DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

December 6, 2024

Cindy Metcho, Compliance Manager
Anthem Blue Cross Partnership Plan, Inc.
21215 Burbank Blvd.
Woodland Hills, CA 91367

Via E-mail

RE: Department of Health Care Services Medical Audit

Dear Ms. Metcho:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Anthem Blue Cross Partnership Plan, Inc., a Managed Care Plan (MCP), from November 27, 2023 through December 8, 2023. The audit covered the period from October 1, 2022, through October 31, 2023.

The items were evaluated, and DHCS accepted the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and final CAP remediation document (final Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Lyubov Poonka, Chief
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief *Via E-mail*
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Grace McGeough, Chief *Via E-mail*
Process Compliance Section
Managed Care Monitoring Branch
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Anthony Martinez, Lead Analyst *Via E-mail*
Audit Monitoring Unit
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Nicole Cortez, Unit Chief *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

Emmy Louie, Contract Manager *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Anthem Blue Cross Partnership Plan
Audit Type: Medical Audit

Review Period: 10/01/22 – 10/31/23
On-site Review: 11/27/23 – 12/08/23

MCPs are required to provide a Corrective Action Plan (CAP) and respond to all documented deficiencies included in the medical audit report within 30 calendar days unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format, which will reduce the turnaround time for DHCS to complete its review. According to ADA requirements, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, as well as the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Supporting Documentation, and 4. Completion/Expected Completion Date. The MCP must include a project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text and include additional details, such as the title of the document, page number, revision date, etc., in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. Implementing deficiencies requiring short-term corrective action should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to remedy or operationalize completely, the MCP is to indicate that it has initiated remedial action and is on the way toward achieving an acceptable level of compliance. In those instances, the MCP must include the date when full compliance will be completed in addition to the above steps. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable, according to existing requirements.

Please note that DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP; therefore, DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP unless DHCS grants prior approval for an extended implementation effort.

DHCS will communicate closely with the MCP throughout the CAP process and provide technical assistance to confirm that the MCP offers sufficient documentation to correct deficiencies. Depending on the number and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates.

1. Utilization Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.2.1 Referral Tracking for In-Network Providers The Plan did not track or monitor referrals to in-network specialists.	Anthem acknowledges DHCS' concern regarding the potential increased risk of Fraud, Waste, and Abuse, if there is no mechanism in place to track and monitor referrals. However, this function is satisfied within Anthem's Special Investigations Unit (SIU). Anthem's SIU Investigators have access to several data mining tools as well as departments dedicated to data mining and analysis that incorporate data warehousing and database management. The data work includes the use of predictive modeling, provider profiling, risk scoring, trend analysis, and other analytics. Thus, data mining and analysis is the primary method our investigators use in the detection and prevention of fraud, waste and abuse (FWA). Anthem's SIU also use a variety of technologies to support our FWA initiatives, including in-house custom built applications as well as fraud prevention platforms from outside vendors. Tools for identifying	CA_CRXX_001Member Verification of Services - CA Investigations of Suspected Fraud and Abuse	11/19/2019	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "Plan Policy: UMXX-003 Access to Specialty Care (revised date 07/23/2023), states, "No authorization is required by the Plan to see an in-network specialist." If a member needs to see a specialist regarding their health, the PCP will refer the member to an in-network specialist. If the PCP cannot find an in-network specialist, they can reach out to the Plan for assistance." (DHCS Medical Audit Report (Issued 05/14/24), page 7) • Plan Policy, "CRXX-001: Member Verification of Services - CA" (revised 10/25/22), demonstrates the Plan has a process to detect fraud and abuse, by on a quarterly basis verifying with members that services billed by providers were received. (1.2.1_CA_CRXX_001- Member Verification of Services - CA_Evidence) • Plan Policies, "PCXX-011: Adult Preventive Care Services – CA" (revised 6/14/24) and "UMXX-41: Pre-service Authorization of Services – CA" (revised 4/25/24), demonstrate Plan policies

