Government Business Division
Policies and Procedures

Section (Primary Department) **Medicaid Cultural and Linguistics**		**SUBJECT (Document Title)** **Cultural and Linguistics Program - CA**	
Effective Date 02/02/2004	**Date of Last Review** 10/11/2023	**Date of Last Revision** 06/28/2024	**Dept. Approval Date** 06/28/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross Medi-Cal (Anthem or Plan) is committed to providing culturally and linguistically appropriate health care services in a competent manner to meet the needs of a culturally diverse membership, which includes members with limited English proficiency (LEP), variable literacy levels, variable or alternate format needs, hearing, speech visual impairments Seniors and Persons with disabilities. Seniors include adult members 65 years of age and older. Persons with disabilities include both children and adult members with a disability that meets the Social Security Administration disability standard.

Anthem is committed to complying with all federal and state regulatory requirements, including but not limited to Title VI of the Civil Rights Act of 1964 and all subsequent updates, the Americans with Disabilities Act (ADA Title II) and all subsequent updates, Title 42 of the Code of Federal Regulations (CFR), and relevant Executive Orders.

Anthem ensures all medically necessary covered services are available and accessible to all members, including members under the age of 21 regardless of race, color, national origin, creed, ancestry, religion, sex, language, age, gender, gender identity, sexual orientation, marital status, health status, ethnic group identification, genetic information, mental disability, physical disability, or medical condition.

Objectives of the Medi-Cal Cultural and Linguistics (C&L) Program

I. Regulations and Requirements of Agencies and Contracts

a. Adhere to all applicable federal and state regulations and contractual requirements.
b. Provide timely and appropriate documentation in response to audits, requests for proposals, contract reviews and other requests.

II. Plan Staff

a. Employ and/or contract with culturally competent and proficient bilingual associates reflecting the demographics of the membership.
b. Employ appropriately experienced, educated, and qualified staff to administer and implement approved Medicaid C&L Program policies and procedures.
c. Complete cultural competency training annually and/or when newly hired.
d. Complete the Diversity, Equity, and Inclusion (DEI) training program in compliance with DHCS APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements (Supersedes APL 99-005).
e. Complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI).
f. Provide culturally and linguistically appropriate health care-related services to Plan members.
g. Train associates on how to deliver culturally and competent services to all beneficiaries, including those with LEP, diverse cultural and ethnic backgrounds and religions, and on how to demonstrate sensitivity when communicating with people with disabilities and regardless of gender, age, sexual orientation, or gender identity.

III. Providers & Provider Office Staff

a. Contract with culturally competent and proficient bilingual providers reflecting the demographics of the membership.
b. Require cultural competency training to providers and provider office staff.
c. Educate providers on how to access the cultural competency toolkit and how to locate cultural and linguistic tools on the Plan's provider website.
d. Require providers and provider office staff to deliver health care services in a culturally and linguistically appropriate and effective manner.
e. Educate providers on guidelines and requirements for accessing free interpreter services for members, and the availability of the Interpreter Services Desktop Reference.
f. Educate providers on how to assist members with obtaining materials in alternate formats directly via the state website and/or with the assistance of the Customer Call Center.
g. Require providers to offer members with LEP access to the Plan's free interpreter services and to document the request or refusal of an interpreter in the medical record.
h. Discourage the use of family and friends, particularly minors, as interpreters.

i. Train providers and provider office staff on the requirement to document members' request, acceptance, or refusal of interpreter services in the medical record.
j. Educate providers on the availability of the Health Plan to assist in finding culturally appropriate community services for members.
k. Train providers on how to assist members with filing a complaint or grievance and appeals process.
l. Educate providers on the availability of free written translation and oral interpretation services and how to request auxiliary aids and services for people with disabilities.
m. Train providers on how to demonstrate sensitivity when interacting with people with disabilities and regardless of gender, sexual orientation, or gender identity.
n. Educate providers and office staff on the Diversity, Equity, and Inclusion (DEI) training program.
o. Require providers and office staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI).

IV. Identification and Notification of Cultural & Linguistic Services to Members

a. Identify the preferred written and spoken languages, race, and ethnicity of members.
b. Maintain current data regarding language availability of provider offices contracted with the Plan and provide access to provider demographic data to members.
c. Notify members of their right to access free cultural and linguistic services and how to access those services.
d. Inform members about the availability of free written translation and oral interpretation services and how to request auxiliary aids and services for people with disabilities.
e. Assign members to primary care providers (PCPs) who speak their preferred language whenever possible or provide access to an interpreter to assist with communication between members and their provider(s).

V. Interpreter Services

a. Make free, qualified interpreter services available to all LEP members.
b. Discourage the use of friends and family members (particularly minors) as interpreters.
c. Provide 24-hour, seven-days a week telephonic and TTY services to facilitate members' requests for over the phone, face-to-face and sign language interpreters. In some areas, video remote interpreter (VRI) services are offered through partnerships with some medical clinics where on-demand interpreter

services are provided via iPad Kiosk. Provide interpreter services to assist members with filing complaints and navigating the grievance and appeals process.

d. Require provider offices to inform members of their right to access a qualified interpreter and to document members' requests, acceptances, or refusals of interpretation services in members' medical records.

VI. Member Materials

Provide members with accurate and culturally appropriate documents and health education materials translated by a qualified translator into the required threshold and concentration languages on a routine basis.

a. Maintain documented process for members, provider offices and Plan staff to order health education materials in multiple non-English languages.
b. Provide materials (both member facing and health education related) to members with visual or hearing impairments as requested, in alternative formats such as Braille, large print (no less than 20-point, Arial font), data or audio CDs, in accordance with ADA guidelines, at no cost.
c. Make reasonable modifications and provide appropriate auxiliary aids and services to assist members, who may be visually impaired or have limited reading ability with understanding information found in member and health education materials.
d. Inform members about how to file a discrimination grievance directly with DHCS, in addition to information on how to file a discrimination grievance with the plan.

