Government Business Division
Policies and Procedures

Section (Primary Department) **Medicaid Grievance and Appeals Dept.**		**SUBJECT (Document Title)** **Quality of Care - Core Procedure**	
Effective Date 06/09/2011	**Date of Last Review** 11/12/2025	**Date of Last Revision** 11/12/2025	**Dept. Approval Date** 11/12/2025
Department Approval/Signature:			

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

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

POLICY:

To ensure quality and appropriateness of care rendered by monitoring for potential or identified Quality of Care (QOC) issues on an on-going basis.

1) To identify, investigate and resolve QOC issues for members identified through internal referrals by health professionals, utilization, case management and audit activities, in addition to member complaint/grievance that have a potential quality issue.
2) To ensure that all potential and identified QOC issues are tracked and trended for monthly reporting and re-credentialing purposes.
3) To ensure that data is analyzed for trends that affect the quality and safety of care and services rendered to all covered Medicaid members.
4) For the purposes of this policy, the term "QOC issue" may encompass, but is not limited to, the following detailed definitions listed below:
   a) Provider Preventable Conditions (PPC), Health Care Acquired Conditions (HCAC), Hospital Acquired Conditions (HAC), Preventable Adverse Events (PAE), Critical Incidents, Sentinel Events, Never Events, other reportable events.
5) QOC issues include potential, suspected, and realized events that may or may not have resulted in harm incurred by member(s).

DEFINITIONS:

Adverse: A patient safety event that resulted in harm to a patient.

Adverse Event: An event that results in unintended harm to the patient by an act of commission or omission, rather than by the underlying disease or condition of the patient.

Appeal: Request for reconsideration of a decision, administrative action, QOC or service issue, with the goal of finding a mutually acceptable solution.

Critical Incident: An event that may negatively impact the health, safety, or welfare of an individual.

Event: Discrete, auditable, and clearly-defined occurrence.

External Referrals: Any oral or written expression of dissatisfaction from a member or member representative regarding any aspect of health care services received by an individual or entity outside of the health plan.

Grievance: An expression of dissatisfaction from a member or member representative about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled at the Managed Care organization (MCO) or Prepaid Inpatient Health Plan (PHIP) level and access to the state fair hearing process. Possible subjects for grievances include, but are not limited to, the QOC or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights. A member, member's authorized representative or provider with a member's written consent may file a grievance.

Hazardous (or unsafe) condition(s): A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event.

Hospital-Acquired Conditions (HAC): An undesirable situation or condition that affects a patient, that arose during a stay in a hospital or medical facility. It is a designation used by CMS for determining MS-DRG reimbursement, beginning with Version 26 (10/01/08).

Section 5001(c) of the Deficit Reduction Act of 2005 requires the Secretary of Health and Human Services to identify conditions that are: (a) high cost or high volume (or both), (b) result in the assignment of a case to a DRG that has a higher payment when presented as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based practice guidelines. There are 14 categories details are on QOC Referral Tip Sheet.

Internal Referrals: Any oral or written expression of dissatisfaction regarding any aspect of health care services received from any individual or department within the health plan.

Never Event: Twenty- Nine (29) events identified by the National Quality Forum as occurrences that should never happen in a hospital that are usually preventable. Never events are grouped into the following seven (7) categories:

1) Surgical
2) Product or Device
3) Patient Protection
4) Care Management

5) Environmental
6) Radiologic
7) Criminal

Patient Elopement: Situation in which an admitted patient (inpatient) leaves the health care facility without staff's knowledge.

Preventable Event: An event that could have been anticipated and prepared for, that occurs because of an error or other system failure.

Quality: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality of Care (QOC) Issue: A medical, social, environmental, or economical event that has the potential to have an adverse effect on the health and welfare of our internal and external customers, members, or the organization.

Quality of Care (QOC) Issue Referral Form: An internal document completed by associates receiving the potential QOC complaint / issue to document facts and information. The completed form is immediately forwarded to the health plan's Quality Management Department for investigation of the issue.

Sentinel Event: A subcategory of Adverse Events, a Sentinel Event is a patient safety event (not primarily related to the natural course of the patients' illness or underlying condition) that reaches a patient and results in any of the following:

1) Death
2) Permanent harm
3) Severe temporary harm

Serious Event: Describes an event that results in death or loss of a body part, disability, or loss of bodily function lasting more than seven days or which is still present at the time of discharge from an inpatient health care facility or, when referring to other than an adverse event, a non-trivial event.

Trend: Three (3) or more confirmed commonalities in a quarter and/or six (6) or more confirmed commonalities in a year.

Triggers for Peer Review: The triggers for peer review are conditions and / or situations that are found on the Never Events, Hospital-Acquired Conditions, and Sentinel Events lists.

Unambiguous: An event that is clearly defined and easily identified.