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	overutilization include coding software, fraud and abuse analytics, and our own internal, proprietary health care analytics. These tools aid in identifying providers with a high likelihood of aberrancies that exhibit FWA characteristics, so that potentially fraudulent or erroneous claims can be prevented from being paid until those claims have been validated. The word 'provider' refers to any health care professional, medical group, independent practice association or facility. **Refer to: CA_CRXX_001 - Member Verification of Services-CA Investigations of Suspected Fraud and Abuse**			reflect PCP role in coordinating member care based on medical necessity and demonstrates that the member can schedule an appointment with specialists in a timely manner, as well as, services that require prior authorization and outlines review process, including medical necessity. **MONITORING AND OVERSIGHT** • Plan monitors FWA through several data mining tools as well as departments dedicated to data mining and analysis that incorporate data warehousing and database management. These tools aid in identifying providers with a high likelihood of aberrancies that exhibit FWA characteristics, so that potentially fraudulent or erroneous claims can be prevented from being paid until those claims have been validated. (Attach B 2023 Anthem Aug Deliverables) • Timely Access Playbook ○ Plan monitors timely access standards relating to appointment and telephone wait times, including after hours. Survey assesses compliance with timely access standards, rates of compliance by county, provider type within an established compliance threshold. Providers that fall below the threshold face possible corrective action.

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				○ Plan conducts Provider Appointment Availability Surveys annually. Plan monitors timely access standards relating to appointment and telephone wait times, including after hours. Survey assesses compliance with timely access standards, rates of compliance by county, provider type within an established compliance threshold. Providers that fall below the threshold face possible corrective action. (1.2.1_Timely Access - PPM Playbook 1_Evidence) **The corrective action plan for finding 1.2.1 is accepted.**
1.2.2 Prior Authorization in Potential California Children's Services (CCS) Eligible Conditions The Plan did not ensure prior authorization decisions were made in a timely manner while awaiting the	Anthem will take the following actions to address the finding. 1) Anthem will update processes outlined in P&P document **"CA_UMXX-004 CCS Referral and Coordination of Care"** to include education of provider on not delaying services while awaiting CCS eligibility decision. 2) Anthem will update processes to include education of staff on timeframe limits for authorizations	CA_UMXX-004 CCS Referral and Coordination of Care CCS Prior Authorization Referral Process 041524	6/14/2024	The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** • CA UMXX-004 Referral and Coordination of Care CCS Prior Authorization Referral Process was updated to educate providers to not delay services while awaiting CCS eligibility decision. (1.2.2_CA_UMXX_004_ CCS Referral and Coordination of Care_Evidence)

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confirmation of CCS eligibility.	when no CCS determination has been received. This process will add language on providing partial authorization so there is no delay in care. 3) Anthem updated the **"CCS Prior Authorization Referral Process 041524"** to reflect procedure updates and charting requirements (updated page 1) 4) Anthem will provide PIE audit charts/spreadsheets of CCS cases that demonstrate TAT compliance. 5) Anthem will provide documentation of internal CCS team meeting minutes to go over updated policies and desktop processes.			• CCS Prior Authorization Referral Process was updated to instruct County Assisted Registered Nurse to confirm whether services (1.2.2_CCS Prior Authorization Referral Process 041524) **TRAINING** • PA Case Process email dated 6/10/24 and CCS PA Referral Process Procedure demonstrate MCP staff has been trained on the updated process. (1.2.2_PA Case Process1 (1), 1.2.2_CCS Prior Authorization Referral Process 041524) **MONITORING AND OVERSIGHT** • UM TAT Audit Scores from September 2024 demonstrates the MCP has a process in place to monitor turnaround times while awaiting confirmation of CCS eligibility. The scores document results from Q2 2024. (1.2.2_UM_TAT_Audit_Scores_Sept2024) **The corrective action plan for finding 1.2.2 is accepted.**
1.3.1 Written Consent for Appeals	To swiftly address this issue, a Desktop Procedure **(DTP - G&A Consent for**	DTP - G&A Consent Ror Appeals	7/3/2024	The following documentation supports the MCP's efforts to correct this finding:

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Made on Behalf of a Member The Plan did not ensure the members' written consent was obtained when a provider filed an appeal on the members' behalf.	**Appeals)** was created on June 3, 2024. The document outlines the process of obtaining Member Consent for Appeals. As part of the process, Grievance & Appeals (G&A) associates are now required to make three different attempts on three different business days and/or times to contact the member to secure consent prior to dismissing an appeal request from a provider or authorized representative on behalf of a member. This document containing the new process will be distributed to all G&A staff. Additionally, Anthem will hold a meeting to thoroughly review the document and answer any queries, ensuring that all staff are fully aware of, and understand, the process change. This will enable our team to better serve our members and be alignment with DHCS recommendations. **Refer to: CA Member Appeal Ack POBM Rep Form Letter ENG**	CA Member Appeal Ack POBM Rep Form Letter ENG		**POLICIES AND PROCEDURES** • "DTP - G&A Consent For Appeals" ○ The policy demonstrates the process of obtaining Member Consent for Appeals. G&A associates are required to make three different attempts on three different business days and/or times to contact the member to secure consent prior to dismissing an appeal request from a provider or authorized representative on behalf of a member. (1.3.1_DTP – G&A Consent for Appeals_Evidence, Provisions, 2., page 1) **TRAINING** • "Meeting Minutes 06-26-24" demonstrates the Plan discussed the new desktop procedure for member appeals & provided education of the new requirement to make three different attempts on three different business days and/or times to contact the member. **MONITORING AND OVERSIGHT** • "Quality Oversight of Medicaid Appeals & Grievances"

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				describes the Plan's monitoring process that includes the criteria evaluated during the audits & the methodology used for reviews. The process identifies areas for improvement & provides targeted feedback - including staff training - allowing the Plan to continuously enhance the quality of service. (Quality Oversight of MCAG, II. PROCEDURES, pages 2 & 3) **The corrective action plan for finding 1.3.1 is accepted.**
1.3.2 Oral Notification of Resolution for Expedited Appeals The Plan did not ensure the provision of oral notifications to members regarding the resolution of expedited appeals.	To promptly address this oversight, there will be a meeting with our Grievance & Appeals (G&A) staff. This meeting will act as a reminder to the team to always attempt to call the member for all expedited appeal resolutions, regardless of whether the member is receiving inpatient care at the time. Furthermore, G&A will conduct a comprehensive review of the **"CA Appeals Checklist"** with our staff to ensure that the protocol is understood and followed consistently. The checklist clearly states: "If expedited resolution, ensure that oral notification is made to the provider	CA APPEALS CHECKLIST	7/3/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Plan Policy, "GAMC-051 Member Appeals" (revised date 05/17/2023), demonstrates that the Plan makes reasonable efforts to provide oral notices to members of expedited appeal resolutions. In addition, the Plan also utilizes an appeals checklist with instructions for the Grievance and Appeal associate to "review that one oral attempt was made to notify the member of the resolution, and there is a documented note in the case." (DHCS Medical Audit Report (Issued 05/14/24), page 11) **TRAINING** • The Plan provided meeting minutes (06/26/24) which

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	and the member. Note: If a member cannot be contacted or is on the DNC registry, this should be documented." Through these actions, Anthem's aim is to reestablish compliance with our guidelines, enabling us to better serve our members and meet the standards set forth in our DHCS contract.			demonstrates the Plan met with G&A staff to review CA Appeals Checklist requirements. The G&A managements emphasized the importance of orally notifying the members and providers with the resolution of all expedited appeals. (1.3.1 & 1.3.2-Meeting minutes 06-26-24) • Checklist, "CA Appeals Checklist" (06/04/24) demonstrates the Plan has provided this checklist to Appeal Nurses reviewing each appeal case. (1.3.2_CA APPEALS CHECKLIST_Evidence) **MONITORING AND OVERSIGHT** • "Expedited Focused Appeal Audit" (implemented 07/12/24) demonstrates the Plan established a process that makes sure the proper execution of oral notifications for expedited appeals concerning inpatient care. This audit is performed monthly, and it involves a review of 5% of the expedited appeal cases completed in preceding month. The Plan takes step to address instances of non-compliance by performing root cause analysis, taking Corrective Action Plan, and providing training and education. (Attach B 2023 Anthem Oct DHCS Comments) • Expedited Appeals Focused Audit Results for August and September 2024 demonstrates the Plan has implemented the monitoring process. (1.3.2_Expedited Appeals Focused Audit Results_Aug-Sept2024)

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				The corrective action plan for finding 1.3.2 is accepted.