VII. Community Linkages

a. Support and foster culturally diverse health promotion activities and referral of members to culturally appropriate services and community-based organizations.
b. Develop and maintain relationships within the community that support the objectives of the Community Advisory Committee.

VIII. Monitoring and Evaluation

a. Utilize survey ,the new modified population needs assessment and the Population Health Management (PHM) Strategy data to monitor, evaluate and improve the Cultural and Linguistic Program.
b. Link the C&L Program to the Plan Quality Improvement (QI) process.
c. Maintain a Cultural and Linguistic Grievance and Appeals process.
d. Assess language availability of provider network.
e. Assess language needs of the membership.
f. Collect and store member's and authorized representative's (AR) alternative format selections. Give "primary consideration" to the member's request of a particular auxiliary aid and service.

g. Assess member's and member's authorized representative alternative format selections data and submit report to DHCS as/when requested.
h. Maintain and continually monitor, evaluate, and improve cultural and linguistic services that support the delivery of covered services to members under 21 years of age.

DEFINITIONS:

None

PROCEDURE:

I. Regulations and Requirements of Agencies and Contracts

Anthem maintains compliance with agencies, contracting programs and accrediting bodies by maintaining and reviewing current federal regulations and contractual requirements; developing and implementing programs as required; issuing program reports in preparation for audits; and responding to agency findings as requested.

a. Special Services for American Indians:
    i. In accordance with Section 5006 of Title V of the American Recovery and Reinvestment Act (ARRA) of 2009 (42 USC 1396o (a), the Plan does not impose enrollment fees, premiums, deductibles, or co-payments upon American Indian enrollees who receive services through an Indian Health Program (or an Indian Tribe, Tribal Organization or Urban Indian Organization) or by referral to an Indian Health Program.
    ii. American Indians have the right to get health care services at Indian Health Care Centers and Native American Health Clinics. American Indians may stay with or disenroll from Medi-Cal while getting health care services from an Indian Health Center or Native American Health Clinic. American Indians have a right not to enroll in a Medi-Cal managed care plan or may leave their health plans and return to med—Cal at any time and for any reason. Members are informed of this in the Member Handbook.

II. Plan Staff

Anthem recruits and employs qualified management and staff to administer and support the functions of Plan services and programs. Anthem recruits bilingual associates reflecting the demographics of the membership by requiring bilingual capabilities in certain job positions. There is a centralized database, updated quarterly, identifying associates tested for bilingual proficiency and if they successfully passed. The associate listing is available for review upon request. Cultural competency training for plan staff is member focused and includes but is not limited to the importance of cultural awareness,

disability sensitivity, an understanding and appreciation of diversity, and evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). Plan staff complete cultural competency training annually and as needed to help support the diverse needs of the membership, facilitate culturally and linguistically appropriate services, ensure plan staff practice disability sensitivity, as well as gender diversity sensitivity when working with members. In addition, Plan staff complete the Diversity, Equity, and Inclusion (DEI) Training Program to enhance awareness of diverse imperatives and issues related to improving access and quality of care for members/potential members. Plan staff are also trained on how to work effectively with members using interpreters. Training of Plan staff is conducted via various means such as web-based training and documented and available for review.

An annual sensitivity, diversity, cultural competency and Health Equity training is provided, and it considers structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Network Providers and Allied Health Personnel receive pertinent information regarding the new modified PNA and the annual Population Health Management (PHM) Strategy findings and the identified targeted strategies. The most appropriate communication method(s) are used to assure the information can be accessed and understood. The training includes the following:

a. Promoting access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and
b. Information about the Health Inequities and identified cultural groups in the Plan's Service Area which includes but is not limited to the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

Multiple departments within the organization have responsibility for supporting and implementing objectives and activities related to the Medi-Cal C&L Program, as outlined in the Medi-Cal C&L Program Work Plan. Associates supporting these activities have degrees in health or related fields and/or directly relevant experience to the health care industry. Organizational charts and job descriptions are available for auditors and accreditation agencies to review upon request.

III. Providers and Provider Office Staff

Cultural competency training for providers, including office staff, is member focused and includes the importance of cultural awareness, disability sensitivity, an understanding and appreciation of diversity, and evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). Such training includes but is not limited to emphasis on the importance of members' beliefs about illness and health and traditional home remedies that may impact what the provider's treatment methodology is trying to accomplish. In addition, Providers and Providers Office staff complete the Diversity, Equity, and Inclusion (DEI) Training Program to enhance awareness of diverse imperatives and issues related to improving access and quality of care for members/potential members.

