available at: <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>.

Health Care, (IOM Report), Recommendation 7-1 states that race and ethnicity data, as well as primary language data, should be collected and reported. It notes that standardized data collection of race and ethnicity is a “critically important step in understanding and eliminating disparities in health care” and that “[e]ffective data collection is the linchpin of any comprehensive strategy to eliminate racial and ethnic disparities in health.”³

Both the primary “spoken” or oral language and primary “reading” or written language should be obtained from each *new* enrollee upon initial enrollment as well as *current* enrollees. An LEP person’s primary spoken language may be different than his or her written language or change over time so he or she should be allowed to identify which is the appropriate language that is needed for interpretation versus translation services. As one example, several of our Health Consumer Centers serve the Hmong population, many of whom speak but do not read Hmong. Also, to ensure uniformity of data collection, we also recommend that DMHC provide the categories for race, ethnicity and primary spoken and written language, preferably categories used by the U.S. Census.⁴ Unless DMHC requires a uniform collection instrument with set categories or choices, the opportunity is lost to create usable data that can be compared and analyzed.

B. Individual Data Collection & Recording

Race, ethnicity and primary spoken and written information must be collected from each individual enrollee and recorded in the health records of each enrollee at the plan and provider level, including the information system of the health plans, in order to comply with Health & Safety Code §§ 1367.04(b)(3) & (4) which require that the plans survey the linguistic needs of their enrollees and provide standards for **individual** enrollee access to interpretation services. SB 853 establishes requirements that health care plans develop a demographic profile of its enrollee population that would include not only language needs but also the racial and ethnic composition of its enrollees and collect the data for each enrollee/member/applicant.

The current regulations allow the use of population-based data for the plan assessments. While such data may be useful and reliable data sources to supplement the enrollee demographic profile, it must not supplant the collection of individual demographic information for each enrollee.

III. Standards for Language Assistance Services

A. Use of Qualified Interpreters & Quality Translations

According to Health & Safety Code §§1367.04 (b)(2) & (5), the statute requires that the regulations shall include standards “to ensure the quality and timeliness” of interpreter services and “the quality and accuracy” of written translations. The proposed regulations lack a clear requirement to use qualified or competent interpreters and translators. The regulations list

³ IOM Report, *Executive Summary* at 21, available at: <http://darwin.nap.edu/books/030908265X/html/215.html>.

⁴ The vast majority of states allow for the collection of race, ethnicity and primary language data. Office of Minority Health & NHeLP, *Assessment of State Laws, Regulations and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans, Executive Summary* at 4, available at: <http://www.omhrc.gov/omh/sidebar/datastats13.htm>. The IOM Report Recommendation 7-4 states that racial and ethnic data should be reported by OMB categories with the use of subpopulations where possible.

the range of interpretation services that can be used but does not require the use of “qualified” interpreters. It also only refers to the proficiency of interpreters and translators but does not require that interpreters or translators be competent, tested or trained.⁵ Proficiency only refers to one’s ability to communicate accurately in both English and the target language. One of the documents to which the statute refers as a guide, is the Office for Civil Rights, U.S Department of Health and Human Services’ Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting LEP Persons (OCR LEP Guidance). It describes the competence of interpreters and translators and notes that “quality and accuracy” of language assistance services is “critical to avoid serious consequences to the LEP person. OCR LEP Guidance at 9, available at: <http://www.hhs.gov/ocr/lep/revisedlep.html>. It further explains that “competency requires more than self-identification as bilingual” (*id.* at 10). Moreover, ideally, face-to-face interpreters are preferred over telephonic interpreters and plans should not rely on telephonic interpreters for commonly spoken languages. (*See* CA. Code of Regulations §§1300.67.04(c)(2)(G)(ii), (H), &(H)(2) for recommended changes to the proposed regulations).

Moreover, similar to the competency of all interpreters and translators, any bilingual provider and bilingual provider staff should be qualified. In prior versions of the regulations, there was a requirement for the plans to assess the language skills among its contacting providers that has been deleted from the current version. This requirement is critical to ensuring that the plan’s provider network is providing adequate interpreter services to LEP enrollees at the provider site. Our Health Consumer Centers assist LEP consumers daily and in our experience bilingual staff are not necessarily qualified interpreters. The plan must have a system to assess the proficiency and evaluate the effectiveness of the language skills of the provider and/or provider staff. Moreover, the statute explicitly states that a “contract between a health care service plan and a health care provider shall require compliance with the standards developed under this section. In furtherance of this section, the contract shall require providers to cooperate with the plan by providing any information necessary to assess compliance.” Therefore, this provision must be put back into the regulations. (*See* CA. Code of Regulations §§1300.67.04(c)(2)(E)(i) for clarifying language to the proposed regulations).The proposed regulations do not assure the quality and accuracy of the written translations and do not require that translated documents meet the same standards required for the English language version of the document. There is also no reference to any option of enrollees who cannot read to ask for an oral translation of certain written materials and no reference to the deadline of twenty-one (21) days for plans to translate requested materials in the regulations. This is critical. Our Health Consumer Centers work with LEP consumers who are not literate in any language and need oral assistance. Moreover, according to Health & Safety Code § 1367.04(b)(1)(D), plans must advise enrollees of the availability of interpreter services. Furthermore, the regulations do not address the appropriate literacy level for which the materials should be translated. Both the Medi-Cal and Healthy Families contracts refer to materials being written at the 6th grade literacy level. Also, OMH CLAS Standard 7 refers to the Multilingual Health Education Network which uses a 4-6 literacy level (*see* OMH CLAS Final Report at 80). For these points, we have provided additional clarifying language to the regulations. (*See* 100.67.04(c)(2)(D), (F)&(F)(iv)(bb) for suggested changes to the regulations).