PROCEDURE:

1) **Identification of QOC Issues**
   a) QOC issues may be identified by internal sources, including but not limited to:
      i) Behavioral Health
      ii) Claims Review
      iii) Case Management
      iv) Report of a Critical Incident
      v) Concurrent Review
      vi) Internal Audit
      vii) Legal Department
      viii) Medical Record Review
      ix) Member Complaints and Grievances
      x) National Customer Care (NCC)
      xi) Pharmacy Department
      xii) Provider Relations Department
      xiii) Quality Management Department
      xiv) Regulatory Department
      xv) HEDIS and/or QARR data
   b) QOC issues may be identified by external sources, including but not limited to:
      i) Department of Insurance
      ii) Department of Health and Human Services
      iii) State Department of Health
      iv) State Medicaid Agency
      v) Centers for Medicare and Medicaid Services (CMS)
      vi) Members
      vii) Members' Authorized Representatives
      viii) Providers
   c) Criteria or "triggers" are used in identifying QOC issues during the performance of utilization review activities, review of member complaints and grievances, review of medical necessity appeals, tracking and trending of member and provider complaints, and physician practice monitoring activities.
   d) The triggers are reviewed annually, updated as needed.

2) **Referral of QOC Issues to the Health Plan Quality Management (QM) or Grievance and Appeals Department**
   a) All identified or potential quality concerns are forwarded to the health plan QM Department or Grievance and Appeals Department electronically, using a *Quality of Care Issue* Referral form, for investigation and intervention, as necessary.
   b) Situations to be reported include, but are not limited to:
      i) A pattern of substandard care that is likely to result in future dangers to members.

ii) Failure to comply with accepted ethical and professional standards of behavior.
iii) An action that represents a clear and serious breach of accepted professional standards of care, such that continued care of members by the provider could endanger their safety or health.
iv) Instances of an individual receiving, or not receiving, health care services that are inappropriate for their medical condition according to current clinical practice guidelines.

3) **Health Plan QM or Grievance and Appeals Department Responsibilities**
   a) Upon receipt of an identified or potential QOC issue, the responsible health plan QM or Grievance and Appeals Department associate will enter all relevant information into the corporate Quality of Care Event Tracking System, informally, the QOC database. Please note that not all HPs are using the QOC tracking system to capture QOC issues, but will capture in another local system; however, they will follow the QOC Policy for the process.
   b) Once a QOC issue is identified, the health plan QM or Grievance and Appeals Department will request medical records and any supporting documentation or other information relevant to the case for review.
   c) Medical record collection time frame requirements will be followed in accordance with federal, state, contractual, and/or health plan policy and/or procedure.
   d) The health plan QM or Grievance and Appeals Department will make every effort to facilitate the prompt and easy gathering of information from the provider.
   e) Once the requested information has been received, the health plan QM or Grievance and Appeals Department will review the information, and a summary of all information relevant to the case will be documented in the corporate QOC database, NextGen/PEGA System or Health Plans Specific Tracking system.
   f) A preliminary severity level will be assigned to the case by the health plan QM or Grievance and Appeals Department, in accordance with health plan policy and/or procedure (if applicable).
   g) All relevant information and any actions taken during the investigation process will be documented in the applicable database.
   h) Data will be collected, documented, and reported in accordance with federal, state, contractual, and/or health plan policy and/or procedure requirements.

4) **Health Plan Medical Director Review**
   a) Once all relevant information has been documented in the applicable database, the case is assessed by the QOC licensed staff using the approved leveling categories.
   b) The QOC licensed staff person may document the case as a Level 0 or 1. If the QOC licensed staff assesses the case as a Level 2 or above, the case is forwarded to the health plan medical director for review.

c) After reviewing all available information, the health plan medical director will make a determination as to the presence of a significant quality issue and will verify the current level assessed by the QOC licensed staff or will assess a different level.
d) The health plan medical director will refer to the Criteria for Initial Quality Review (see #9 under Procedures, page 10) to determine a severity level rating for the QOC issue.
e) If the issue is determined to be a Severity Level "0" or "1," no further action is necessary, and the case file will be closed.
f) If the issue is determined to be a Severity Level "2," the medical director will determine the appropriate intervention or next steps. The case will not initiate peer review action.
g) If the issue is determined to be a Severity Level "3" or higher, the health plan medical director may initiate peer review action.
h) For provider terminations or other significant interventions taken in response to a confirmed QOC issue that is related to clinical incompetence or unprofessional conduct, the Credentialing Committee will follow the appropriate Provider Termination policy to ensure all regulatory mandates are met.
i) For all cases referred to the health plan medical director, all relevant information and any actions taken during the course of the investigation will be documented in the applicable database.

5) **QOC Event Categories**
   a) QOC categories include, but are not limited to:
      i) Adverse Events
      ii) Sentinel Events
      iii) Never Events (which include Hospital-Acquired Conditions)
      iv) Critical Incidents
      v) HAC

6) **Initial Severity Level Assignment**
   a) **Level 0 - Not a QOC Issue:** This level is determined by the QM staff.
      i) Did not meet criteria as a QOC issue.
      ii) Track and trend only.
   b) **Level 1 - No Quality Issue Substantiated:** This level is determined by the QM staff.
      i) Care rendered is within the national and community standard of care and behavior for that condition or situation.
      ii) Given the information received, there was no clear cause or effect; the quality issue is indeterminate.
   c) **Level 2 - Quality Issue - Does Not Impact the Care Outcome:**
      i) Care raises mild concern about QOC.
      ii) Level would be in a higher category if a pattern of similar episodes developed
      iii) The amount and types of care were inadequate.
      iv) Care was not provided in a timely manner.