An annual sensitivity, diversity, cultural competency and Health Equity training is provided, and it considers structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Network Providers and Allied Health Personnel receive pertinent information regarding the new modified PNA and the PHM Strategy findings and the identified targeted strategies. The most appropriate communication method(s) are used to assure the information can be accessed and understood. The training includes the following:

a. Promoting access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and
b. Information about the Health Inequities and identified cultural groups in the Plan's Service Area which includes but is not limited to the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

Trainees are made aware of methods and styles of communication that are effective with respect to culture, language, religion, literacy levels, sexual orientation or gender identity and people with LEP in order to support a positive interaction between the patient, providers, and office staff, as well as Plan staff.

a. Providers are trained regarding:
    i. How to access no-cost language assistance services and how to request free auxiliary aids and services for members with disabilities and requirements.

ii. Documenting members' preferred language in the medical record
iii. Maintaining request or refusal of interpreter services in the medical record
iv. Discouraging the use of family and friends, particularly minors, as interpreters
v. Availability of translated materials and how to order accurate and culturally appropriate translations of member materials.
vi. Health Plan assistance with finding culturally appropriate community services for members and how to access them.
vii. Accommodating the communication needs of members with disabilities including their authorized representative (AR) and Seniors and Persons with Disabilities and the facilitation of Alternative Format (AF) requests.
viii. How to enter any new member Alternative Format Selections (AFS) that they receive at the time of the request through the DHCS AFS online screens or by calling the AFS Helpline or Anthem Customer Care Center.
ix. Steps to assist members with filing a complaint or grievance and appeals process.

b. The Anthem provider website includes cultural and linguistic information; tips for working with interpreters, interpreter access information, interpreter services display signs, an Employee Language Self-Assessment tool for providers to use to assess languages capabilities of office staff and a form to document member request/refusal of interpreter services.
c. The Plan is responsible for provider training. Providers are trained when they are placed on active status. This orientation training is documented and includes cultural and linguistic requirements and resources, and related policies and procedures that are included in the Provider Manual.
d. After initial orientation, providers continue to receive ongoing training and information by the Health Plan staff, and through newsletters, provider bulletins (such as the Cultural Competency training bulletin, which is sent via fax blast on an annual basis and on a monthly basis for newly contracted providers), and other updates located on the Anthem provider website. Anthem identifies additional resources for providers where an investigation of a complaint or grievance indicates additional provider training for cultural and linguistic issues is warranted. Training of providers is documented and available for review upon request.
e. Anthem seeks to maintain a provider network that reflects the demographics of the membership and can support the needs of diverse members. The Provider Data Quality (PDQ) department assesses the adequacy of the contracted provider networks based on member population and other variables such as member language preferences and reports its findings to the Quality Management Committee (QMC). The QMC addresses barriers to provider availability and accessibility.

f. Provider Data Solutions (PDS) - Demographic Data Operations (DDO)maintains the provider database that includes languages spoken at provider offices. Information on the linguistic availability of providers is required on the provider applications, and DDO enters this information into a database system. The provider database is used to produce and update the Provider Directory. Updates to provider demographic data, including language, are entered into the database as received from provider offices. Members can use the Provider Directory to obtain information on languages spoken by provider offices, or they can contact the Customer Care Center (CCC).

IV. Identification and Notification of Cultural and Linguistic Services to Members

a. Identification of Members' Languages:
    i. Anthem obtains member language information from the Medi-Cal Program eligibility files (834), which is loaded to the membership databases. For new members, the language identifier in the file is used to determine the appropriate language for new member packets. New member packets are specific to the program in which the member has enrolled. The eligibility rosters include the languages spoken by Anthem members and can be accessed by PCPs via the Anthem provider website.
b. Notification to Members of Cultural and Linguistic Services:
    i. Members are informed in the Member Handbook of their right to:
        a. Free interpreter services 24 hours a day, 7 days a week, including sign language interpreters.
        b. TTY services
        c. Auxiliary aids and services for seniors and people with disabilities and the provision of Materials in non-English languages and alternative formats (including Braille, large print (no less than 20-point, Arial font) and audio CD) at no cost.
        d. Language assistance with the grievance and appeals process, including how to file a discrimination grievance directly with DHCS, in addition to information about how to file a discrimination grievance with the plan.
c. Non-discrimination notices and language assistance taglines are included in significant publications and communications in accordance with ACA Section 1557 and DHCS APL 21-004 (revised 5/3/22). Signage regarding the availability of free language assistance services and auxiliary aids and services for people with disabilities is available to providers on the Anthem provider portal.
d. Assignment of PCP:
    i. Members are able to select a PCP upon enrollment and can use the Find a Doctor tool at www.anthem.com/ca/medi-cal or Provider Directory to

assist them in the process. A hard copy of the Provider Directory is included in the new member packet if requested by the member at the time of enrollment, available on the Anthem member website at www.anthem.com/ca/medi-cal or can be requested by contacting the CCC. Members can refer to the Member Handbook for guidelines on how to select a PCP, or they can call the CCC for assistance. If a member does not select a PCP, the Plan may select a PCP for the member. The member's preferred language will be used as part of the selection criteria.

V. Interpreter Services

Telephonic and face-to-face interpreter services are available to members and providers at no cost. Members are informed of the availability of interpreter services at no cost in the Member Handbook and member newsletters. Providers are notified of the requirement for and availability of free 24-hour telephone interpreter services in the Provider Manual, newsletters, and Anthem provider website. The use of family and friends, particularly minors, as interpreters is strongly discouraged.

In addition, video remote interpreter (VRI) services are offered through partnerships with some medical clinics where on-demand interpreter services are provided via iPad Kiosk.

