

Cultural & Linguistic Program Description

MPND9002

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Program Purpose

To demonstrate the commitment of Partnership HealthPlan of California (Partnership) to deliver culturally and linguistically appropriate health care services to a culturally and linguistically diverse population of members and potential members in a way that promotes Health Equity for all members.

Introduction

This Cultural and Linguistic (C&L) Program description defines how Partnership uses its resources to achieve the goals and commitments to delivering culturally and linguistically competent health care services to all Partnership members, including members with Limited English Proficiency (LEP) or sensory impairment. In alignment with the National CLAS standards, this program description also describes how Partnership offers care and services in a way that is effective, health equity-driven, understandable, and respectful and responds to diverse cultural health beliefs and practices and linguistic/communication needs.[1]

Partnership works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 25-005.[2] Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members regardless of sex, race, color, national origin (including LEP and primary language), religion, ancestry, 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 group as defined in Title VI of the Civil Rights Act of 1964[3] or Section 1557 of the Affordable Care Act of 2010,[4] the Americans with Disabilities Act of 1990,[5] or as specified in APL 25-005. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.

All covered services, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically

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[1] National Culturally and Linguistically Appropriate Services Standards

[2] All Plan Letter 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services and Threshold and Concentration Languages

[3] Penal Code 422.56

[4] ACA 1557

[5] Americans with Disabilities Act of 1990

appropriate manner that promotes health equity for all members. Member-facing materials are routinely distributed in all of Partnership's threshold languages, meeting the requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,[6] and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

Partnership's C&L Program objectives are accomplished through interdepartmental collaboration and include:

- Collecting and updating data on the race/ethnicity, language, sexual orientation gender identity, and other relevant needs, such as age-related needs, of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities.[7,8,9,10,11]
- Continually assessing, monitoring, improving, and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.
- Addressing deficiencies and gaps in Partnership's C&L services.
- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members.

Measurable objectives can be found later in this document and in the joint Quality Improvement Health Equity Transformation Program (QIHETP) and Cultural and Linguistics (C&L) annual work plan. Starting in 2026, the C&L/QIHETP annual work plan will be renamed as the C&L annual work plan.

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[6] APL 18-016 Readability and Suitability of Written Health Education Materials
[7] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[8] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[9] 42 CFR 438.206(c)(2); 438.10; 438.404
[10] W&I Code 14029.91
[11] Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

Programs and Services

Partnership's C&L programs and services outlined below encompass the services directly provided to members and potential members, as well as the support provided to Partnership staff, providers', and delegates' capacity in understanding the C&L needs of our member population. Partnership will take action as appropriate to improve its culturally and linguistically appropriate services when deficiencies are noted.

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) to address potential changes to threshold and concentration standard languages (see MPND9002 attachment C for threshold languages) as well as any changes in state and/or federal law. Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in APL 25-005 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals, as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to APL 25-005 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.[12] Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

In addition to DHCS's language data collection and analysis process for Partnerships' member population, Partnership conducts its own data analysis at the community and/or census level to determine and report out on the languages spoken by five (5) percent or 1,000 individuals, whichever is less, and by 1% of the population or 200 individuals, whichever is less. For more details on this process, please refer to the separate Community Language Assessment report.

At the time of the writing of this document, Partnership's concentration standard and/or threshold languages are Russian, Tagalog, Spanish, and Punjabi, as determined by DHCS. For information on threshold languages as determined by Partnership using NCQA methodology, please refer to the Community Language Assessment report.

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[12] APL 25-005 and Threshold and Concentration Languages

These practices help to address potential changes to threshold and concentration standard languages, as well as any changes in state and/or federal law. This information is used as part of the assessment of language services for members to improve the Cultural and Linguistics program offerings, and when possible, to guide network development. Partnership retains a list of the DHCS-provided threshold and concentration languages (see MPND9002 attachment C for threshold languages), and Partnership-determined threshold and concentration standard languages. Adjustments to the list will be based on findings from the Community Language Assessment report and DHCS's triennial timeline.

Partnership distributes a written notice in English and other languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record.[13] Partnership may use or disclose the member's preferred language with Partnership network practitioners/providers, subcontractors, or other covered entities for the purposes of ensuring communication and care delivery are in a culturally sensitive and linguistically appropriate manner. Members are informed that their language preferences may be shared when language information is directly collected.

Partnership also assesses and collects data on the cultural and linguistic needs of the member population through the written Population Needs Assessment (PNA). Each year, Partnership assesses the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population. This information is collected from its member population data and integrated into the PNA, which helps drive the goals of Partnership's Population Health Management Strategy, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are part of the driving force by which Partnership responds to the cultural and linguistic diversity and needs of Partnership's member population. The annual report is written in accordance with the requirements of the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA).

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.[14] This collaborative work is referred to as

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[13] APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and APL 22-017 MMR Standards

[14] DHCS Population Health Management Policy Guide

the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process. Based on this collaborative work, and input from various stakeholders, including Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee), Partnership annually reviews, and updates as needed, its strategies and work streams, health equity efforts, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs. Findings from both the PNA and CHA/CHIP work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

Partnership members are entitled to timely language assistance services at no cost to them, such as oral interpretation services (including the provision of auxiliary aids and services) and written translation of critical and vital informing materials in their preferred threshold language, including oral interpretation and American Sign Language, as well as their preferred alternate format. Partnership members can request Interpreting and/or translation services by contacting the Member Services Department or any other member-facing department (Utilization Management, Population Health, Care Coordination, Grievance & Appeals, Behavioral Health, and Transportation Services). Members using TTY/TDD can also call a toll-free number.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services, Nondiscrimination Notices, and Member Information

In alignment with APL 25-005[15] and other DHCS requirements, Partnership provides nondiscrimination notices and Language Assistance Notice of Availability. Nondiscrimination notices are provided and inform Members, Potential Members, and the public about nondiscrimination, protected characteristics, accessibility requirements, and information on how to file a grievance. A Language Assistance Notice of Availability is also provided in a visible font size in English and the top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members, potential members, and the public of all available language assistance services at no cost to them as well as how to access them (including written translation and interpretation). To see these two notices in detail please refer to attachment A & B in MCNP9004 Regulatory Required Notices.

