PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPQP1016 (previously QP100116)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Potential Quality Issue Investigation and Resolution</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 01/20/1996</td><td colspan="4">Next Review Date: 06/12/2025
Last Review Date: 06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 06/12/2024</td></tr>
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I. RELATED POLICIES:

A. CMP30 - Records Retention and Access Requirements
B. CMP36 - Delegation Oversight and Monitoring
C. MPCR200 - Credentialing Committee and CMO Credentialing Program Responsibilities
D. MPCR600 - Range of Actions to Improve Practitioner Performance
E. MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MPCR602 – Reporting Actions to Authorities
G. MPQD1002 – Quality and Performance Improvement Program Description
H. MPQP1053 – Peer Review Committee

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Grievance and Appeals

III. DEFINITIONS:

A. Potential Quality Issue (PQI): A possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.
B. Quality Issue: A confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.
C. Clinician or Provider: Any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity if licensure or certification is required by State law or regulation.
D. Corrective Action Plan (CAP): A plan approved by the Peer Review Committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and timeframes for completion.
E. Severity Level: Refer to Attachment A: Practitioner Performance and Systems Scores Grid
F. Egregious Lapse: Where the quality of care was significantly outside accepted and common standards of practice and/or where the adverse outcome of the care provided was especially serious.
G. Quality Investigator: A Registered Nurse (RN) responsible for assessing and improving the quality of care provided by the providers serving Partnership HealthPlan of California (Partnership) members. These nurses perform the PQI Investigations and prepare the files for review by the CMO/ physician designee.
H. Provider of Concern (POC): The clinician, service provider, vendor, agency, facility or organization

under review during a PQI investigation.

IV. ATTACHMENTS:

A. Practitioner Performance and Systems Scores Grid

V. PURPOSE:

To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue (PQI), to determine opportunities for improvement in the provision of care and services to Partnership members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

VI. POLICY / PROCEDURE:

A. IDENTIFICATION OF POTENTIAL QUALITY ISSUES

1. PQIs are identified through the systematic review of a variety of sources, including but not limited to:
   a. Information gathered through concurrent, prospective, and retrospective utilization review;
   b. Referrals from any health plan staff;
   c. Facility Site Reviews;
   d. Claims and encounter data;
   e. Pharmacy utilization data;
   f. Health Effectiveness Data Information Set (HEDIS®) medical record abstraction process;
   g. Medical record audits;
   h. Grievances and Appeals
2. PQI reviews shall be conducted on services provided by:
   a. Contracted clinicians or providers, including subcontractors and pharmacists, who provide inpatient and/or outpatient services;
   b. Non-contracted providers: complaints involving non-contracted providers will be discussed with the Chief Medical Officer (CMO)/designee to determine next steps prior to ordering medical records;
   c. Durable Medical Equipment (DME), medical transportation and respiratory supply vendors;
   d. Hospitals, skilled nursing facilities, long-term care and rehabilitation facilities, and Home Health agencies.
   e. Ancillary service providers including, but not limited to laboratory and radiology, physical therapy, acupuncturists.
   f. Behavioral Health: the Behavioral Health Clinical Director reviews complaints regarding behavioral health for investigation, intervention, and resolution as part of the general PQI review process.

B. PQI REFERRAL

1. A PQI may be reported by any of the following:
   a. Any Partnership staff member;
   b. Anonymously using the Partnership "confidential line" which is available 24 hours a day, 7 days a week (1-800-601-2146);
   c. Any member of the community;
   d. Any contracted or non-contracted clinician or provider.
2. A PQI is referred internally to the Quality Improvement (QI) department via the PQI Referral Intake System found on PHC4ME. For external PQI referrals and general PQI inquiries, send a secure email via PQI@Partnershiphp.org. The email must be encrypted through a secure messaging system.
3. Timeframe limitations: Partnership will not routinely investigate a PQI which occurred more than two years prior to the notification of the concern to the QI department.

a. Cases occurring more than two years before reporting involving a potentially serious matter or egregious lapse in care may be reviewed on an ad-hoc basis upon the discretion of the CMO/physician designee.