Free interpreter services are available to members, providers, and staff at key points of contact, including medical care settings (telephone, advice and urgent care transactions, and outpatient encounters with health care providers, including pharmacists) and non-medical care settings (member services, orientations, and appointment scheduling) to ensure Member's timely access to care will not be delayed.

a. Telephonic Interpreter Services:
    i. The Plan furnishes members and providers with free 24-hour, 7 days a week access to telephonic interpreter services. To access interpreter services during business hours, members can call the CCC. The member's first point of contact is an Interactive Voice Recognition (IVR) system, allowing members to continue the call in either English or Spanish. Members who select Spanish as their preferred language are routed to a CCC associate with a Spanish bilingual skillset first. If none are available, members are routed to another CCC associate that accesses an Anthem-contracted interpreter to assist with member communications. Members who speak a language other than English or Spanish can also speak to a CCC associate who will access an Anthem-contracted interpreter to assist with member communications in the requested language. After regular business hours, telephonic interpreter services are available through the 24/7 NurseLine.

ii. Members with hearing impairments can utilize the CCC TTY number during business hours. After hours, members can use the 24/7 NurseLine TTY number, the California Relay Line or the National 711 TTY line for assistance as identified in the Member Handbook.

b. Face-to-Face and Sign Language Interpreter Services:
   i. Members and providers may schedule free face-to-face and sign language interpreter services by contacting the CCC. When a request is received, the CCC will submit an online Interpreter Request form to the Interpreter Services Coordinator, who will contact the contracted vendor, member, and provider to arrange face-to-face and sign language interpreter services. In addition, the Health Plan can directly submit the face-to-face and sign language interpreter request via email to the Interpreter Services Coordinator.
   ii. Requests for face-to-face and sign language interpreter services are scheduled at least seventy-two (72) hours in advance to allow time to locate an interpreter who speaks the member's language. Twenty-four (24) hours' notice is requested for cancellations.

VI. Member Materials

Anthem immediately and fully translates written informing materials, including but not limited to the Medi-Cal Member Handbook (Evidence of Coverage); new member packets; marketing materials; form letters, including notice of action letters and grievance and appeal acknowledgement letters, grievance resolution letters and Notice of Appeal Resolution letters. Vital documents are defined in the Marketing and Member Communications policy Requests for Translations and Alternative Formats of Member Communications. Vital Documents are documents or portions of documents that, without written translations, LEP individuals would lack meaningful access to Health Plan products and services.

The Medicaid Marketing Strategy and Planning (MSP) department (formerly Medicaid Marketing and Member Communications) maintains a Request for Translations and Alternative Formats for Member Communications policy to help ensure compliance with contractual and regulatory requirements. Documents that are not translated up-front contain a Language Assistance Program (LAP) notice.

Anthem utilizes updated datasets, in the most current Medi-Cal Managed Care Department (MMCD) All Plan Letter from Department of Health Care Services (DHCS), to determine threshold and concentration standard languages for the translation of member materials. These languages are identified and reviewed on a routine basis. The Welfare and Institutions Code (WIC) Section 14029.91 requires DHCS to determine these languages

when a non-managed care county becomes a new managed care county; a new population becomes a mandatory Medi-Cal managed care population; and a period of three years has passed since the last determination. The APL 21-004 (revised 5/3/22) provides an updated threshold and concentration language dataset to account for the new mandatory populations being enrolled in Medi-Cal managed care as a result of the California Advancing and Innovating Medi-Cal (CalAIM) Benefit Standardization initiative. The threshold and concentration languages for all counties as of July 2021 are Arabic, Armenian, Cambodian, Chinese (Traditional and Simplified), Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese. Member materials are translated by qualified and accredited translators within contractually required time specifications where they may exist.

a. When a member has requested to receive translated written information in either traditional or simplified Chinese characters, the plan provides written information in the member's preferred characters. If the member does not indicate a preference for simplified or traditional Chinese characters, then the plan will provide translations in traditional Chinese characters. And it is only upon member request that the Plan will provide translated written information in simplified Chinese characters.
    i. The content owner of the source document, in conjunction with MSP, obtains appropriate internal approvals for the English version of materials prior to translation and printing through the Collateral Materials Approval Process (CMAP). For documents requiring DHCS or LA Care approval, translation takes place post oversite agency approval of the finalized English version The full process is managed within CMAP. MSP transfers, maintains, and makes available the translated materials in PDF format and archives records of translated materials.
    ii. Translations referred to as "back translations" are performed by translation vendors other than the original translation company on critical, complex, or legal documents. "Back translations" are done from the translated version into English under two circumstances:
        a. To further verify the accuracy of the translated material and
        b. When materials are only available in a translated language and need to be produced in English.
    iii. Translation vendors submit certificates for each translated piece that include verification of the accuracy, completeness, and cultural appropriateness of the original document. Once the translation is printed, the translated document is stored in a digital asset manager and is available to the oversight agency upon request, along with a copy of the translation certificate.

b. Reading Levels:
   i. The Plan provides members with documentation that is comprehensive and written to comply with the maximum readability level of 6th grade to support ease of understanding. The Fry Readability Formula is used to assess reading levels. Informing materials are printed in at least 12-point block type with titles and captions in at least 12-point bold face type.

c. Provision of Member Information in Alternative Formats:
   i. As required by APL 21-004 (revised 5/3/22), In the event a member is unable to read or understand printed materials, Anthem will provide additional assistance to the member as needed, including providing appropriate auxiliary aids and services to members with impaired sensory, manual or speaking skills, Seniors and Persons with Disabilities and the provision of qualified interpreters and written materials in alternate formats such as Braille, large print (no less than 20 point, Arial font), data and audio versions, free of charge and in a timely manner. In determining what types of auxiliary aids and services to provide, the Plan gives “primary consideration” to the individual’s request of a particular auxiliary aid or service. In addition, the plan provides auxiliary aids and services to a family member, friend, or associate of a member if required by the ADA, including if said individual is identified as the member's authorized representative (AR), or is someone with whom it is appropriate for the Plan to communicate (e.g., a disabled spouse of a member). Anthem accommodates the communication needs of all qualified members with disabilities, including ARs, and is prepared to facilitate alternative format requests for Braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate.
   ii. Anthem provides appropriate auxiliary aids and services to members with disabilities, including alternative formats, upon request. Additionally, the Plan informs members who state that they have difficulty reading print communications on account of a disability of their right to receive auxiliary aids and services, including alternative formats.
   iii. If a member selects an electronic format, such as an audio or data CD, the information may be provided unencrypted (i.e., not password protected), but only with the member's informed consent. Anthem informs a member who contacts the Plan regarding an electronic alternative format, that unless the member requests a password protected format, the member will receive notices and information in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse.