The Language Assistance Notice of Availability and nondiscrimination notices are provided in a font size no smaller than 12-point and are available in all Threshold

[15] APL 25-005

Languages/Concentration Standard Languages and in an accessible format. Alternative formats available to members include braille, large-size print font no smaller than 20-point, accessible electronic format, or audio format, and Auxiliary Aids-at no cost to the member, and upon request. Consideration is also given for the special needs of members with disabilities or LEP members. Although quick response codes, otherwise known as QR code may be used alongside the nondiscrimination notice and notice of availability, they are not to be replaced by the use of QR codes.

Nondiscrimination notices and the Notice of Availability of Language Assistance Services are also sent with all member correspondences, which include, but are not limited to:

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory
- Form letters and notices critical to obtaining services
- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters
- Notices of Organization and Coverage Determinations
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public
- Other written communications and/or informational notices for members, Potential Members, and the public as applicable.

In alignment with APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats, the nondiscrimination notice and the Notice of Availability includes Partnership’s toll-free and/or Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services. The nondiscrimination notice also includes information on how to file a discrimination

grievance directly with Partnership, DHCS' OCR, and HHS' OCR. The regulatory notices are posted in the following places in a clear and prominent manner:[16]

a) In the Member Handbook/EOC and other electronic and written communications,
b) In all physical locations in 20-point font sans serif where Partnership interacts with the public and where members seeking health programs or activities would be able to read or hear the notice;
c) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
d) In all Member information and other informational notices, in accordance with federal and state law and this APL.

Partnership maintains a library of member-facing materials in all Partnership threshold languages, including vital information such as major correspondence, health education materials, and other benefit-related member informing materials. In alignment with DHCS requirements, all member facing material and correspondences (member informing and health education) are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, and are sent in the member's preferred language (including Partnership's threshold languages) and format; translation of member facing materials are provided at no cost to members. Member informing materials are approved by DHCS before distribution, while health education materials are approved by a Qualified Health Educator as defined by APL 18-016.[17]

Partnership also provides members with requested information in their preferred format in a timely fashion. Preferred formats include braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon member request.

Any mailed correspondence is sent according to the member's preferred threshold language or format (as described above) as requested. Documents like letters or utilization review determinations are typically translated within 2 business days after submission of request; members may also request translation of other documents. Members receive their fully translated materials in a timely manner and in alignment with department-specific timelines, but no later than 30 days after the request was made.

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[16] APL 25-005

[17] APL 18-016 Readability and Suitability of Written Health Education Materials

Translation Service

Partnership utilizes Propio (formerly United Language Group) as the certified translation service of all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Partnership's Threshold or Concentration Standard Languages. Partnership translates all member facing materials into its designated threshold and concentration standard languages or other languages as requested. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, or other languages as necessary, at no cost to the member from a qualified translator.

If a member has requested to receive translated written information in either traditional or simplified Chinese characters, Partnership must provide written information in the member's preferred characters. If member does not indicate a preference, Partnership will provide translations in Traditional Chinese characters. Only upon member request, Partnership is required to provide translated written information in Simplified Chinese characters.

Member requests are fulfilled in a timely manner. Translation services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days; however, turnaround times may vary depending on the complexity and rarity of the language requested and dependent on specific departmental turnaround times, but no more than 30 days from the request; this includes requests for braille and large font (see table 1 below).

Table 1: Department Specific Translation Turnaround Times for Vital Documents

Department Specific Translation Turnaround Times for Vital Documents	
Type of Document	**Department Turnaround Time**
Information about eligibility, benefits and coverage (e.g., welcome packets, benefit summary,	Translation times vary depending on the size of materials. Small to medium size materials range from 2 to 14 business days. Larger items such as an Evidence of Coverage (EOC) may take up to 30 days.
Explanation of benefits (EOB)	2-30 days depending on complexity.
Notifications pertaining to denial, reduction, modification or termination of services and benefits.	Notice of Action (NOA) translations: 48 hours.
Information about the right to file a complaint, grievance or appeal (e.g., the portion of the notice that does not contain individual-specific information).	Non-Discrimination Notices contain information about the right to file a complaint, grievance or appeal. These are part of our acknowledgement and resolution letters. Those follow regulatory timeframes

	set by DHCS as stated below. No additional time for translated documents is given. • Acknowledgement Letter - 5 calendar days from the receipt date of the case. • Resolution Letter - 30 calendar days from the receipt date of the case.
Notification of practitioner termination.	Practitioner termination notice: 2-4 business days for translation depending on the length of the notice.

Threshold and concentration languages are defined by DHCS APL 25-005. All translations are verified by separate, additional Propio translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see MPND9002 attachment D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 25-005.[18] Per this APL, a translator translating for Partnership member must:

- Adhere to generally accepted translator ethics principles, including client confidentiality,
- Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and,
- Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original written statement.