3. Access and Availability of Care

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3.1.1 Corrective Actions for Timely Access Deficiencies The Plan did not ensure that corrective actions were implemented for providers who did not comply with appointment wait time standards.	Anthem understands that DHCS expects us to manage the Timely Access CAPs to ensure that each non-compliant provider is trained under the CAP. It is with that understanding that Anthem has updated our **"PNXX-033**" policy (page 14) and our **Timely Access PPM Playbook 1** (page 16) to include the requirement that remediation and closure of Corrective Action Plan requires an attestation that each non-compliant provider has reviewed the timely access standards, therefore ensuring that the corrective action is fulfilled at the individual provider level. Anthem has updated our **PNXX-033** policy (page 14) and our **Timely Access Playbook** (page 16) to include the requirement that remediation and closure of Corrective Action Plan requires an attestation that each non-compliant provider has reviewed the timely access standards.	Timely Access - PPM Playbook 1 CA_PNXX_033	4/9/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "CA PNXX 033: Access to Care Standards" (04/09/24) which states that the requirements of the Corrective Action Plan must be fulfilled at the provider-level. Each non-compliant provider that is still contracted with the group must meet the training requirements of the CAP to demonstrate that they are aware of the Timely Access to Care requirements. CAP Closure requires the subject Provider Group to submit evidence of Timely Access training for each non-compliant provider. (Access to Care Standards). • Updated Desktop Procedures, "Timely Access Playbook" (April 2024) which states that the provider or PMG/IPA must submit an acceptable CAP response. Examples of appropriate evidence and documentation include Policies and Procedures, Training Attestation accounting for each non-compliant provider, and Training Materials. (Timely Access PPM Playbook). **MONITORING AND OVERSIGHT** • Committee Charter, "Access to Care Complains Evaluation and Solution Support Committee (ACCESS Committee)" as evidence

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				that the MCP has started an ACCESS Committee to analyze internal data sources to address Access to Care issues including Timely Access. The ACCESS Committee provides local plan oversight and monitoring of key access to care measures and issues across the state. The committee will review and analyze a variety of data sources to identify root causes of access issues. (ACCESS Committee Charter). • Excel Spreadsheet, "CAP Tracker" as evidence that the MCP has created a CAP tracker for each non-compliant provider. Each non-compliant provider must attest that they have included the Timely Access Bulletin in their office's Policy and Procedures, reviewed the timely access standards with their front office staff, and distributed the Timely Access Flier to Front office staff. The MCP's CAP Tracker also includes an area in which the provider groups can include in their CAP response the individual non-compliant providers, the nature of each provider's non-compliance, and the specific corrective actions that were implemented at the provider level. (CAP Tracker - ACCESS IPA Evidence). • "Timely Access Dashboard" (October 2024) as evidence that the MCP has implemented a monitoring process to track that providers offer member appointments with a PCP within 10 business days of the request and a specialist within 15 business days of the request. One of the three elements the Dashboard takes into account is the DMHC Provider Appointment Availability Survey (PAAS) rate of compliance with Appointment Availability standards including PCP