C. PQI REVIEW PROCESS

During case review, professionally recognized standards of care will be used to assess the care provided. A PQI may be a single event or occurrence or may involve several events or recurrences. While one report alone may not represent a quality issue, trending of similar events may reveal a quality issue and may lead to the re-opening of a case previously reviewed or closed.

1. PRIMARY REVIEW BY QUALITY INVESTIGATOR REGISTERED NURSE (RN) – Upon receipt of a PQI referral, the Patient Safety-Quality Investigations team's Project Coordinator opens a new case file in the PQI database, and assigns the case to a Quality Investigator-RN (Investigator) to conduct the primary review and manage the case to completion.
   a. The Investigator conducts a thorough internal investigation on all potential quality issues (provider performance and/or system issues), including a review of the incident as reported or alleged, as well as relevant medical records, and gathers responses from providers or other Partnership departments, when appropriate. The Investigator then presents a summary of the case at the internal PQI team rounds for a secondary review and assignment of the severity level by the CMO/physician designee. (See Attachment A - Practitioner Performance and Systems Scores Grid.)
   b. If the issue is urgent or the potential severity may represent an egregious lapse in the quality of care, the Investigator will immediately contact the CMO/physician designee for resolution and next steps. The CMO/physician designee may refer to an outside Peer Review Organization (PRO) depending on the case and availability of an appropriate PRO.
   c. If the PQI occurred at an organization with an accredited PRO responsible for oversight of the care provided by the Clinician or Providers of Concern (POC), the PQI is found to be urgent, and the potential severity of the PQI has been determined by the CMO/physician designee to reflect an egregious lapse in quality, the PQI will be referred to the outside PRO. A response will be required from the PRO acknowledging receipt of the notification regarding the concern. When a PQI is referred to the outside PRO, a copy will be sent to the Chief of Quality and Quality Director at the outside organization and the POC will be notified of the PRO referral. If the severity score is not determined prior to the referral, the case will be leveled as Provider, Unable to Determine (PUTD) or System, UTD.
      i. Notification that another PRO is reviewing a case does not prevent Partnership from investigating a case through the Partnership PQI and Peer Review process.
   d. If the Investigator determines that the member needs immediate assistance beyond the scope of peer review, appropriate information will be forwarded to other appropriate departments for action and follow-up (e.g., Member Services or Care Coordination).
2. SECONDARY REVIEW BY CMO/PHYSICIAN DESIGNEE – The CMO/physician designee review includes assessment of, but not limited to: appropriate level of care; appropriate diagnostics; therapy and treatment; technical expertise; referral; consultation; timeliness; and adequate documentation. During the CMO/physician designee review, the CMO/physician designee may:
   a. Notify (by secure email and certified letter) the POC describing the issue and requesting investigational response and may also request additional documentation including related to system issues. If no response is received within the requested timeline (usually 14 days, although providers may request extensions), an attempt to contact the provider will be made via any or all of the following methods: a certified letter, telephone call, fax, or secure email. A severity level may be determined based upon available documentation.
   b. Assign a severity level (see Attachment A - Practitioner Performance and Systems Scores)

and instruct the Investigator to close the case or prepare the case for presentation to the Peer Review Committee (PRC) depending on the severity level of the findings. Additional information such as licensing board information and Partnership's Grievance, Credentialing, and PQI history may be used to determine an appropriate score and/or actions.

c. Notify the POC (see Attachment A - Practitioner Performance and Systems Scores) for the action/follow-up recommended or required, based upon the severity level assigned and as determined by the reviewing physician(s).

d. Upon determination that a PQI case requires a second opinion review by a specialty physician or subject matter expert, a request for investigational review and response will be sent.

e. Emergency action: If the CMO/physician designee determines that a situation exists where immediate action is required to protect the life or well-being of a Partnership member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life or safety of any patient or person, the CMO (or, if the CMO is unreachable, the Partnership Physician Chair of the Credentials Committee or other physician designee) may summarily suspend the POC's credentialed status. See policy MPCR601 – Fair Hearing and Appeal Process for Adverse Decisions.

f. Upon determination that a PQI case is out of Partnership's jurisdiction (e.g., serious mental health cases) the case will be referred to the appropriate oversight body (e.g., County Mental Health).