Partnership has requirements for their translator certification process, as set forth by Propio Translations in MPND9002 D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members who are monolingual, non-English-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Points of contact may include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient

[18] APL 25-005

encounters with providers; and non-medical care settings, such as member services, orientations, and appointment scheduling. Oral interpreter services are available for any language spoken by the member. Oral interpreter services are available in all of Partnership's threshold languages, and over 140 additional languages are available upon member request through Partnership's contracted language service provider, AMN HealthCare (see MPND9002 attachment A for criteria and authorization requirements for interpreting services). Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also required to provide interpreter services for members, however, workflows vary per delegate. Partnership staff who are qualified interpreters are also available for interpreter services in select languages. Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language. Furthermore, s described in the translation services section above, Partnership offers written translation services of member facing materials in its threshold and concentration languages and upon member request; however, sight translation (oral interpretation) of written information can also be provided upon member request when members need a document translated immediately during medical appointments, when connecting with health plan staff, or in other necessary circumstances. Member's preferred language (if other than English) is also prominently noted in their medical record, as well as their request or refusal of language/interpretation services (including refusal of interpreter services from members with disabilities) in accordance with APL 25-005.[19]

Partnership uses the definition provided by APL 25-005 in vendor selection and to define a qualified interpreter as an interpreter who:

- Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages);
- Be able to interpret effectively, accurately, and impartially to and from such language and English, (or between two non-English languages for relay interpretation), using any necessary specialized vocabulary, or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original oral statement; and

[19] APL 25-005

- Adhere to generally accepted interpreter ethics principles, including client confidentiality.

When providing high quality interpretive services for an individual with disabilities, Partnership uses qualified non-oral interpretation services either through a remote interpreting service or an onsite appearance in alignment with the requirements stated in APL 25-005. This definition asserts that an interpreter who provides interpretive services for an individual with disabilities is an interpreter who:

- Adheres to generally accepted interpreter ethics principals, including client confidentiality; and
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology without changes, omissions, or additions while preserving the tone, sentiment, and emotional level of the original statement; and
- Has demonstrated proficiency in communicating in and understanding English and a non-English language (including American Sign Language) or another communication modality such as cued-language transliterators or oral transliterators.

For an individual with a disability, qualified interpreters can include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

Partnership will not require Members with LEP or members with a disability to provide their own interpreters, pay for the cost of their own interpreter, or rely on staff who are not qualified interpreters or bilingual/multilingual qualified. Partnership does not allow for the use of unqualified interpreters, adult friends, family, or minor accompanying a member to provide interpreting services or facilitate communication except:

- As a temporary measure when there is an emergency involving an imminent threat to the safety or welfare of the Member or the public and a qualified interpreter is not immediately available; or,
- If the LEP Member or member with a disability specifically requests that an accompanying adult interpret or facilitate communication. This request must be done in private with a qualified interpreter present and without an accompanying adult present. Additionally, the accompanying adult must agree to provide that assistance, the request and agreement is documented, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

Prior to using a family member, friend, or in an emergency only, a minor child, for interpretation services, the MCP will inform the Member they have the right to free interpreter services and ensure that the use of an interpreter will not compromise the effectiveness of services or violate the individual's confidentiality. Partnership will make a good faith effort to ensure that the refusal of free interpreter services and the member's request to use a family member, friend or minor child as an interpreter is documented in the medical record.

Auxiliary Aids and Services

In accordance with APL 25-005 and APL 25-016, Partnership provides the following auxiliary aids and services to members in an accessible format, in a timely manner, and at no cost to the member, including qualified interpreters and written materials in alternative formats, to a family member, friend, their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with according to the member or as designated by law. This is done in a way to protect the Member's privacy and to ensure that Members with disabilities have an equal opportunity to participate in, or enjoy the benefits of, the MCP's services, programs, and activities. Auxiliary aids and services may include:

- Qualified oral and sign language interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.

- Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

Please see MPND9002 attachment B to learn more about how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

In accordance with APL 25-005 and APL 25-016, Partnership provides member information in alternate formats to meet the cultural and linguistic needs of members and potential enrollees, including Braille, large print text (20 point or larger), audio, and accessible electronic formats (such as data CDs), at no cost to the member and with primary consideration of the individuals request for specific auxiliary aids or service.

Partnership maintains record of member's linguistic capability upon member enrollment, and as updated thereafter, using data provided by DHCS, received via the 834 enrollment data file, or reported to Partnership by the member and/or their AR, or by subcontractors. Partnership also collects and stores member's alternative format selections (AFS) for receiving written materials in accessible formats. Partnership will make reasonable efforts to direct members to make or update their AFS through BenefitsCal or their local county office. AFS information is shared with subcontractors and network providers, as appropriate, to ensure accessibility of communications.

In alignment with APL 25-016 when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request an encrypted format, the requested member information will be provided in an electronic format that is not password protected. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the member can access the encrypted information in their requested format.[20]

Trainings

In alignment with APL 24-016 and the DHCS contract, Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream

[20] APL 25-016 Alternative Format Selection for Members with Visual Impairments

subcontractors. This training is referred to as CARES: Community, Access, Respect, Engagement, Service. Contracted network providers, contractors, and subcontractors are eligible to submit their own diversity, equity, and inclusion training for review and approval by Partnership's Director of Health Equity in consideration of DHCS regulatory requirements. Separately, Partnership educates contracted network providers, contractors, subcontractors, and staff on Partnership-specific policies, practices, and guidelines for Partnership-specific cultural and language assistance services.