v) Care was not provided in a medically appropriate setting.

vi) Failure to comply with accepted ethical and professional standards of behavior that may represent a pattern of sub-standard care that is likely to result in future dangers to members or the health plan:

- For example, repeated instances of poor surgical judgment; not one of which represents a clear quality issue, but taken as a whole, represents a poor pattern of care

The health plan medical director can decide whether the pursuit of remedial action is appropriate; he or she does not need to consult the Peer Review Committee (PRC) before action is taken.

d) **Level 3 - Clear and Significant Quality Issue – Does Impact the Care Outcome:**

i) Clinical practice clearly falls below national and local standards and expectations:

- For example, failure to pursue a diagnosis for a mass found on mammogram.

ii) The amount and types of care were inadequate.

iii) Care was not provided in a timely manner.

iv) Care was not provided in a medically appropriate setting.

The issue is clear and straightforward enough that the health plan medical director does not need to consult the PRC before he or she takes action.

At the discretion of the health plan medical director, Severity Level "3" issues may be submitted to the PRC for review and additional recommendations.

A quality issue has been identified and the PRC decides whether or not to pursue remedial action.

e) **Level 4 - Complex and Significant Quality Issue:**

i) Severity Level "4" issues might be repeated, complex, unclear, ambiguous, or especially serious.

ii) Situations or cases representing complex or ambiguous issues or data:

- For example, multiple inter-related diagnoses, multiple providers, or a prolonged episode of care.

iii) The situation or case involves an apparent serious, but not emergent issue and/or a repeated pattern of sub-standard care that is likely to result in future dangers to members or to the health plan:

- For example, unsuccessful attempts at achieving provider compliance with recommended remedial actions by the health plan medical director.

The health plan medical director will consult with the MAC and/or the PRC. The MAC and/or the PRC will render a decision before action is taken.

f) **Level 5 - Emergency Quality Issue – Issue Raised is Egregious:**

i) The alleged action by the provider represents a clear and serious breach of accepted ethical behavior:

- For example, a substantiated allegation of sexual molestation.

ii) The alleged action represents a clear and serious breach of accepted standards of care, such that continued care of patients by the provider could endanger their safety or health:
- For example, a surgical event or situation that indicates loss of judgment or skill.

The situation is of such severity that it warrants immediate, but temporary suspension of the provider in order to protect members from apparent dangerous conduct or incompetence, or to protect the health plan's reputation and/or operations.

7) **Remedial Action Steps**
   a) **Level 0:** Track and trend.
   b) **Level 1:** The information is documented in the provider's file, track and trend.
   c) **Level 2:** The review and outcome is documented in the provider's case file and stored in the QOC database per state and federal regulatory requirements and health plan medical record policy, track and trend.
   d) **Level 3 and Level 4:**
      i) In a Level "3" or a Level "4" situation, the health plan medical director will present the case to the PRC for review and action.
      ii) The committee(s) may decide that there is no significant quality concern, and the issue is resolved and appropriately documented in the provider's file.
      iii) If or when the committee(s) decides to pursue remedial action, the health plan medical director will attempt to reach an agreement with the provider on a remedial action plan.
      iv) Remedial action takes the form of one or more of the following activities:
         - Telephone discussion with the provider.
         - Written correspondence with the provider.
         - Increased intensity of utilization management activity, such as prior review by the health plan medical director before any members are admitted to the hospital or prior review of 100 percent of all referrals and procedures.
         - A consultation requirement for specified categories of cases.
         - Appearance before the PRC for discussion of the issue(s).
         - Satisfactory completion of designated continuing education.
         - Other action(s) as deemed appropriate by the health plan medical director and the PRC.
      v) Action(s) taken will depend on the area and the type of problem identified and on whether the issue was an isolated event or part of a clear pattern or trend.
      vi) Substandard care, when found, is rarely intentional. Often, the sharing of a "best practice" with a provider will educate, raise awareness, and serve as a model for corrective action.
      vii) If the health plan medical director cannot reach an agreement with the provider on a satisfactory remedial action plan, he or she will refer the issue to the PRC.

viii) The health plan medical director will report all corrective action plans arising out of a Level "3" or Level "4" quality issue to the PRC at the committee's next meeting.

ix) If the committee(s) cannot reach agreement with the provider on a satisfactory corrective action plan, the committee(s) will invoke the Peer Review Procedure regarding disciplinary action.

x) Disciplinary action against a provider may not occur before one or more of the remedial actions described above have occurred.

xi) Track and trend Provider

e) **Level 5:**

i) The PRC may determine that the issue is a Level "5" emergency issue.

ii) In that instance, the committee(s) would instruct the health plan medical director to follow the Peer Review Procedure relating to a Level "5" emergency quality issue.

iii) The PRC committee determinations will be communicated in writing to the practitioner/provider as appropriate and in accordance with procedure.

f) **Monitoring**

i) The health plan QM Department, in collaboration with the Grievance and Appeals Department, and at the direction of, the health plan medical director, is responsible for initiating and completing any remedial actions according to the decisions and recommendations of the r the PRC.

8) **Resolution Time frames**

a) The health plan will resolve a clinically non-urgent QOC issue within ninety (90) days of receipt of the issue.

b) Individual health plan state-specific time frame requirements may be more stringent, in which case the state-established time frames will be followed.