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				within 10 business days of the request and a specialist within 15 business days of the request. The PAAS risk score, grievance data, and analysis is also included in the Dashboard. (Timely Access Dashboard Update). **The corrective action plan for finding 3.1.1 is accepted.**
3.1.2 Appointment Waits Time Grievances Monitoring The Plan did not ensure that its providers offered member appointments with a PCP (Primary Care Physician) within ten business days of the request, and a specialist within 15 business days of the request.	Anthem will improve our timely access to care by monitoring our grievance reports and target several provider education and engagement activities to educate provider groups, community representatives, providers, members and front office staff. These activities include distribution of provider bulletins and timely access materials, speaking engagements through Community Advisory Committee Meetings and Joint Operations Committee meetings, and individual interventions organized by Provider Relations. As a result, our Timely Access survey scores have improved this year. Anthem's Grievance & Appeals (G&A)	Access to Care Grievances Desktop Procedure	12/11/2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Desktop Procedure, "Access to Care Grievances" (12/11/23) which was created and distributed to MCP staff to outline the approach to capturing and addressing access to care grievances. If the MCP receives a grievance regarding a member not being able to be seen within the allowed amount of time for a PCP or Specialist, the MCP's analyst will contact the provider to confirm if the provider cannot schedule member appointments within 10 business days for PCPs or within 15 business days for Specialist. The MCP's analyst should remind the provider of the MCP's network adequacy standards. If the provider cannot schedule appointments within the timeframe, the MCP's analyst will document the reason and submit a request via Provider Relations SharePoint site. The MCP's analyst will ask the member if they would like to change their PCP. (Access to Care Grievances Desktop Procedure Evidence).

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	created and distributed a document titled, **"Access to Care Grievances Desktop Procedure"** to our G&A analysts. This document outlines the approach to capturing and addressing access to care grievances.			**MONITORING AND OVERSIGHT** • Committee Charter, "Access to Care Complains Evaluation and Solution Support Committee (ACCESS Committee)" as evidence that the MCP has started an ACCESS Committee to analyze internal data sources to address Access to Care issues including Timely Access. The ACCESS Committee provides local plan oversight and monitoring of key access to care measures and issues across the state. The committee will review and analyze a variety of data sources to identify root causes of access issues. (ACCESS Committee Charter). • "Timely Access Dashboard" (October 2024) as evidence that the MCP has implemented a monitoring process to track that providers offer member appointments with a PCP within 10 business days of the request and a specialist within 15 business days of the request. One of the three elements the Dashboard takes into account is the DMHC Provider Appointment Availability Survey (PAAS) rate of compliance with Appointment Availability standards including PCP within 10 business days of the request and a specialist within 15 business days of the request. The PAAS risk score, grievance data, and analysis is also included in the Dashboard. (Timely Access Dashboard Update). **The corrective action plan for finding 3.1.2 is accepted.**

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3.8.1 Physician Certification Statement (PCS) Form for NEMT Services
 	
The Plan did not ensure PCS forms were on file to authorize NEMT services for all members.
	Anthem understands that the audit findings related to the PCS form for authorized NEMT services are required to ensure our members have adequate transportation to/from their appointments as needed. To ensure the PCS form is properly utilized, and the process is adhered to, training was conducted to ensure all associates scheduling trips are aware of the PCS requirements. The **"ModivCare_CA Anthem PCS SOP 2024**" to incorporate these changes has been updated. Anthem along with ModivCare are currently revising the plan protocols to eliminate the outdated provision of three courtesy trips without a PCS form. **Refer to: ModivCare_CA Anthem Urgent Trip with No PCS Authorization Process Training Resource ModivCare_CA Anthem PCS Remediation Training Attestation_CA PCS 2024 ModivCare_CA Anthem Redlined**	Modivcare_CA Anthem PCS SOP 2024
		Modivcare_CA Anthem Urgent Trip with NO PCS Authorization Process Training Resource
		Modivcare_CA Anthem PCS Remediation Training Attestation_CA PCS 2024
		Modivcare_CA Anthem Redlined Protocols_6.11.24 Version
			6/11/2024	The following documentation supports the MCP's efforts to correct this finding:
				