Partnership provides trainings for contracted practitioners of Network Providers within 90 days of their start date, with retraining as needed during re-credentialing cycles. The training program for providers will be region specific and include consideration of health-related social needs and disparities that are specific to Partnership's servicing counties and demographics. Practitioners from different regions will receive different course recommendations that are unique to their region. Practitioners are required to acknowledge review of their region's respective disparity report during the completion of the training. For more information on the provider training, please see the MCEP6004 DEI/Cultural Connection Training policy.

Partnership staff will receive the staff-specific DEI training on an annual basis. Partnership staff training records are managed by Human Resources while the Provider training records are managed by Provider Relations and Health Equity Department.

Also in alignment with APL 24-016, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as digital training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of service. It will review 3 major themes to ensure coverage of Partnership member demographics including, but not limited to, members' 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 person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 themes described in the training, see the MCEP6004 DEI/Cultural Connection Training policy.

The Cultural and Linguistic unit audits DHCS-identified delegates' annual trainings to ensure that they are in compliance with required elements.

Partnership's State Hearing Representative is working towards becoming a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored.

Beyond offering training to promote Cultural and Linguistic related topics, Partnership works to identify and act on at least one area of opportunity to improve the diversity, equity, inclusion (DEI) and cultural humility within the following groups per the findings of the annual Health Equity Accreditation workforce analyses:

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Cultural and Linguistic Program Evaluation

On an annual basis, Partnership writes a Cultural and Linguistic Program Evaluation as part of a larger set of linked documents, referred to as the Cultural and Linguistic Trilogy documents. This Trilogy of documents consists of the MPND9002 Cultural and Linguistic Program Description, the Annual Cultural and Linguistic Workplan, and the Annual Cultural and Linguistic Program Evaluation. The Annual Cultural and Linguistic Program Evaluation details the performance of the Cultural and Linguistic program. This evaluation is drafted using elements and findings from the Cultural and Linguistic Program Description and the Annual Cultural and Linguistic Workplan. Key elements in this annual evaluation include review and analysis of key program structure/processes, review and assessment of progress towards workplan goals, annual trending of data, gaps and/or barriers, review of the Community Advisory Committee (CAC) feedback, overall program effectiveness, and opportunities for improvement.

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership contracts with qualified bilingual providers as a linguistic service to members and potential members at no cost and, when possible, to reflect the linguistic needs of Partnership’s members. Using the results from an annual, self-reported survey of our primary care sites, as well as documentation of staff changes, Partnership publishes updates to the Provider Directory to best reflect the linguistic capabilities at provider offices.

Annually, Partnership performs an audit of its delegated cultural and linguistic services providers to ensure their services meet the needs of our members, including members

under 21 years of age as well as their parents, guardians, and authorized representatives. Identified gaps are addressed as needed.

In accordance with Partnership's Policy HR509 Bilingual Standards, Partnership assesses the linguistic capabilities of its bilingual staff from member-facing departments to ensure they meet the necessary linguistic requirements to serve as qualified bilingual staff. Partnership's Human Resources Department maintains a record of staff members deemed as qualified bilingual staff, and their evaluation results.

Member-facing Departments include:

- Behavioral Health
- Care Coordination
- Grievance & Appeals
- Member Services
- Population Health Management
- Transportation Services
- Utilization Management

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees select regulatory requirements related to Cultural & Linguistics program and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Other key departments within Partnership also support the Cultural and Linguistic program and program compliance.

Partnership also created the Population Needs Assessment Committee to review findings and strategies, as needed, to address cultural and linguistic needs identified in the collaborative work referred to as the CHA and CHIP process (please refer to MPND9001 for more detail). Please note, in 2026, this committee will be disbanded. To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

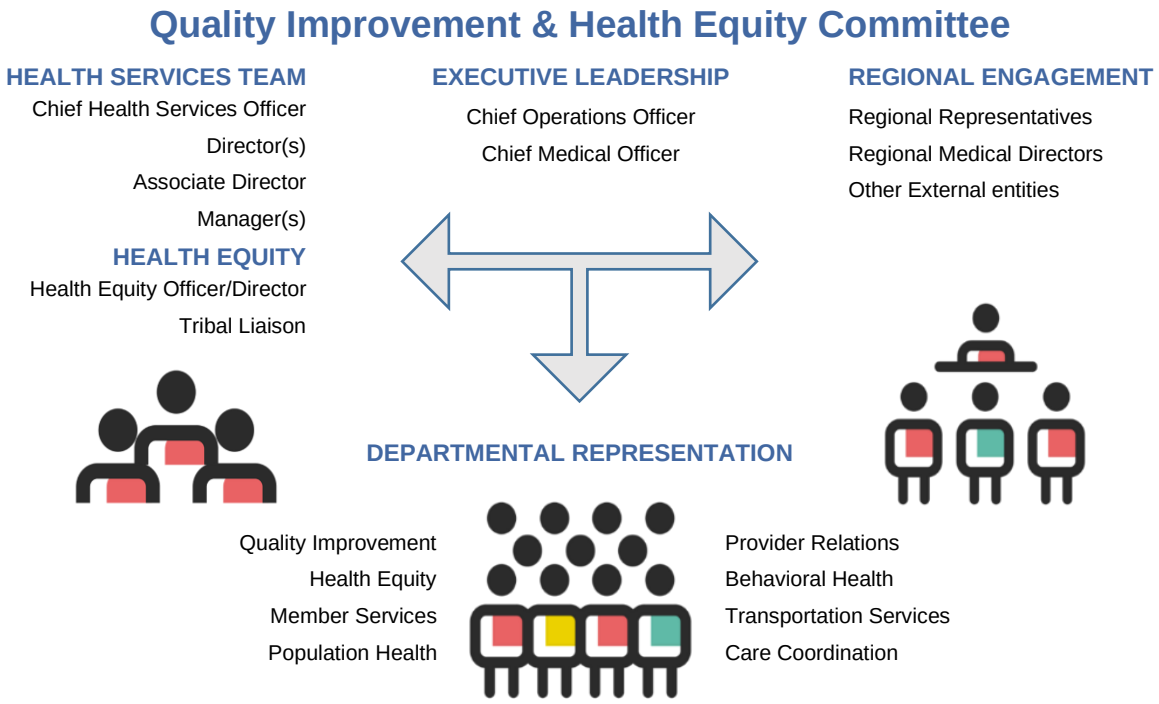
Partnership also houses the Quality Improvement Health Equity Transformation Program (QIHETP). The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system is to address improvements in the quality of care delivered by all of its providers in any setting and