9) **Format of Notice Regarding Resolution**

a) The state must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.

10) **Tracking and Trending**

a) All QOC issues are entered into the applicable database for tracking and trending.

b) The database includes a monthly production report with QOC cases from all lines of business. The report includes the affected practitioner, incident date and reported date, quality issue, level assigned, outcome including corrective actions assigned.

c) A "significant trend" is defined as three or more commonalities in a quarter and/or six (6) or more in a year.

d) In the event that a significant trend is identified, the applicable department will forward the information to the health plan Credentialing Committee. The PRC would forward to the credentialing committee.

e) All QOC files and records will be electronically maintained in the applicable database for confidentiality and retained in accordance with the Records and Information Management Policy, state regulations, health plan contractual requirements and health plan policy and/or procedure.
f) An action plan will be developed and implemented by the applicable department to address the root cause identified during the course of the QOC investigation.
g) The action plan will include the following information
    a. Affected practitioner
    b. Incident date
    c. Quality issue
    d. Date reported to the designated peer review body
    e. Organizations actions

11) **Reporting**

a) State reporting is governed by individual health plan state regulatory and contractual requirements.
b) QOC issue reports are generated at least quarterly by the health plan QM or Grievance and Appeals Department as appropriate and include:
    i) Monitoring and analysis of aggregate QOC issues.
c) At the direction of the health plan medical director, the applicable department may prepare a quarterly report for the PRC of any peer-protected corrective actions taken. Included in the report:
    i) The outcomes of actions taken and the disposition or final resolution of the issue(s).
    ii) The identification of opportunities to improve care.
    iii) Recommendations to revise medical policy.
    iv) Recommendation for a study of appropriate components of the health care delivery system to focus on root causes of aberrant patterns of care.
    v) Recommendations for action plans.
d) The PRC will review the quarterly report received from the applicable department to identify opportunities to improve care and make recommendations for quality improvement actions.
e) On an annual basis, an analysis and evaluation of health plan QOC events is reported to the corporate Quality Improvement Committee (QIC) as part of the health plan's annual QM Program Evaluation.
f) The Credentialing Department utilizes reports generated on potential and identified QOC issues/events to monitor, track, and trend practitioner performance for review during the recredentialing process . The reports are reviewed by Credentialing Department and the Credentialing Committee at least monthly to comply with NCQA accreditation standards. This report includes any corrective actions deemed appropriate by the peer review committees.

g) Never Events and Hospital-Acquired Conditions will be reported in accordance with federal, state, and contractual requirements.

12) **Sharing of QOC Investigation Outcomes with Members**

a) The sharing of QOC investigation outcomes with members is governed by individual health plan state regulatory and/or contractual requirements. Please refer to the individual health plan policies and procedures listed in the "Related Policies and Procedures" section for information regarding the sharing of outcomes with members.

REFERENCES:

- Agency for Healthcare Research and Quality (AHRQ), Never *Events – Background*,
- Centers for Medicare & Medicaid (CMS), *https://www.cms.gov*
- National Quality Forum
- NCQA Standards and Guidelines for Accreditation in Credentialing 2025, CR 5A factor 5 and CR 5 B
- NCQA Standards and Guidelines for Health Plan Accreditation 2025, CR 5A factor 5, CR 5B
- NCQA Standards and Guidelines for the Accreditation of Managed Behavioral Healthcare 2025, CR 5A factor 5, CR 5B
- The Joint Commission (TJC), Patient Safety Systems (PS)
- The Joint Commission (TJC), Sentinel Events
- Title 42 CFR - Public Health, Part 438, Managed Care, Subpart F- Grievance System, § 438.400, *Statutory basis and functions, (b)*
- Title 42 CFR - Public Health, Part 438, Managed Care, Subpart F- Grievance System, § 438.402 (a) *General Requirements*,
- Title 42 CFR - Public Health, Part 438, Managed Care, Subpart F- Grievance System, § 438.408, *Resolution and notification: Grievances and appeals (a), Basic Rule*
- Title 42 CFR - Public Health, Part 438, Managed Care, Subpart F- Grievance System, § 438.408, *Resolution and notification: Grievances and appeals (b) Specific timeframes*- (1) *Standard Disposition of grievances*
- Title 42 CFR - Public Health, Part 438, Managed Care, Subpart F- Grievance System, § 438.408, *Resolution and Notification: Grievances and appeals (c) Extension of timeframes* (1)
- Title 42 CFR - Public Health, Part 438, Managed Care, Subpart F- Grievance System, § 438.408, *Resolution and notification: Grievances and appeals (d), Format of notice- (1) Grievances*
- Title 42 CFR – Public Health, Part 438, Managed care, Subpart F-Grievance System, § 438.400
- Title 42 CFR § 438.3(g), 42 CFR §434.6(a) (12) and § 447.26. 42 CFR § 447.26
- Virginia Cardinal Managed Care Contract, section 12.1.1

Section (Primary Department)	**SUBJECT (Document Title)**
Medicaid Grievance and Appeals Dept.	**Quality of Care - Core Procedure**

Other Reference(s):