				POLICIES AND PROCEDURES
				
				• "ModivCare_CA Anthem PCS SOP 2024"
				  ○ The policy was updated to reflect the removal of courtesy trips for members without a PCS form. (SOP PCS Form Process: Anthem Blue Cross, 2. UNAUTHORIZED TRANSPORTATION REQUESTS, 2.3, page 2)
				  ○ The policy also states that requests are to be rejected due to the lack of a PCS form on file for all non-urgent type trip requests. (SOP PCS Form Process: Anthem Blue Cross, 2. UNAUTHORIZED TRANSPORTATION REQUESTS, 2.2, page 2)
				
				TRAINING
				
				• "CA Medicaid Risk and Issues Committee Agenda" demonstrates the Plan presented the PCS findings from the CAP to the appropriate committees & provided an update of what they were doing to remediate. (2024_June_Risks and Issues_Meeting Minutes, Vendor Management, pages 3-5)
				
				• "PCS Remediation Training Attestation_CA PCS 2024" demonstrates the transportation broker reviewed with its staff the revised SOP,

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Protocols_06.11.24 Version			along with all requirements for the CA PCS remediation plan. (See 3.8.1 ModivCare_CA Anthem PCS Remediation Training Attestation_CA PCS 2024) **MONITORING AND OVERSIGHT** • "3.8.1_Monthly PCS Audit Procedure" demonstrates the Plan's monitoring process. On a monthly basis, the Plan will audit PCS forms for NEMT trips approved for the previous month to verify the PCS form process. (Vendor Strategy Oversight Desktop Procedure Manual_v4, Purpose, page 1) o Detailed trip report is generated o 1% random sampling used to request copies of the corresponding PCS form o The Plan summarizes the findings & issues recommendations/corrective actions, as appropriate. o Audit findings will be presented monthly to the committees. **The corrective action plan for finding 3.8.1 is accepted.**

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Grievance Resolution Letters The Plan did not send resolution letters for quality of service grievances within the required 30 calendar days.				The following documentation supports the MCP's efforts to correct this finding. **MONITORING AND OVERSIGHT** • Daily Activity Log demonstrates the MCP monitors timelines of case deadlines. G&A managers receive the daily activity reports to monitor upcoming dates for case closure. (4.1.1_4.1.3_Daily Activity Log1_Evidence) • Analyst Workbasket example demonstrates the MCP has a process in place for its individual analysts to monitor and prioritize its workload by displaying the case age and upcoming due dates. (4.1.1_4.1.3 - Pega - Analyst Workbasket_Evidence) • GBD Medicaid Resolution Letter TAT for Quarters 1,2, and 3 demonstrates the MCP is tracking its compliance rate for grievance resolution letter timeliness. (4.1.1 - CA GBD Medicaid Resolution Letter TAT) **The corrective action plan for finding 4.1.1 is accepted.**

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4.1.2 Plan's Resolution of Quality of Service Grievances The Plan sent member resolution letters without completely resolving the members' quality of service grievances.	Since the finding of this audit, we have reiterated the importance and provided examples to the staff of what a complete resolution letter entails. We are continually emphasizing and reinforcing this critical aspect of member communication during our internal staff meetings to prevent such oversights in the future. Furthermore, we have reviewed the "**Check List Admin Grievance Requirement**" with our staff to ensure that the protocol is understood and followed consistently. We are confident that these measures will greatly improve the quality of our resolution letters, ensuring that all member concerns are thoroughly addressed and resolved. We are committed to providing excellent service to our members and adhering to the compliance standards set by DHCS.		9/14/2023	The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** • P&P, "Quality Oversight of Medicaid Appeals & Grievances" (01/02/24) demonstrates the Plan has established and implemented an effective system for routine monitoring of Grievance and Appeal activities to demonstrate consistency and compliance with policies, processes, and guidelines. If the Plan's internal audit reveals a trend where a certain analyst consistently receives low scores in terms of providing members with a comprehensive resolution, the process is to implement a coaching and monitoring plan to resolve the issue. However, if there is no observable improvement despite these interventions, the Plan will then consider initiating a formal correction plan. In extreme cases, Anthem will not rule out the possibility of termination if performance continues to lag significantly. **TRAINING** • PowerPoint, "Team Huddle" (09/14/23) demonstrates the Plan reminded staff to make sure they address every part of the grievance. An example was given to staff. G&A Expert is skilled for with the below template into the case notes and completing each step outline on the check list during the grievance case reviewed. This check list is needed to be in all grievance cases.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The G&A Expert is in charge to attesting each item on the check list was done by indicating Yes or No on the template in the grievance case notes. • Meeting, "Team Huddle" (07/01/24) demonstrates the Plan met with staff to review the Administrative Grievance Case Review Checklist requirements. The G&A management went into detail about the importance of closing the loop and providing complete resolution to resolving the members' quality of services grievances. **MONITORING AND OVERSIGHT** • Audit Tool, "Medi-Cal G&A Quality Audit" (Effective Date 01/01/23) which demonstrates the Plan is ensuring the resolution letters are being sent when required, resolution letters are accurate and addressing all issues. • Internal Audit, "QOS Internal Audit Results" (April – July 2024) demonstrates the MCP performs monthly internal audits for each associate, If the internal audit reveals a trend where a certain associate consistently receives low scores in terms of providing members with a comprehensive resolution, the process is to implement a coaching and monitoring plan to resolve the issue. Beyond continuous training and coaching, the MCP G&A team operates under clearly defined performance