take appropriate action to improve upon the health equity and health care delivered to members. Partnership's QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

For more information on QIHETP, refer to MCED6001 QIHETP Program description.

As part of the QIHETP, in accordance with MPND9001 and MCEP6002, the Quality Improvement Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal Partnership specific committee. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. Furthermore, the QIHEC meets bi-monthly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the QIHETP workplan (see figure below). Lastly, the QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). For more details on the QIHEC, refer to MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).



Community Engagement

Partnership's Community Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community (see attachment MPND9002-E CAC Guiding Principles and Policy MCCP2024 for more details on these committees). The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD) (including representatives who receive LTSS and/or individuals representing LTSS recipients), persons with chronic conditions, Limited English Proficient (LEP) Members, adolescents and/or parents and/or caregivers of children, including current and/or former foster youth and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

One role of the CAC and FAC is to advise Partnership on the development and implementation of its C&L services program. The CAC and FAC also work to identify and help prioritize opportunities for improvement.

The CAC can also provide input and advice, including, but not limited to, the following:

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;

- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Annual C&L Program Evaluation
- Plan marketing materials and campaigns.
- Communication of needs for Network development and assessment;
- Community resources and information;
- Population Health Management
- Health Equity;
- Accessibility of Services; Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan;
- Input on Quality Improvement and the Population Needs Assessment;
- Health related initiatives; Reforms to improve health outcomes, accessibility, and coordination of care for Members; and
- The MCP's Provider Manual.
- Resource allocation; and
- Other community-based initiatives

To learn more about the CAC, please refer to MPND9002 attachment E CAC Guiding Principles.

In addition to CAC, Partnership also has dedicated staff to gather input and participation from the communities it serves in order to ensure that it meets the needs of its members. The Cultural Community Manager leads engagement with communities experiencing health disparities across 24 counties and oversees reinvestment liaisons, who will collaborate with local counties to implement future reinvestment projects addressing disparities identified through community and partner input. The role also seeks input from individuals with relevant experience and expertise to meet the diverse cultural, linguistic, and other needs of members by:

- Conducting interviews and focus groups to elicit feedback from members of various local communities, including Partnership members, on key health disparities in order to improve health outcomes.
- Disseminating community feedback to internal departments, external workgroups, and committees to inform and enhance programs and initiatives.
- Building and maintaining relationships with community-based organizations, translating community needs into actionable recommendations for the health plan.
- Advising on Partnership's community engagement across multiple departments.
- Leading engagement with network providers/practitioners, subcontractors, and downstream subcontractors to implement focus groups or individual 1:1 meetings, across the network, to directly gather direct feedback from members.

Delegate/Vendor Audits

In alignment with DHCS requirements, Partnership delegates some C&L services to subcontractors, including interpreter services, translator services and the coordination of auxiliary aids and services in a culturally and linguistically appropriate way. A formal agreement is maintained and inclusive of all delegate functions. Partnership's Health Education unit conducts an audit no less than annually on these delegated bodies. This audit helps to ensure that delegates have appropriate policies and procedures in place to meet compliance with state and federal language and communication assistance requirements as well as civil rights laws requiring access to members with disabilities and other C&L service requirements. The annual audits also help to ensure Subcontractors and Downstream Subcontractors deliver culturally and linguistically competent care, including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language. Any unmet requirements result in the delegate receiving preliminary CAPs. Any preliminary CAPs that were not closed within the timeframe given by the Audit team are deemed final CAPs. Any final CAPs will go to Delegation Oversight Review Sub-committee (DORS) for additional review and direction, even if the delegate submits appropriate documentation before the DORS meeting.

Furthermore, Partnership will make reasonable efforts to report activities that aim to ensure members are aware of their right to receive effective communication, what requests for auxiliary aids and services have been made by members, if any, how Partnership has responded to those requests, and Partnership's response to any complaints regarding the receipt of effective communication.

Partnership acknowledges the type of relationship described above is known to the National Committee for Quality Assurance (NCQA) as a vendor relationship. Partnership has no known entities acting upon its behalf that would constitute a delegate as defined by the NCQA Health Equity Accreditation standards.

Goals and Work Plan

Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards (the improvement of service appropriateness or accessibility) and/or for the reduction of health care inequities that are presented annually in the C&L work plan; these goals may differ year to year. This annual work plan describes the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS and/or reduction of health care inequities Partnership invests in the C&L program and goals as part of increasing access to care in order to improve member health outcomes; these

efforts ultimately align with our mission to help our members, and the communities we serve, be healthy.