- Credentialing Policy: Competence and Conduct Criteria – Health Delivery Organizations Policy # 4.1
- Credentialing Policy: Ongoing Sanctions Monitoring Policy # 12
- Credentialing Policy: Professional Competence and Conduct criteria –Practitioners Policy #4.0
- Credentialing Policy: Report of Adverse Action Policy # 11
- Credentialing Policy: Site Visits Policy # 7
- Credentialing Policy: Termination and Immediate Termination Policy # 10

Related Materials

- Iowa
  RFP MED-16-009 AGP Iowa HQHI Proposal
- Tennessee's Population Health Program Description (TN Only)
- 
  PQOC Referral Form Draft.docx
- 
  Quality Of Care Triggers Tip Sheet 20
- 
  Quality of Care Issue Referral Form_Dec 2

RESPONSIBLE DEPARTMENTS:

Primary Department: Medicaid Grievance and Appeals Department

Secondary Department(s):

Credentialing
Disease Management
Long Term Services and Support
Medicaid Grievance and Appeals Department
National Customer Care
Provider Relations
Provider Services Organization
Regulatory

EXCEPTIONS:

Because of the multitude of exceptions due to variances in individual health plan contracts, state regulatory requirements and health plan policies and procedures, please refer to the health plan policies and procedures listed in the "Related Policies and Procedures" section of this procedure for exceptions.

Arkansas:
Provider - Led Arkansas Shared Saving Entity Provider Agreement 2019 Section 9.3.10. The PASSE shall not delegate responsibility for the quality-of-care investigations, compliance reviews, or onsite quality of care visits to Administrative Services Subcontractor site or health care provider site.

Indiana:
Care and Service Coordinators will be trained on responsibilities related to recognizing, screening, monitoring for, and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect, self-neglect, and/or exploitation as defined in 455 IAC 2-4-2; 455 IAC-1-2-2 (g-h), and in alignment with PathWays for Aging Scope of Work requirements in Section 5.13

The Contractor must acknowledge receipt of each grievance within three (3) business days. In accordance with 42 CFR 438.408(a) and 42 CFR 438.408(b)(1) the Contractor must make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance. This timeframe may be extended up to fourteen (14) calendar days if the enrollee requests the extension or the Contractor shows there is need for additional information and the delay is in the member's interest (upon State request) as required by 42 CFR 438.408(c)(1) and 438.408(b)(1). In accordance with 42 CFR 438.408(c)(2) and 42 CFR 438.408(b)(1), if the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. The Contractor shall provide the member with a written notice of any extension within two (2) calendar days of the extension, including the reason for the extension and the member's right to file a grievance if they disagree with the extension.

Indiana specific definitions:
In alignment with the PathWays for Aging Scope of Work, Exhibit 1, Section 5.14, the Contractor's grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, must comply with law, including 42 CFR 438, Subpart F as well as IC 27-13-10 and IC 27-13-10.1 (if the Contractor is licensed as an HMO) or IC 27-8-28 and IC 27-8-29 (if the Contractor is licensed as an accident and sickness insurer). The Contractor shall operate unified appeals and grievance processes with their companion DSNP plan, meeting the requirements in 42 CFR 422.629 through 42 CFR 422.634.

The term inquiry refers to a concern, issue or question that is expressed orally by a member that will be resolved by the close of the next business day.

The term grievance, as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "adverse benefit determination" as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, aspects of interpersonal relationships, such as rudeness of a provider or employee or the failure to respect the member's rights. A grievance is a complaint about the way a member's health plan is giving care. For example, a member may file a grievance if the member has a problem calling the plan or if the member is unhappy with the way a staff person at the plan has behaved toward them. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see appeal).

The term appeal, per 42 CFR §438.400(b), is defined as a request for a review of an action. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received. A member may also make a complaint if they disagree with a decision to stop services that they are receiving. For example, a member may ask for an appeal if Medicare doesn't pay for an item or service they think they should be able to get. There is a specific process that a member's health plan must use when they ask for an appeal.

Missouri:
In addition to all policy and procedures described above, Healthy Blue shall adhere to the following state contractual requirements:

2.19.6 Critical Incident Reporting – The health plan shall comply with all health, safety, and welfare monitoring and reporting required by state or federal law. In addition, the health plan shall develop and implement processes and procedures to receive, review, and respond to reports of incidents and quality of care concerns related to services provided, contracted, or funded by the health plan. Reports of incidents and quality of care concerns include those received by the health plan from any source or those referred to the health plan by the state agency.

a. At a minimum, the health plan shall document, track, and evaluate the following types of incidents and quality of care concerns:
    1) Deaths in which quality of care may have been a contributing factor;
    2) Suicides or suicide attempts resulting in serious medical interventions;
    3) Homicides or homicide attempts resulting in significant medical interventions;
    4) Allegations of physical, sexual, or verbal abuse or neglect;
    5) Accidental injury in a facility that results in significant medical intervention;
    6) Use of seclusion and/or restraints;
    7) AWOL (absence from a facility without permission);

8) Medication errors or adverse medication reactions requiring significant medical intervention; and
9) Quality of care concerns.

b. The health plan shall remediate individual or systemic concerns in a timeframe necessary to ensure the safety and wellbeing of the individual member and other members.
c. The health plan's Quality Assessment Committee shall review trended incident and quality of care data to inform performance improvement opportunities in at least a quarterly basis.
d. The health plan shall submit a report summarizing the total number, outcomes of the health plan's review, and remedial actions taken in response to reported incidents and quality of care concerns.
e. The health plan shall notify the state agency within one business hour of the health plan's awareness of an incident that is high profile. In this context, "high profile" means that the incident is high risk, or is likely to be the subject of news media, or is otherwise controversial in nature.