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				benchmarks. It is through measurable internal percentage rate goals that each associate is required to meet. • Check List, "Administrative Grievance Case Review Checklist" (06/17/24) demonstrates the Plan has provided this check list for the G&A analyst's reviewing grievances in efforts to demonstrate a full review and meets all requirements. The G&A expert will complete the check list template and place into the case notes during the grievance case review. **The corrective action plan for finding 4.1.2 is accepted.**
4.1.3 Plan's Resolution of Quality of Care Grievances The Plan did not resolve quality of care grievances within 30 days of receipt of the grievance.				The following documentation supports the MCP's efforts to correct this finding. **POLICIES AND PROCEDURES** • P&P, "Quality Oversight of Medicaid Appeals & Grievances" (01/02/24) demonstrates the Plan has established and implemented an effective system for routine monitoring of Grievance and Appeal activities to demonstrate consistency and compliance with policies, processes, and guidelines. If the Plan's internal audit reveals a trend where a certain analyst consistently receives low scores in terms of providing members with a comprehensive resolution, the process is to implement a coaching and monitoring plan to resolve the issue. However, if there is no observable improvement despite these interventions,

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				the Plan will then consider initiating a formal correction plan. In extreme cases, Anthem will not rule out the possibility of termination if performance continues to lag significantly. **TRAINING** • Meeting, Presentation, "CA Grievance Refresher Training", (08/14/24) demonstrates the MCP met with the Clinical Grievance Staff to discuss the importance of resolving the QOS/QOC within 30 calendar days. Additionally, the Plan discussed grievance resolution letters must be clear, concise, and explains the grievance decision. (4.1.3 - CA Grievance Meeting 08.2024 and 4.1.3 - CA Grievance Refresher 2024). **MONITORING AND OVERSIGHT** • Audit Tool, "Medi-Cal G&A Quality Audit" (Effective Date 01/01/23) which demonstrates the MCP is ensuring the resolution letters are being sent when required, resolution letters are accurate and addressing all issues. • Audit, Internal Audit, "QOC Grievance Internal Audit Results (Apr 2024-Aug 2024) demonstrates the MCP's seasonal nurse reviewers are conducting internal monthly audits to maintain consistent performance and compliance. The data collected from these audits is then analyzed to identify any emerging