iv. The Plan informs the members that they may request an encrypted (i.e., password protected) electronic format. If the member requests notices and information in a password protected electronic format, the Plan provides a password protected electronic format with unencrypted instructions on how the member is to access the encrypted information, per the DHCS guidance in the AFS Mailing FAQs.

d. Ordering and Requesting Materials:

i. Providers are instructed, by the Plan, regarding ordering non-English materials through newsletters, the Provider Manual, and training workshops. Members are instructed on how to request non-English materials and on how to request free auxiliary aids and services for people with disabilities in their preferred language using the LAP tagline included in the Member Handbooks/Evidence of Coverage. Materials requested in threshold and concentration standard languages not currently in print may be printed as a text document on Plan letterhead and provided to the requesting member.

ii. Members and providers may request translated, alternate format or translated alternate format member materials such as health education items, Member Handbook/Evidence of Coverage, and provider directories by contacting the CCC. When members and providers request translated materials, the CCC associate forwards the request to order the materials and also refers to the language indicator in the members' profile to confirm the preferred written language of the member is captured. For members, the CCC will also update the members alternate format preference on the DHCS website when requests are received while also ensuring alternate format indicators are updated in Anthem's system. The electronic order form is sent to the fulfillment center, and the center sends the materials directly to the member or provider. Materials may also be ordered from the Plan website, www.anthem.com/ca/medi-cal by selecting the proper option and navigating to the desired location.

iii. Print inventory is monitored by Print and Fulfillment for usage on a monthly basis. If determined that a piece has been requested fewer than four times in 12 consecutive months and requested in quantities of less than 150, the item will be designated as a "low-usage" item. Once determined to be a "low-usage" item, the piece will be put into a library of electronic documents for production only when requested.

iv. When a request is made by a member or provider for an item determined to be "low-usage," and the request is made through the CCC or other approved channel, the request is processed and forwarded to the Fulfillment Vendor.

The Fulfillment Vendor alerts the Print and Fulfillment department and obtains approval to produce any Print-On-Demand items.

v. A translation on demand (TOD) process has been established in the event an item has not yet been translated. A new job request will be opened and the piece translated. A backordered status will be in place until the translated PDF is provided for production/fulfillment.

Estimated time frames	6-10 business days from request to print (except Evidence of Coverage, which can take up to 22 business days)
Request is forwarded to MSP and accessed by Program/Project Manager	2 days to open job request
Time to complete translation	3 days for HIPAA translations 10 days for all other translation requests (except Evidence of Coverage, which is up to 22 days)
Time to print and fulfill request	4 days if stocked item 7-10 if on demand

e. Processes for Collecting and Sharing Alternative Format Selection Data
   i. Anthem submits all Alternative Format Selections (AFS) data collected in a one-time file to DHCS to be uploaded to the DHCS Alternate Formats database. DHCS "Alternative Format Selection Technical Guidance" assists the Plan with regular sharing of AFS information with DHCS.
      a. The Data Elements required for submission are:
         1) Client Index Number (CIN)
         2) Beneficiary Name
         3) Format Requested
         4) Date Requested
   ii. File Name Format:
      a. Anthem saves the file as a comma separated value (.csv) format.
      b. Please name the file as: AFS_Anthem Blue Cross_Collection.csv.
      c. Example: AFS_Anthem Blue Cross_Collection.csv.
   iii. Anthem submits to the Plan's designated Secure File Transfer Protocol (SFTP) folder: //DHCS-MCOD-Operations/Anthem Blue Cross/ AFS/Production. (see table 2 Plans and SFTP folders of DHCS's "Alternative Format Selection Technical Guidance").
f. AFS Technical Guidance to receive the DHCS Alternative Formats Data
   i. AFS extract file is available every Monday.

ii. Go to SFTP folder //DHCS-MCOD-Operations/Anthem Blue Cross/AFS/Production.

iii. Download the extract file. The extract file is a Microsoft Excel Comma Separated Value File (.csv), with field names in the first row.

iv. The file name is in the following format -

a. File name format: AFS_Extract_YYYY-MM-DD_ HCPGroupXX.csv

b. File name example: for HealthNet, AFS_Extract_2020-06-02_ HCPGroup08.csv

c. You can open the extract CSV file in Microsoft Excel (if it is less than 1 million rows) or import it to database applications such as Microsoft Access.

d. The language fields originate from MEDS, similar to the 834 and the Weekly Plan File from Maximus.

v. Anthem disseminates alternate format data to all impacted Delegated Groups and vendors via monthly extracts using standard SFTP processes. Anthem Delegated groups are offered CQFluency as an approved vendor to facilitate all alternate format requests but may choose their own approved vendor.

VII. Community Linkages

a. Referrals to Culturally Appropriate Services:

i. The Plan uses community resource directories to identify culturally appropriate agencies and contacts county-specific organizations for resources. Members and providers are referred to community organizations and agencies when appropriate. Plan associates document requests for cultural services. CCC associates are trained to refer requests for cultural services to the appropriate Health Plan staff.

ii. The Plan will arrange timely referral and coordination of covered services if a provider has a moral objection to performing a covered service.

b. Culturally Diverse Health Promotion Activities:

i. The Plan develops and supports multicultural health promotion activities within the communities where members live. Examples of these activities include health fairs, programs that address specific health and social issues, community-based organization appreciation events and cultural fairs at local schools and community centers.

c. Community Advisory Committee:

i. The Community Advisory Committee (CAC) provides a link between Anthem, community-based organizations, and members. Through CAC Anthem is able to cultivate culturally smart feedback specific to the community. Areas of focus include health education topics; cultural and linguistic needs; physician

network development; availability of community resources; and recommendations on potential project improvements topics.