New York:

The QOC referral form categories are reviewed annually by the QM department and the Medical Advisory Committee (MAC) for recommendations and approval.
Definitions:

a) Level "1a" - No quality issue
   The following situation may be considered Level "1a":
   i. Care rendered is within the national and community standard of care and behavior for that condition or situation.
b) Level "1b" – Quality issue is indeterminate
   The following situations may be considered a Level "1b":
   ii. There is no clear cause and effect.
   iii. The hospital's QM department's response states that an investigation is occurring; however, the outcome of their findings are not available to the health plan.

All QOC cases are assigned a preliminary severity level by the QM Nurse. The Severity levels are the following:

a) Severity (0)- Track and Trend only
b) Severity (1a) - No quality issue
c) Severity (1b) - Quality issue is indeterminate
d) Severity (2) - Quality issue that does not impact the outcome of care
e) Severity (3) - Quality issue that impacts the outcome of care
f) Severity (4) - Complex quality issue
g) Severity (5) - Emergency quality issue

The Medical Director or physician designee reviews all the relevant information and places each case and quality issue into one of the following final severity levels:

a) Severity (0)- Track and Trend only
b) Severity (1a) - No quality issue
c) Severity (1b) - Quality issue is indeterminate
d) Severity (2) - Quality issue that does not impact the outcome of care
e) Severity (3) - Quality issue that impacts the outcome of care
f) Severity (4) - Complex quality issue
g) Severity (5) - Emergency quality issue

It is at the discretion of the Medical Director if the case should be presented to MAC.

North Carolina:

The following applies to Healthy Blue and Healthy Blue Care Together (NC Medicaid health plans):

Healthy Blue and Healthy Blue Care Together assures mandated behavioral health providers, defined by the North Carolina General Statute 122C, Article 2 of the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. and the North Carolina *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services (10A North Carolina Administrative Code 27G),* consistently report critical incidents in the Incident Response Improvement System (IRIS) which is maintained by the North Carolina Department of Health and Human Services. Mandated providers required to report are defined as follows:

Category A – facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals. These include 24-hour residential facilities, day treatment, PRTFs and outpatient services

Category B – G.S. 122C, Article 2, community-based providers not requiring State licensure

A critical incident is defined as any event that results in death or serious physical harm, abuse, neglect, or exploitation of the individuals diagnosed receiving care from a North Carolina facility, Category A or B, providing services to the individuals diagnosed with a mental health condition, developmental disability or substance use disorder. The use of restrictive interventions is also reported as a critical incident.

A Level III incident is defined in 10A NCAC 27G .0103(b)(32) and results in:

(a) a death, sexual assault, or permanent physical or psychological impairment to a client;
(b) a substantial risk of death, or permanent physical or psychological impairment to a client;
(c) a death, sexual assault, permanent physical or psychological impairment caused by a client;

(d) a substantial risk of death or permanent physical or psychological impairment caused by a client; or

(e) a threat caused by a client to a person's safety.

- The health plan's policy for critical incidents, and deaths will be submitted to the Department for review and approval ninety (90) Calendar Days after Contract Award, and annually thereafter.
- Network Providers are required to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0600, in the NC Incident Response Improvement System.
- Network providers will develop and implement written policies governing their response to level I, II or III incidents that include requirements in 10A NCAC 27G .0602/.0603/.0604.
- Upon learning of a level III incident that occurs while a member is in the care of a provider or on a provider's premises, the health plan will:
    - Determine necessary actions have been taken to protect the client's health and safety.
    - Determine client records are secured as set forth in 10A NCAC 27G .0603.
    - Determine that a meeting of an internal review team is convened within 24 hours.
    - Ensure the client's legal guardian, as applicable, and other authorities are notified.
    - Review the internal review team's preliminary findings and final report.
    - Consider any internal review team's request for an extension of up to three months to file the final report, if necessary to gather all relevant documents.
    - Conduct local monitoring of the provider according to the requirements as set forth in 10A NCAC 27G .0608.
- The health plan will monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and to ensure the health and safety of Members.
- Information on incidents and deaths will be reported in accordance with Department procedures.
- Provider contracts will include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with RFP Section VII. Attachment F. Required Standard Provisions for CFSP and Provider Contracts.
- The health plan will review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence, and provide this information to the Department as requested.
- The health plan will adhere to the critical event reporting requirements for members obtaining services in DSOHF facilities as detailed in RFP Section VII. Attachment M. Addendum for Division of State Operated Healthcare Facilities.
- The health plan will participate in efforts by the Department to prevent, detect, and remediate critical incidents.

Critical incidents are reviewed by the Provider Appeals and Peer Review Committee. Critical incident trend reports are also reviewed semi-annually by the Provider Appeals and Peer Review Committee and Quality Management Committees. Significant provider quality of care concerns or trends to be considered during the re-credentialing process will be reported by the Provider Appeals and Peer Review Committee to the Healthcare Network Team and reported to NC Medicaid, Division of Health Benefits (DHB) by the Compliance Department.