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				trends and areas for potential improvement. The MCP's nurses have been consistently compliant and achieving 100% scores. • Check List, "Administrative Grievance Case Review Checklist" (06/17/24) demonstrates the MCP has provided this check list for the G&A analyst's reviewing grievances in efforts to demonstrate a full review and meets all requirements. The G&A expert will complete the check list template and place into the case notes during the grievance case review. • Daily Activity Log demonstrates the MCP has daily monitoring systems that allow for effective tracking and management of case deadlines. The managers receive a Daily Activity Log which provides comprehensive visibility into upcoming due dates for case closures. (4.1.1_4.1.3_Daily Activity Log1_Evidence) • Worksheet, "Pega - Analyst Worksheets" (08/16/24 date report pulled) demonstrates the MCP's G&A analysts have the ability to print out their Pega - Analyst Workbaskets. This allows them to have a clear view of their tasks and the respective due dates, aiding them in prioritizing their workload and ensuring the timely closure of cases. **The corrective action plan for finding 4.1.3 is accepted.**
4.1.4 Medical Director Review of	To rectify this situation, Anthem is formulating a plan that involves	QOC Grievance Meeting	6/11/2024	The following documentation supports the MCP's efforts to correct this finding.

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Quality of Care Grievance The Plan did not refer all quality of care grievances to the Medical Director for resolution.	collaboration with our Medical Directors. Our aim is to establish a process that ensures a Medical Director reviews all quality-of-care grievances prior to the resolution. This is an immediate solution which we believe will help us align with the stipulations of our contract. In the near term, Anthem will set up a meeting with all relevant stakeholders to create a process or workflow that we can manually follow. This interim solution will serve to bridge the gap while work on a long-term, automated solution is created. Anthem's Information Technology (IT) team will be an integral part of developing a streamlined, automated process for future implementation. Anthem also understands development and testing of a system of this nature will take time. Meanwhile, the implemented manual process will help ensure our commitment to thorough reviews and	06.11.2024		**POLICIES AND PROCEDURES** • Plan Policy, GAMC 015 Grievance Process: Members-CA (revised date 10/15/24), states that all grievances related to the medical quality of care issues are immediately submitted to the Plan's Medical Director for action. It outlines the process: Clinical grievances are assigned to Grievance and Appeals Clinical Associates for review and appropriate action. **MONITORING AND OVERSIGHT** • While Plan is developing an automated process (long term) that will demonstrate that a Medical Director reviews all quality-of-care grievances prior to resolution. In the interim, the Plan developed a process (manual workflow) to bridge the gap while work on the long-term, automated process is completed. Technical assistance was provided to demonstrate that processes aligned with both contractual requirements. Revised processes should address the following: o Per Contract, the Medical Director is responsible for resolving QOC grievances. o Per Contract, Grievances related to QOC issues shall be referred to a Medical Director. o Plan policy indicates all medical QOC grievances are immediately submitted to the Medical Director for action; however, it does not outline processes that will demonstrate

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	uphold the quality of care that our members deserve. **Refer to: QOC Grievance Meeting 06.11.2024**			that a Medical Director reviews all quality-of-care grievances. Cases reviewed lacked documented evidence that a Medical Director reviewed or took action on the case prior to resolution. ○ Current process is for nurses to review QOC grievances and recommend severity levels before sending to a Medical Director for a final review. Process needs to be revised that demonstrates evidence of the Medical Director's review. If severity level is two or higher, a PQI case is opened. The resolution of QOC grievances and PQI investigations are separate and distinct processes with different resolution timeframes. Not all QOC grievances present PQI issues that require further investigation. The underlying QOC grievance still needs to be resolved within 30 calendar days. • QOC MD Workflow (interim process) indicates nurses review and summarize findings and resolution steps. Case is then routed to MD for review and resolution approval. Nurse will notate MD review and approval and generate resolution letters. • Automated Process: ○ Automated process was implemented on 10/09/24 to demonstrate that every clinical grievance is reviewed by a Medical Director prior to resolution (See REQ-GBD-20496937) that demonstrates the automated process.

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				○ Plan provided additional supporting documentation (case files) that demonstrates implementation, as well as evidence of Medical Director review (highlighted in yellow). Evidence of a PQI is also documented and shows these are two distinct and separate processes (See CA PQI-GBD-2184). **The corrective action plan for finding 4.1.4 is accepted.**

Submitted by: Beth Maldonado
Title: Director II, Compliance

Signed by: [Signature on file]
Date: June 24, 2024