B. Use of Ad Hoc Interpreters, including Family Members, Friends, and Minors

⁵ There are state and national standards promulgated by the California Healthcare Interpreters Association (www.chia.org) and the National Council of Interpreting in Health Care (www.ncihc.org), respectively available on their websites

Even more troublesome, currently, the regulations merely discourage the use of friends and family members, and even allow minors to act as interpreters. Untrained interpreters, including family members and friends, are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices that can seriously distort the interpretation. They may not know critical medical terminology and be unable to interpret medical information vital in ensuring that the doctor understands the patient's condition and the patient understands her diagnosis and course of treatment. The use of family members and friends also raises privacy concerns. The potential for harm is exacerbated when children are used because they have to take on additional burdens, decision-making and other responsibilities. It may also cause friction and a role reversal within the family structure. The child is expected to convey technical information and may have to be taken out of school. The Healthy Families program has recognized the inherent dangers of using minors as interpreters and has prohibited their use unless the situation is an emergency. The lack of adequately trained health care interpreters can result in an increased risk of medical errors. One recent study revealed a greatly increased incidence of interpreter errors of potential clinical consequence when untrained interpreters were used instead of those with training.⁶ A subsequent study found that while interpretation errors of potential clinical consequence occurred in 12% of encounters using trained interpreters, they occurred in 22% of encounters in which *ad hoc* interpreters were employed.⁷ Therefore, the regulations should prohibit the use of *ad hoc* and untrained interpreters and translators, especially minors, unless it is an emergency or the patient requests it after being informed of the availability of trained interpreters at no cost (and it is recorded in the medical record.) (See CA. Code of Regulations §1300.67.04(c)(1)(F)(iv) for proposed changes to the regulations).

C. Timeliness

The proposed regulations provide for a very vague definition of “timely” interpretation that provides far too great a range of interpretation and would be difficult to enforce. We are concerned that without an outside time limit, LEP patients will have to wait inordinate amounts of time, suffer from rescheduled appointments and/or never receive health care. Guidance regarding the definition of “timely” may be gleaned from other state requirements, such as a New York regulation which requires hospitals to provide skilled interpreters in inpatient and outpatient settings within 20 minutes and in emergency rooms within 10 minutes.⁸ The California Health Care Safety Net Institute of the California Association of Public Hospitals defined a “reasonable” wait time as 30 minutes.⁹ Rather than the current open-ended definition, we strongly recommend that the term “timely” be given a specific time period, within fifteen (15) minutes. Given the broad range of options available to the health plan, ranging from the use of bilingual staff or providers to telephonic interpreters, and the establishment of a written protocol to obtain an interpreter, there should be no reason for delays for more than fifteen

⁶ Glenn Flores *et al.*, *Errors in Medical Interpretation and Their Potential Consequences in Pediatric Encounters*, 111 PEDIATRICS 4 (Jan. 2003). Of 165 total errors committed by nonprofessional interpreters, 77% had potentially serious clinical consequences. See also, Garret Condon, *Translation Errors Take Toll on Medical Care*, CLEV. PLAIN DEALER, Jan. 20, 2003, at C3.

⁷ Glenn Flores, Abstract, *Pediatric Research*, April 2003, Volume 53, Number 4. For hospital interpreters with at least 100 hours of training, the rate of errors of potential clinical consequence was only 2%.

⁸ 10 N.Y. Comp. Codes R. & Regs. § 405.7(a)(7).

⁹ *Straight Talk: Model Hospital Policies and Procedures on Language Access, Introduction* at 19 (2005) available at: <http://www.safetynetinstitute.org/UpdatedSite/StraightTalkFinal.pdf>

minutes. (See CA. Code of Regulations §1300.67.04(c)(2)(C) & (G)(i) for specific language to the proposed regulations).