Ohio:

Ohio Provider Agreement Appendix D Section 2.e.i
Sentinel Events
The Anthem's Care Coordination Portal – Care360 will send electronic notifications of sentinel events to entities involved in the member's care coordination.

1) The Anthem will provide timely electronic notification of sentinel events to all entities involved in the member's care coordination to support appropriate care coordination, including the OhioRISE Plan for OhioRISE Plan enrolled members. Sentinel events, with expectations of required reporting timeframes, must be entered as follows:
    a) All cause (physical health and behavioral health) inpatient hospitalizations/re-hospitalizations must be entered on the same day as admission.
    b) ED visits must be entered upon notification to Anthem.
    c) Identified gaps in care must be entered within 72 hours of identification, unless immediate action is necessary to ensure health or safety of the member
    d) Residential treatment admissions must be entered within 72 hours of admission.
    e) Residential treatment discharges must be entered at least 72 hours prior to the planned discharge
    f) Members with Mobile Response and Stabilization Services (MRSS) contact must be entered within 24 hours.

Ohio Provider Agreement Appendix D Section 2.d.vii
Incident Reporting

1) Anthem will report the following incident types upon discovery/identification/notification for all members: Abuse, Neglect, Exploitation, Misappropriation of greater than $500, unnatural/accidental death, and self-harm or suicide attempts requiring medical intervention within one business day into Ohio's Incident Management System (IMS). For members also enrolled in the OhioRISE Program or OhioRISE Waiver, Anthem must also report all natural death incidents to the OhioRISE Plan immediately upon discovery of the incident, but no later than one business day after discovering the incident.
    a) Anthem must collaborate, communicate, and coordinate as neededwith the CCE and/or the OhioRISE Plan/CME to support a prevention plan and/or

intervention (e.g., re-evaluating risk stratification, doing a home visit, offering services and resources, creating a prevention plan)

b) For members assigned to a CCE, incidents must be submitted in accordance with the 1915c and 1915i waivers by the CCE. Anthem will work with the CCE to support the prevention plan and/or intervention. Anthem must collaborate with the CCE to ensure the incident is submitted in the appropriate incident system.

Ohio Provider Agreement Appendix D Section 2.d.viii
Member Safeguards

1) Anthem will comply with member safeguard requirements in Appendix A, General Requirements, when Anthem identifies or becomes aware of risks to a member's health, safety, or welfare.
2) Anthem must develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact a member's health, safety, or welfare.
3) When Anthem identifies or becomes aware of risk factors, it must put in place services and supports to mitigate and address the identified issues as expeditiously as the situation warrants.
4) When a member poses or continues to pose a risk to the member's health, safety, or welfare, Anthem may develop and implement a health and safety action plan between Anthem and the member, identifying the risks and setting forth interventions recommended by Anthem to remedy risks to the member's health, safety, and/or welfare.
    a) Anthem's development and implementation of a health and safety action plan must be in accordance with ODM's specifications.
    b) Anthem will document in the clinical record the member's health and safety action plan, any refusal of the member to sign the health and safety action plan, and/or lack of adherence by the member to the agreed upon actions or interventions.

Virginia:
The Virginia health plan must comply with 42 CFR § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §434.6(a)(12) and § 447.26. The Virginia health plan's reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR § 447.26.

No reduction in payment for a provider preventable condition shall be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of

treatment for that patient by that provider. Reductions in provider payment may be limited to the extent that the following apply:

a. The identified provider preventable conditions would otherwise result in an increase in payment; and
b. The Department can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

Under 42 CFR §§438.3(g), 434.6(a)12(i), and 447.26(b), the Virginia plan is prohibited from making a payment to a provider for provider-preventable conditions that meet the following criteria:

a. Is identified in the State Plan.
b. Has been found by the Department, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
c. Has a negative consequence for the beneficiary.
d. Is auditable; and
e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Non-payment of provider preventable conditions must not prevent access to services for Medicaid beneficiaries.

Payments for Hospital Acquired Conditions (HACs) must be adjusted in the following manner: For Diagnosis Related Grouping (DRG) cases, the DRG payable must exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days must be reduced by the number of days associated with diagnoses not present on admission for any HAC. The number of reduced days must be based on average length of stay (ALOS) on the diagnosis tables published by the ICD vendor (Thomas Reuters) used by the Department. For example, an inpatient claim with forty-five (45) covered days identified with an HAC diagnosis having an ALOS of 3.4, must be reduced to forty-two (42) covered days.

Washington:
This policy applies to both Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO).

Apple Health Integrated Managed Care Contract K8091 § 13.2.1.7: The Contractor shall complete the resolution of a grievance and notice to the affected parties as expeditiously as the Enrollee's health condition requires, but no later than forty-five (45) calendar days from receipt of the grievance. The Contractor may extend the timeframe for processing a Grievance by up to fourteen (14) calendar days if the Enrollee requests the extension. For any extension

not requested by an Enrollee, the Contractor must document that there is need for additional information and that the delay is in the Enrollee's best interest and give the Enrollee prompt oral notice of the delay.