This annual plan is reviewed and/or approved by various committees, including:

- The Quality Improvement and Health Equity Committee (QIHEC)
- The Internal Quality Improvement (IQI) Committee
- The Quality Utilization Advisory Committee (Q/UAC)
- The Physician's Advisory Committee (PAC) as final approval

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L work plan to all stakeholders, and constituents as appropriate.

2026 Goals

Partnership identified multiple goals for 2026. Multiple goals will carry over from 2025 to track trends data from year to year. Goals carried over from 2025 were modified based on findings of the Cultural and Linguistic Program Evaluation. These goals are listed below. Additional goal details can found in the C&L workplan:

- Goal 1: By December 31, 2026, 92% of members who have requested materials in an alternative format will be mailed in their preferred format.
    - This goal was chosen to ensure members receive information in a way that they can understand.
- Goal 2: By December 31, 2026, increase the percentage of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.
    - This goal was chosen to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 3: By December 31, 2026, improve the rate of timely translations in the Utilization Management and/or Care Coordination by 1% from baseline of 96% or 98.5%, respectively.
    - This goal was chosen due to the recognized need for quality translation services and an overall positive member experience.

- Goal 4: By March 31, 2026, complete the 2025 C&L Program Evaluation.
    - This goal was chosen to ensure the complete evaluation took place.

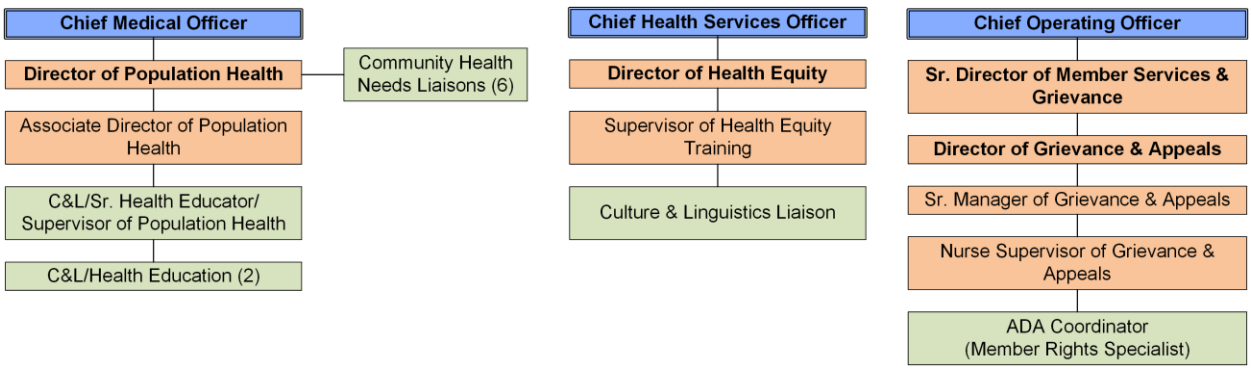
Partnership will continue to monitor these goals through the annual C&L work plan to ensure the goals are met. Progress toward these goals will be reviewed by appropriate Population Health staff on a quarterly basis. Progress toward these goal will also be reviewed and/or approved no less than annually by the committees described above,

with PAC having the final approval. The C&L work plan describes in more detail the measures that will be collected, frequency of monitoring, and staff responsible for goal progress.

Cultural and Linguistic Team Structure

Population Health operations are supported by a leadership team and administrative staff that recruits, promotes, and supports a culturally and linguistically diverse structural and organizational environment that is responsive to Partnership members.

Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy (MPND9001), and identifying the health disparities, wellness needs, and health education needs of Partnership's members. These efforts are also supported by other Partnership departments and include making referrals to culturally and linguistically appropriate community service programs and aligning organizational and community efforts to meet these needs, in accordance with DHCS, NCQA, and CMS requirements. To accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population, including the provision of cultural and linguistic services. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, identify and refer to culturally and linguistically appropriate community service programs when available, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, and promote collaboration of effort and reduce duplication of services. Below is an overview of Partnership staff who support key Cultural and Linguistic services. While other Partnership teams also support the cultural and linguistic services that make up the C&L program as needed, the graphic below depicts the main reporting structure of key staff who support the C&L program.



Team Roles and Responsibilities by Department

Population Health Department

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of services. Required education includes an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum 2 years' experience in a managed care plan preferred, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of 7 years' clinical/medical practice experience.

Director of Population Health

The Director of Population Health is the key business leader who oversees the organization's Population Health Management strategy and is responsible for providing leadership, alignment, support, strategic development and implementation of associated activities and interventions. Provides clinical guidance and strategic direction for departmental activities by applying their understanding of population health management priorities, health care policy, financing, and regulations to promote optimal health outcomes for members. A Bachelor of Science Nursing or Doctorate in Public Health is required. At least 5 years of experience in a leadership/management role is also required. Experience in a managed care, health care provider network and/or working with Medi-Cal population is preferred.

Associate Director of Population Health

Under the leadership of the Director of Population Health, manages and provides direction to the Population Health team managers and supervisors to ensure Basic Population Health Management activities are performed in compliance with DHCS and NCQA requirements. Participates in the development, implementation, and maintenance of Population Health programs and achievement of department goals and objectives in a fast paced, dynamic environment. This role ensures compliance with established operational criteria, NCQA, and DHCS Standards, and PHC policies and procedures. A bachelor's degree is required, but an RN license is preferred. A minimum of 5 years of relevant experience in health care operations, a minimum of 3 years of management experience with effective problem solving, or equivalent combination of education and experience is required.