IV. Standards for language assistance at contracted hospitals

We have serious concerns with the proposed regulations, which allow contracting hospitals to use standards developed pursuant to the Health & Safety Code § 1259 (Kopp Act). SB 853, Health & Safety Code §1367.04, requires all health plan providers, including hospitals, physicians, and other allied health professionals contracting with the health plan, to meet or exceed the minimum standards established in the regulations and statutes. As noted above, there is no statutory authority to exempt any network provider, including contracting hospitals, from the requirements established in this section. Allowing the hospitals to use policies established under the Kopp Act would not meet the minimal standards required under § 1367.04 and these regulations. In fact, the Kopp Act does not provide clear standards and does not provide as much guidance with regard to the provision of interpreter and translation services as the proposed regulations. Its minimal requirements are less stringent than those in SB 853 and the proposed regulations. For example, it has no explicit requirement regarding the translation of materials but only requires hospitals to review standardized forms to determine which should be translated. It also contains a large loophole for hospitals to escape the obligation to provide interpreter services 24 hours a day through a provision which includes the qualifying phrase, ‘to the extent possible.’¹⁰ Moreover, many hospitals are not meeting the Kopp Act requirements and there is no monitoring of compliance with the Kopp Act. Allowing the contracting hospital to meet other standards would also make monitoring by DMHC more challenging and may cause confusion for contracted hospital. In fact, it would allow some contracting hospitals to escape any compliance monitoring by the plans so any reference to Kopp Act must be removed. (See CA. Code of Regulations §1300.67.04(c)(2)(J) & (c)(4)(A) for amendments to the proposed regulations).

V. Staff Training

The regulations do not specify when the staff training should be conducted. As the OCR LEP Guidance recommends, staff training should be conducted as part of the orientation for new employees or within a short period of time after employment begins. It would also be useful to provide trainings at regular intervals after the initial orientation in order to ensure that the staff is kept up-to-date about the language access policies and procedures, as well as the changing demographics of the patient population, especially for those who have more frequent contact with LEP enrollees. (OCR LEP Guidance at 18). Moreover, the OCR LEP Guidance also noted that management staff, even if they do not interact regularly with LEP patients but must supervise front-line staff, should be fully aware of and understand the plan so they can reinforce its importance and ensure implementation by staff.” *Id.* Ideally, all health care plan staff should be trained and be made aware of the language assistance policies and procedures since any staff might have contact at some point with LEP members. (See CA. Code of Regulations §1300.67.04(c)(2)(J) & (c)(4)(A) for edits to the proposed regulations).

¹⁰ Cal. Health & Safety Code §1259(c)(3).

VI. Cultural Competence Reporting

In prior versions of the proposed regulations, there was a section containing the reporting requirements related to the cultural appropriateness of the plan's internal policies and procedures. This provided useful guidance to the plans and public about the type of information that DMHC expects the plans to collect and provide to DMHC. The current regulations do not address this statutory requirement and provides not timeline for its submission. We would recommend that the list be put back into the regulations since the statute requires DMHC to monitor the plan's services for cultural competency and to require the report to be submitted within one year of the approval of the regulations and annually after that. (*See* CA. Code of Regulations §1300.67.04(d)(2) for suggested changes to the proposed regulations).

Since the statute requires DMHC to report to the Legislature biennially and the Advisory Committee on Managed Health Care (or other advisory bodies established by the director), DMHC must audit the plans and collect the cultural appropriateness information at least every two years to comply with its statutory public reporting requirement. Since the proposed regulations state that DMHC only needs to review plan compliance "periodically," this open-ended time period is very vague and we believe that a defined period of time, such as annually, provides much clearer guidance on the timely monitoring process to evaluate the effectiveness of the plan's cultural and linguistic services program and to comply with the statute. (*See* CA. Code of Regulations §1300.67.04(e) for amended regulatory language).

VII. Contracts with Providers

The current regulations do not specify whether the plan or the network provider is responsible for providing the interpreter and/or translated materials. The regulations must make it clear whether the health plan or network provider is responsible so the LEP patient will know what to expect when she or he seeks care, either at the health plan, doctor's office or hospital, and who to ask for an interpreter or translated materials, as well as what to do if she or he has any problems at the time. Any delegation of the responsibility to provide the interpreter at the physician's office must be clearly stated in the plan's contract with the network provider. This information must be available to the LEP member in order for the LEP enrollee to obtain the needed language assistance at all points of contact. (*See* CA. Code of Regulations §1300.67.8 for recommended language).

In closing, California has a unique opportunity to provide leadership in this area and become a model for other states wishing to ensure that culturally and linguistically appropriate services are provided to all LEP health plan members in the state. We believe that the two hearings held in Los Angeles on February 14, 2006 and in Oakland on February 16, 2006, in which several Health Consumer Alliance programs participated, illustrated many of the reasons why these regulations are so important. We hope that the testimony provided DMHC with valuable information to support strong regulations to ensure the provision of culturally and linguistically appropriate health care services to all health plan enrollees, including LEP members. We support many of the comments made by the LEP patients and community advocates who testified at the hearings. Moreover, we would like to state our strong agreement with the written comments submitted by the California Pan-Ethnic Health Network and the Asian Pacific American Legal Center.

We have attached to this letter the text of the proposed regulations issued on December 23, 2005 with our recommended revisions and have highlighted our changes in red on the electronic version. There are additional minor suggestions that have not necessarily been included in this letter. Please do not hesitate to contact me if you have any questions. We hope that you find these comments helpful and look forward to working with your staff and other interested stakeholders on finalizing the regulations. Thank you again for allowing us to provide input during this first public comment period and participate in the rulemaking process.

Sincerely,

Doreena Wong
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