If the Contractor extends the timeline for a Grievance not at the request of the Enrollee, it must give the Enrollee written notice within two (2) calendar days of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision. 42 C.F.R. § 438.408(c)(2)(ii); and 42 C.F.R. § 438.408(b)(1).

Ensure everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that access to care and health outcomes. Quality of Care associates consider health inequities throughout the process to continually promote Health Equity where possible to provide whole health to everyone.

REVISION HISTORY:

Review Date	Changes
11/12/2025	• Annual Review (NV Managed Care Rebid) • Added NV as an applicable market
08/21/2025	• Annual Review • Removed FL, IA, and NJ as applicable markets • Removed NJ Exceptions

03/13/2025	• Off-Cycle Review
	• Updated Policy, Procedure, and References sections
	• Updated Primary Dept. from QM to Medicaid Grievance and Appeals dept.
	• Added in under tracking and trending; The database includes a monthly production report with QOC cases from all lines of business. The report includes the affected practitioner, incident date and reported date, quality issue, level assigned, outcome including corrective actions assigned.
	• Added in under tracking and trending to meet NCQA requirements CR 5B.; The action plan will include the following information
	  ○ Affected practitioner
	  ○ Incident date
	  ○ Quality issue
	  ○ Date reported to the designated peer review body
	  ○ Organizations actions
	• Updated OH and WA Exceptions section

11/05/2024	• Off-Cycle Review (NC Readiness Review)

Review Date	Changes
	• Updated NC Exceptions section
09/12/2024	• Annual Review • Removed MD, MN, NE and NV as applicable markets • Updated Definitions, Procedure and References • Added related materials/forms • Added Grievance and Appeals as a Secondary Department • Added IN Exception • Removed MD, MN, and NE exceptions • Revised NC, OH, VA and WA exceptions • Added severity levels chart • Added health equity language for WA
02/16/2024	• Off-Cycle Review (OH Edits) • Added OH as an applicable market • Added OH Exceptions • Alphabetized Other References
07/13/2023	• Annual Review • Updated Procedure including: Updated Triggers Review section, Removed references to the MAC and Updated section 10 c. • MHD approved 11/28/2023 (Reference # PP24-HB016)
12/02/2022	• Off-Cycle Review to add WV as an applicable market
09/19/2022	• Off-Cycle Edit • Added MO exception language • MHD approved 10/12/2022 (reference #: PP23-HB021)
06/09/2022	• Annual Review • Updated Policy and References • Revised Definitions and placed in alphabetical order • Updated Prior Procedure References to Other References and revised section • Removed Related Materials section • Revised MN and WA exceptions
06/30/2021	• Off-cycle Review • Added North Carolina state statute requirements.
03/18/2021	• Annual Review • Added NE as an applicable market • Revised NJ Prior Procedure Reference • Added NE exception • Revised WA exception
12/18/2020	• Off-Cycle Review • Added MO as applicable market

Review Date	Changes
	• MHD approved policy 12/18/2020 – Reference # PP21-HB021
11/30/2020	• Off-Cycle Review • Updated WA exception language
02/13/2020	• Annual Review • Removed KS as applicable market and exception language • Added NC as applicable market • Tweaked verbiage regarding documentation into QOC database • Updated Procedure • Deleted Market GO live message in Arkansas exception section • Revised Related Materials • Revised WA Prior Procedure Reference • Added verbiage in remedial action level 5 section • Revised MN, VA and WA exceptions
01/10/2019	• Annual review • Add DC as an applicable market • Revise IA & VA reference language • Revised exception language for AR, MN & WA; add NJ exception language
10/11/2018	• Off-cycle edit to add AR as an applicable market and add AR exception language.
08/09/2018	• Off-cycle edits to revise VA exception language for VA Medallion 4.0 project • Off-cycle edit to add MN as an applicable market and add MN exception language
11/09/2017	• Annual review • Revised content of entire document – some content moved to QOC tip sheet • Revised references section • Added exceptions for MD & WA
05/11/2017	• Off-cycle edits to add Title 42 CFR § 438.3(g), 42 CFR §434.6(a) (12) and § 447.26. 42 CFR § 447.26 references and VA exception language
04/13/2017	• Annual review • Added IN as applicable market • Added State Medicaid Agency as external QOC identifying source • Added language around QOC tracking system usage • Revised plan-specific sections of “References” header
12/08/2016	• Off-cycle edit to add New York – Western as an applicable market
10/13/2016	• Off-cycle edits for TN ECF • Wordsmithing to Policy statement

Review Date	Changes
	• Removed Immediate Jeopardy as QOC issue • Updated TN References • Added LTSS as secondary department
03/10/2016	• Annual review by PPOC and QIC • Removed TX and added WI as applicable markets • Added language around QOC issues • Minor wordsmithing to external appeals and grievance definitions; level 0 & level 1– not a QOC issue • Add report of a critical incident to Identification of QOC issues • Updates to P&Ps listed in references section • Added NY exception
12/03/2015	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016. • Added Iowa to References section
09/02/2014	• Annual Review
01/01/2014	• Added Kentucky Health Plan.
11/18/2013	• Reviewed for VAMM. Revise references to AGP. No content changes. Moved to MBU template.