VIII. Monitoring and Evaluation

Anthem monitors and evaluates the Medi-Cal C&L Program and makes appropriate modifications and improvements as needed. The Medi-Cal C&L Program is linked to and functions under the QI committee.

a. Performance Evaluation for Cultural and Linguistic Issues:
    i. Plan staff, providers, provider's office staff, subcontractors and downstream subcontractors are monitored to deliver culturally and linguistically competent care including providing interpreter services to Limited English Proficient (LEP) members and for any other cultural and linguistic (C&L) issues through the grievances process. C&L grievances are reported within the QI committee reporting structure.
b. Quality of Interpreter Services:
    i. Telephone, face-to-face and sign language interpreter subcontractors/vendors, and downstream subcontractors present and maintain documentation supporting their quality systems and the competency of their interpreters.
c. Quality of Translated Materials:
    i. Translation vendors are pre-qualified and must be able to competently certify their work for translation accuracy, including spelling, grammar, and cultural appropriateness. Plan has a method to ensure qualifications of translators and quality of translated written member informing materials, utilizing a review process of translation, editing, and proofreading with two qualified translators. References for translators are obtained before being accepted as vendors. The names, addresses, phone numbers of references and their comments are recorded on the "Record of References for Translators." These records are also on file in the Procurement Department. Quality documentation is maintained on interpreter and translation services.
d. Grievances:
    i. Grievances are processed by the Grievance and Appeals (G&A) Department and follow the approved policies and procedures of the department. The G&A Analyst/Nurse reviews and investigates member grievances related to discrimination and to ensure all information/documents related to the discrimination grievance are properly forwarded to the Discrimination Grievance Coordinator in a timely manner, upon completion. C&L grievances are identified by the G&A department using the following categories: disability (ability), ethnicity/culture, insurance (status), language, race and other (age, gender, sexual orientation, gender identity, sexual harassment,

weight, etc.). For Administrative Issues (Quality of Service) related to cultural and linguistic grievances, the G&A Analyst/Nurse consults with appropriate departments for investigation. Free interpreter services (telephonic and face-to-face interpreters, including sign language) and toll-free TTY/TDD numbers are available to members and associates to facilitate investigation and resolution of grievances and appeals through all levels of the process, including assistance with completion of forms and other procedural steps. Members with visual impairments or other disabilities and/or member's authorized representatives are given information regarding the availability of alternative format selections such as Braille, audio format, large print, and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate during the grievance process.

ii. The Discrimination Grievance Coordinator is responsible for ensuring compliance with federal and state nondiscrimination requirements.

iii. The Discrimination Grievance Coordinator must:
    a. Answer questions and provide appropriate assistance to Anthem Blue Cross Medi-Cal's staff and members pursuant to Anthem Blue Cross Medi-Cal's state and federal nondiscrimination legal obligations.
    b. Advise Anthem Blue Cross Medi-Cal about nondiscrimination best practices and accommodating persons with disabilities.
    c. Investigate and process any American with Disabilities Act (ADA), Section 1557 of the Patient Protection and Affordable Care Act and or Government Code section 11135 grievances received by Anthem Blue Cross Medi-Cal.

iv. The G&A Analyst/Nurse is required to investigate grievances alleging any action that would be prohibited by, or out of compliance pursuant to federal or state nondiscrimination laws. The G&A Analyst/Nurse will acknowledge and resolve discrimination grievances within the appropriate grievance time frames and provide members with an appropriate resolution.

v. The G&A Analyst/Nurse must:
    a. Investigate and process any American with Disabilities Act (ADA), Section 1557 of the Patient Protection and Affordable Care Act and or Government Code section 11135 grievances received by Anthem Blue Cross Medi-Cal.
    b. The G&A Analyst/Nurse may reach out to the Discrimination Grievance Coordinator during the investigation process for assistance to ensure the member's grievance is appropriately

handled according to state and federal nondiscrimination legal obligations.

c. The G&A Analyst/Nurse will prepare and forward all member grievances related to discrimination to the Discrimination Grievance Coordinator within two (2) calendar days of mailing the member grievance resolution letter.
d. The information must include:
    1) The original complaint
    2) The provider's or other accused party's response to the grievance
    3) Contact information for Anthem Blue Cross Medi-Cal's personnel responsible for Anthem Blue Cross Medi-Cal's investigation and response to the grievance.
    4) Contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance.
    5) All correspondence with the member regarding the grievance, including the grievance acknowledgement and grievance resolution letter(s) sent to the member.
    6) The results of Anthem Blue Cross Medi-Cal's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

vi. The Discrimination Grievance coordinator is required to forward all grievances related to discrimination to the DHCS OCR designated discrimination grievance email box in a secure format to DHCS.DiscriminationGrievances@dhcs.ca.gov within 10 calendar days of mailing the member grievance resolution letter.

vii. Members are notified in the Member Handbook/Evidence of Coverage that they may file their grievance directly with DHCS, the Plan or LA Care for Los Angeles Medi-Cal members. The Member Handbook/Evidence of Coverage informs members on how to make a complaint, identifies the informal and formal grievance, appeal, and state fair hearing procedures for filing grievances and, that interpreter services are available to assist members with the grievance and appeals process. Members are also informed of the availability of alternative format selections such as Braille, audio format, large print, and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate. The Provider Manual is used to train providers on the grievance and appeals process, including how to submit a grievance on behalf of a member; for

those members who want to file a grievance themselves, they can contact the Plan directly.