Supervisor of Population Health

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff. Bachelor's degree in business, Communication, Healthcare Administration, or a related field, or 3-5 years of managed care experience; or equivalent combination of education and experience is required. General knowledge of managed care and principles of population health management is preferred.

Senior Health Educator

The Senior Health Educator is a public health masters-prepared (or MCHES-certified) professional who maintains administrative oversight of health education and supports oversight of cultural and linguistic services. This role also implements health education activities that promote member wellness, understanding of benefits, and access to care. This position is responsible for health education programs and cultural and linguistic services. Plans, implements and evaluates health education activities; analyzes and coordinates cultural and linguistic services; Supports the development of the annual Population Needs Assessment (PNA) according to DHCS and NCQA guidelines; and collaborates in developing and implementing organizational interventions identified in the PNA in conjunction with health promotion and equity programs. The Senior Health Educator may also perform supervisor responsibilities. This role requires a Master of Public Health (MPH) degree with a health education or health promotion emphasis, or master's degree in Community Health with a specialization in health education or health promotion, or Master Certified Health Education Specialist (MCHES) awarded by the National Commission for Health Education Credentialing, Inc. This role must have a minimum of 2 years' experience developing health education programs. Previous experience in a supervisory capacity, and/or experience or capacity to manage audit activities in our provider network, and experience or equivalent academic training on identifying health disparities within different cultures is preferred.

Health Educator(s)

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on specific member education projects, and monitors health education materials, and evaluates member grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a bachelor's degree in health education, Public Health, Community Health or related field, experience in Public Health Education. A minimum of 2 years of health education experience is preferred.

Community Health Needs Liaison(s)

Collaborates with internal staff in the development of Partnership's Population Needs Assessment (PNA) through active participation in the Local Health Department's Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) processes. Identifies and support key strategic activities and interventions that promote efforts to encourage members' health outcomes. Works with Health Educator team to identify appropriate member educational materials to share with community partners, providers, and members. Required education includes bachelor's degree in public health, Community Health or related field; A minimum of 2 years of experience in public health is preferred.

Health Equity Department

Chief Health Services Officer:

This position is responsible for the executive management and operational leadership of the following Partnership Health Plan of California Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, and associated initiatives under CalAIM. This position provides executive leadership in organizing the health plan's operations, interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs. A master's degree in nursing, Public Health or Health Administration or a related field is preferred; a bachelor's degree is required. This role must have a minimum of 10 years' experience in healthcare, with 7 years of management experience in healthcare organization, preferably leading and managing major clinical programs & initiatives, general and fiscal operations, or equivalent combination of education and experience.

Director of Health Equity

The Director of Health Equity will partner with other Partnership leaders to develop and drive forward the key strategies to be a diverse, equitable, and inclusive organization. They will be responsible for driving systemic change to increase diversity and representation as well as building programs that foster an inclusive culture of belonging. This position will promote pathways towards raising awareness of health inequities within our membership and concrete plans for addressing them. This will include working to track, trend and improve disparities in care, recognizing the diverse cultural, language, economic, education and health status needs of those in our service area and organization. A bachelor's degree in social work, health care, public policy, business, or related field, 5 years of experience advocating for and implementing change within a multi-cultural environment, with at least 3 years' experience developing

and implementing diversity, equity, and inclusion programs, or equivalent combination of education and experience is required.

Supervisor of Health Equity Training

The Supervisor of Health Equity Training is responsible for executing and managing diversity, equity, and inclusion (DEI) training programs and initiatives to enhance the skills, knowledge and performance of the company, network provider, subcontractors, downstream subcontractors, etc. This role also participates in DEI training meetings, supports DEI Training all plan letter requirements set forth by DHCS, and supports monitoring of training completion of Partnership staff, network providers, subcontractors, downstream subcontractors etc. A bachelor's degree is preferred. At least a minimum of 3 years of experience working directly in DEI initiatives with a proven track record of developing and implementing successful training programs; or any combination of education, training, and 4 years of experience which provides the required knowledge and abilities is required. This role must also be knowledgeable in the use of Learning Management Systems (LMS), Electronic Learning platforms, online learning programs, and industry leading virtual learning programs.

Cultural and Linguistic Liaison(s)

The Cultural and Linguistic Liaison is responsible for overseeing grievance and appeal reviews, as well as conducting cultural and linguistic reviews for our subcontractors to ensure alignment with our commitment to diversity and inclusion. This role will provide support to the department on promoting health equity within our organization and in the community, ensuring fair and just access to healthcare services for all members. A bachelor's degree in public health, Community Health or related field preferred, 2-4 years of experience in Health Equity, or equivalent combination of education and experience is required.

Grievance & Appeals Department

Chief Operating Officer:

This position is responsible for the oversight of operations and executive management of the Claims, Member Services, Health Services (Utilization Management and Care Coordination), and Provider Relations Departments, the Project Management/Operational Excellence unit, Partnership's Northern Region regional office, and the Administration Department within the Southern Region, within Partnership. This position provides leadership in organizing the Health Plan's operations, interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs. Required education includes a master's degree in business, Public Health,

Health Administration, Communication, Marketing, Government, Political Science, or related field; a minimum of seven (7) years of management experience within a health care organization (managed care or prepaid health system experience preferred); general and fiscal operations; or equivalent combination of education and experience is required.