viii. C&L grievance reports are provided to the Cultural and Linguistic Services Department quarterly and are presented biannually to the QMC for review, identification of trends and opportunities for improvement. C&L grievance information is also included in the C&L Annual Data Summary, which is presented to the QMC annually.

e. Cultural and Linguistics Link to QI:

i. The Medi-Cal C&L Program is a collaboration with multiple departments to align program activities, objectives, and links to the quality improvement process through the QI committee reporting structure. Cultural and linguistic activities are also captured in the annual quality evaluation process.

ii. The C&L Program Description and Work Plan identify the program objectives and the activities designed to meet those objectives and the larger goal of providing culturally competent and linguistically appropriate care and services to members.

iii. Per All Plan Letter (APL) 23-021 and DHCS' Population Health Management (PHM) Program, the new modified PNA requirements will allow the Plan to identify the priority needs of our local communities and members and to identify health disparities by meaningfully participating in the Community Health Assessment (CHA)/and Community Health Improvement Plans (CHIPs) conducted by the Local Health Jurisdictions (LHJs). The new PNA process will strengthen engagement and understanding of the health and social needs of our members and the communities in which they live through the cross-sector partnership between Anthem, the local LHJs, and community stakeholders. Annually, the QMC reviews and approves the C&L Program Description and Work Plan within the scope of the quality improvement committee structure.

iv. The QMC reviews activities of the overall QI program for consistency, coordination and focus toward achievement of program goals. As part of that process, the committee performs the following functions related to the overall Medi-Cal C&L Program:

a. Reviews and approves the C&L Program Description and Work Plan.
b. Reviews and approves the C&L Annual Data Summary report, which includes information on telephone and face-to-face interpreter services and information on requests for translation of materials and alternative formats.
c. Receives an annual Access and Availability Report from Provider Database Management, which is reviewed to assess alignment of

network adequacy with the cultural and linguistic needs of the membership.

d. Receives reports on cultural and linguistic-related grievances.
e. Identifies or makes recommendations on methods to improve services to support the cultural and linguistic needs of members.

f. Community Feedback:
   i. The Plan develops and maintains community partnerships with consumers, community advocates and traditional as well as safety-net providers. The Plan includes and involves the Community Advisory Committees in policy decisions related to education, operational and cultural competency issues affecting groups who speak a primary language other than English. Members of the Community Advisory Committee include representatives from relevant community-based organizations that serve the Plan Medi-Cal membership population, as well as Plan members. Plan associates from the Health Plan also participate in the Community Advisory Committee. Community feedback and recommendations are reviewed by the QMC, and recommendations and actions are taken as needed. In Los Angeles County, L.A. Care Health Plan is responsible for the Community Advisory Committee.
g. Surveys:
   i. Plan conducts an annual Consumer Assessment of Health Care Providers and Systems (CAHPS) survey, geo access analysis, and an after-hours survey with cultural and linguistic components included. Results of all surveys are reported at least annually to QI committees and are considered when assessing C&L needs of the membership.
h. New Modified Population Needs Assessment and Population Health Management Strategy:
   i. For the new modified PNA and Population Health Management Strategy, The Plan has established the following requirements:
      a. Meaningful participation in the current or next available cycle of each LHJ's CHA/CHIP in the service areas where Anthem operates.
      b. Submission to DHCS a new annual "PHM Strategy" deliverable to update DHCS on the progress of this engagement and provide updates on the PHM Program to inform DHCS' monitoring efforts.
      c. No longer required to submit an annual PNA and PNA Action Plan under the requirements of APL 19-011, which is retired.
      d. Remain accountable for meeting cultural, linguistic, and health education needs of members, as defined in state and federal regulations.

   Anthem will use 2023 as an initial planning year and will meet with the LHJs to begin planning how Anthem will meaningfully participate in the CHA/CHIP

and develop an associated "SMART" goal that is aligned with DHCS Bold Goals. Anthem will submit the DHCS PHM strategy deliverable in October 2023 to show that we had conducted this initial engagement with the LHJs.

ii. For the 2024 PHM Strategy Deliverable, Anthem will report on:
    a. How we are meaningfully participating on LHJs' CHA/CHIPs
    b. Bright spots
    c. Challenges
    d. How we are responding to community needs
    e. Updates to the SMART goals developed in 2023, as required by the 2023 PHM Strategy Deliverable that are to commence in 2024.
    f. A description of how MCP involvement in the LHJs' CHA/CHIP activities has impacted the PHM Strategy
    g. Any other relevant PNA and PHM updates
    h. Updates to our NCQA PHM Strategy (inclusive of the population assessment)

i. Assess Language Availability of Provider Network:
    i. PDQ annually assesses the language availability of the provider network by comparing the languages reported by providers to the preferred languages of Anthem members. Language availability reports are presented annually within the quality improvement committee structure for approval and recommendations.

REFERENCES:

- 2009 American Recovery and Reinvestment Act (ARRA)
- 45CFR § 92.8
- CA Code of Regulations, Title 22 Social Security, Section 53876
- CA PCXX 003 Initial Health Appointment (IHA) for Children and Adults Policy and Procedure
- DHCS 2024 Medi-Cal Managed Care Operational Readiness Contract
- DHCS All Plan Letter 23-021 (Population Needs Assessment and Population Health Management Strategy)
- DHCS All Plan Letter 23-025 (Diversity, Equity, and Inclusion Training Program Requirements (Supersedes APL 99-005)
- Discrimination Grievance Coordinator Notification Process
- Federal Executive Order 11246, September 26, 1965
- Knox Keene
- LA Care Health Plan Contract
- LA Care Policies
- MMCD All Plan Letter 09-009 Indian Health Services

- MMCD All Plan Letter 21-004 (*REVISED 05/24/2023),* Standards for determining Threshold and Concentration Languages, nondiscrimination requirements, and language assistance services
- MMCD All Plan Letter 22-002, Alternative Format Selection for Members with Visual Impairments
- MMCD Policy Letter 99-05, Cultural Competency in Health Care
- Office of Minority Health National Standards for Cultural and Linguistic Appropriate Services (CLAS)
- Policy and Procedure, CA_GAMC_015 Grievance Process: Members – CA
- Policy and Procedure_CA_Population Needs Assessment (PNA)-CA
- Senate Bill 853
- Senate Bill 923
- Title II of the Americans with Disabilities Act of 1988, the 1991 update, and the 2010 update effective March 15, 2012
- Title VI of the Civil Rights Act of 1964

RESPONSIBLE DEPARTMENTS:

Primary Department:
CA Medicaid Cultural and Linguistics

Secondary Department(s):
Compliance
Customer Care Center
Grievance and Appeals Department
Health Care Management
Health Equity Program
ID Cards and Documentation Services
Marketing
Medicaid Marketing Strategy and Planning
Network Management
Program Policy
Provider Data Solutions (PDS) - Demographic Data Operations (DDO)
Quality Management

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
06/28/2024	• Off-Cycle Review • Updated Policy, Procedure, and References sections • Updated the Population Needs Assessment PNA section with the modified PNA requirements and included Population Health Management Strategy (PHM) information • Removed APL 19-011 PNA and replaced with APL 23-021 PNA and PHM Strategy • Included information from the new modified CA_PNA Policies and Procedures • Updated name of secondary department from "Customer Care Center and Face to Face Interpreter Services Unit" to "Customer Care Center" • Added Program Policy as a secondary department
10/11/2023	• Annual Review • Updated Procedure section
08/30/2023	• Off Cycle Review • Updated Procedure and References sections • Updated primary department name from Medi-Cal C&L to Medicaid C&L • Added Health Equity Program as secondary department • Removed Multicultural Health Programs as a secondary department
07/05/2023	• Off Cycle Review • Updated Procedure section • Updated the Member Materials section (Pg. 10) to include vital document information • Updated The Population Needs Assessment (PNA) section (Pg. 20) to include Network Providers, Subcontractors, Downstream Subcontractors' cultural and Health equity linguistic services programs align with the PNA.
04/17/2023	• Off Cycle Review • Updated Policy and Procedure sections • Updated and alphabetized References section • Added Compliance and Marketing as secondary departments
10/31/2022	• Annual Review • Updated Policy and Procedure sections • Alphabetized and updated Reference section

Review Date	Changes
	• Updated Primary Department name from "Medicaid Cultural and Linguistics" to "Medi-Cal Cultural and Linguistics" • Alphabetized Secondary Departments section and updated Secondary Department name from "Anthem Provider Data Operations" to "Demographic Data Operations (DDO)"
02/07/2022	• Off-Cycle Review • Updates from *Revised* All Plan Letter 21-004 • Updated policy • Updated procedure • Updated references • Updated secondary department name for MAMCOM to Medicaid Marketing Strategy and Planning throughout • Updated policy number from CLA_CLLS_018 to CA_CLLS_018
11/10/2021	• Early annual review • Updates to include policy surrounding the Discrimination Grievance Coordinator and policy surrounding how Anthem will notify DHCS about discrimination grievance resolution letters.
06/02/2021	• Off-Cycle Review • All Plan Letter 21-004 Standards for determining threshold languages, nondiscrimination requirements, and language assistance services update • Updated policy, procedure, and references
01/28/2021	• Annual review • Procedure updated • Secondary department "Provider Data" changed to Anthem Provider Data Operations (DDO)
02/06/2020	• Annual review • Updates to Health Education and Cultural and Linguistic Population Needs Assessment to be in compliance with DHCS New APL 19-011 • Edits to policy and procedure references • References updated
01/17/2019	• Annual Review • Updates to Policy, Procedure, References, Secondary Departments.
02/06/2018	• Off-cycle review. • Updates to Policy and Procedure
10/24/2017	• Annual Review. Updates to policy and procedure and reference sections.
11/14/2016	• Annual Review. Updates throughout policy and procedure.

Review Date	Changes
05/10/2016	• Off cycle edits. • Updated language indicating the Plan maintains a member communications policy that is in adherence to the MMCD policy.
08/26/2015	• Aligned category headers in the policy section with those in the procedure section for consistency and moved content accordingly. • Updated content and department names to reflect current processes and structure. • Made language modifications for consistency and clarity.
07/23/2014	• Updated department names and responsibilities to reflect organizational changes. • Replaced reference to Practitioner's with Providers. • Revised the Face to Face interpreter request language. • Updates were made to streamline this P&P with other Legacy WLP P&P's. • Deleted references to Healthy Family product.
07/24/2013	• Updated department names and responsibilities to reflect company changes. • Added reference to and description of Vital Documents. • Made grammatical corrections.
07/25/2012	• Changed statements referencing the use of minors as interpreters to match exact wording by LA Care audit.
06/28/2012	• Added language that demonstrates compliance with 2010 update to Americans with Disabilities Act, effective March 15, 2012. • Updated committee and department names and responsibilities to reflect company changes. • Added reference to "minors" in statements about discouraging use of family and friends as interpreters, per request from LA Care audit.