Sr. Director of Member Services & Grievance

The Senior Director of Member Services and Grievance is responsible for leading, planning, organizing, and managing all operational functions of the Member Services and Grievance departments organization- wide. This role ensures efficient operations, compliance with policies and procedures and achievement of department goals and objectives. A bachelor's degree in business or related field required; minimum ten (10) years of experience at a manager level or above in a managed care environment and/or call center; or equivalent combination of education and experience is required.

Director of Grievance and Appeals

This Director of Grievance and Appeals has the overall responsibility for leading, organizing, and directing the Grievance & Appeals (G&A) Department. This role provides strategic direction and oversight to ensure Partnership HealthPlan of California meets its regulatory and contractual obligations related to G&A. This role oversees the Investigation Team, which is responsible for end-to-end investigations of member grievances, appeals, and state hearing cases. They ensure all casework is compliant with applicable state and federal requirements, the Department of Healthcare Services (DHCS), and the National Committee for Quality Assurance (NCQA) credentialing standards. They oversee the G&A Compliance & Strategy Team, which monitors the impact of regulatory changes to G&A, extracts data for DHCS-mandated reporting, performs internal auditing of G&A casework, completes quantitative and qualitative NCQA reporting, and implements all G&A-related initiatives. The Director represents G&A in all external DHCS and NCQA regulatory audits, and is a key speaker on G&A trends at internal and external committees. They are responsible for organizing and facilitating the internal quality committee — the Member Grievance Review Committee (MGRC). They also hold budgetary responsibilities. A bachelor's degree from an accredited institution is required; an MBA or equivalent is preferred. At least seven (7) years of experience in the managed care industry is required; a minimum three (3) years' experience in Grievance & Appeals is preferred. A minimum of five (5) years in a leadership role is also required.

Sr. Manager of Grievance and Appeals

The Senior Manager of Grievance & Appeals serves as a key departmental leader who will be responsible for strategic oversight and continuous improvement of all grievance, appeal, state hearing, and expedited case processes. This role leads and mentors a multidisciplinary team including Grievance Clinical Nurse Supervisors, State Hearing Representatives, Grievance Clinical Nurse Specialists, Supervisors, Grievance Case Analysts, Grievance Resolution Specialists, and Grievance Associates, ensuring excellence in case quality, regulatory compliance, timeliness, and member experience. In partnership with the Director, the Senior Manager drives the development and implementation of department wide goals, and quality improvement initiatives. This position represents the department in cross functional work groups, enterprise-wide projects, and external regulatory engagements, serving as a leader and advocating for equitable member resolution. The Senior Manager champions professional development, cultivates a high performance culture, leads efforts that contribute to organizational growth and member satisfaction, and provides strategic leadership, training and direction to staff.

A Master's or Bachelor's degree in Business, Nursing, Healthcare Management, or other related field and 4-5 years experience in the healthcare industry, of which at least 3 years are in a leadership capacity, and/or equivalent combination of education and experience is required. Experience in Grievance & Appeals, case management, customer service, account management, or experience in de-escalation is preferred. This role must be willing to manage onsite and teleworking staff and have excellent written and interpersonal communication skills. Demonstrated conflict resolution and mediation skills are also required. This role must be confident, autonomous, solution driven, proactive, detail oriented, have high standards of excellence, be nonjudgmental, diplomatic, resourceful, intuitive, dedicated, and resilient.

Nurse Supervisor of Grievance and Appeals

The Grievance and Appeals (G&A) Nurse Supervisor provides clinical and operational supervision to the Grievance & Appeals nursing team, including Nurse Specialists, Sr. Nurse Specialists, and State Hearing Representatives. The Nurse Supervisor maintains an active clinical caseload while overseeing the daily operations, workload distribution, and performance of the clinical team. The Nurse Supervisor ensures that casework meets all regulatory and quality standards, including DHCS guidelines, CMS regulations, NCQA standards, and internal best practices. This position supports management in driving team performance, upholding productivity and accuracy standards, and ensuring a cohesive and collaborative team environment. The Nurse Supervisor exercises advanced clinical judgment to assess, guide, and resolve complex

cases and provides direct support and mentorship to staff. The role represents the department clinically in internal and external settings, including participation in hearings and key committees, and plays a central role in the department's clinical oversight and continuous improvement initiatives. A bachelor's degree in healthcare administration, Business Bachelor's degree in Nursing, 3-5 years' experience to include at least one (1) year of case management experience and one (1) year in an acute care setting; or equivalent combination of education and experience is required; CCM is desired. Knowledge of Partnership Grievance & Appeals processes is also desired. General knowledge of managed care with emphasis in UM or CM is preferred.

ADA Coordinator (Member Rights Specialist)

The Member Rights Specialist serves as the Plan's designated ADA Coordinator. This role is responsible for overseeing compliance with federal and state nondiscrimination and accessibility requirements, including the investigation, tracking, and resolution of ADA and discrimination related grievances. The Member Rights Specialist ensures appropriate review of reasonable accommodation requests, provides subject matter expertise to internal departments, and supports regulatory reporting related to member rights and accessibility standards. In addition, the Member Rights Specialist represents the Plan in State Fair Hearings. The Member Rights Specialists will reports to the G&A Nurse Supervisor (RN).

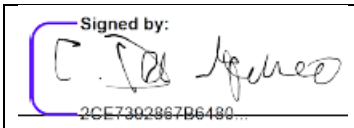
Cultural & Linguistic Program Description Approval

	03/18/2026

Robert Moore, MD, MPH, MBA — *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	04/08/2026

Angela Brennan, DO — *Date Approved*
Physician Advisory Committee Chairperson

	04/22/2026

Dean Germano — *Date Approved*
Board of Commissioners Chairperson