3. TERTIARY REVIEW BY THE PEER REVIEW COMMITTEE (PRC) – Upon determination by the CMO/physician designee that a PQI case requires review by the PRC, the Project Coordinator and Investigator prepare the PQI case file for Peer Review. See MPQP1053 for the Peer Review Committee policy.

a. All PQI cases designated a severity level P2 or S2 or higher (see Attachment A for descriptions) by the CMO/ physician designee must be referred to the PRC for review and determination of next steps.

b. The PRC reviews the worksheets developed by the Investigator and CMO/physician designee, the medical records related to the case, any notifications to and responses from POCs and all other relevant documentation and correspondence related to the case.

i. Following review and discussion of the case, the PRC may uphold the original scoring determination, may level a lower or higher score, or may direct the Investigator to obtain more information for further review.

ii. If a score is leveled, the PRC will direct the Member Safety-Quality Investigations team in the next actions to take, as outlined in the Practitioner Performance and Systems Scores Grid

c. PRC recommendations for cases determined to be S3/P3 may be forwarded to the Credentials Committee for possible action.

d. In cases where the PRC recommends a Corrective Action Plan (CAP):

i. Notice shall be given to the POC within seven calendar days of the recommendation of a CAP being required. Grounds for recommending a CAP include but are not limited to:

a) failure to provide professional services of acceptable quality;
b) failure to follow Partnership utilization review policies;
c) failure to follow Partnership quality improvement policies;
d) failure to treat patients for whom the provider is responsible;
e) failure to adhere to the provider contract or Partnership policies;
f) acts constituting disruptive behavior or an inability to work collaboratively with others;

g) failure to report adverse action by another peer review body or a hospital

If a CAP is recommended, it is included in the PQI case file. A CAP includes the goals, objectives, desired outcomes, timeframes, persons responsible, follow-up, and CAP evaluation. The timeframe for clinicians to respond to a CAP is 30 calendar days. The POC will be sent a reminder notice on day 15. If the CAP is not received by Partnership by day 31, the Investigator will contact the POC. A 15-days extension may be granted for reasonable concerns. If the CAP has not been received by day 46, the case is forwarded to the CMO/physician designee for further determination, including possible review by the Credentials Committee. Upon completion, the CMO/ physician designee reviews the CAP and notifies the POC acknowledging completion with no further action required, or sends communication (certified letter or secure email) outlining what areas still need to be addressed and submitted, again within 14 days of receipt of the follow-up notification. CAP results are reported to the PRC.

ii. The CAP may include but is not limited to:
   a) required completion of continuing education programs applicable to the issue identified and approved by Partnership;
   b) required training/re-training and/or certification/re-certification for performance of those procedures that require specific training and professional certification;
   c) continuing concurrent trend analysis of the adverse quality issues identified in the clinician's practice patterns;
   d) monitoring of POC's medical record documentation by physicians selected by the PRC for a prescribed length of time; and
   e) in-service training for clinicians and/or their staff.

iii. For appropriate quality concerns, the PRC may instruct the Member Safety team to conduct periodic reviews of the POC to verify that the deployed corrective action is effective and eliminates the noted deficiencies.

4. The PRC may also recommend that the Credentials Committee review the POC's status, including but not limited to the following:
   a. clinician or provider contract changes, including modification, restriction, or termination of participation privileges with Partnership;
   b. summary suspension: immediate suspension from credentialed status based on the need to take immediate action to protect the life or well-being and or reduce the possibility of substantial or imminent threat to the life, health, or safety of any Partnership member or other person;
   c. recommendation of counseling for behavior modification;
   d. focused review of the provider's cases including but not limited to:
      a) second opinion for invasive procedures;
      b) retrospective or prospective medical claims reviews;
   e. preceptorship with a physician of the same specialty;
   f. institute a monitoring process through proctoring by another qualified, specialty-matched physician; or
   g. implementation of a practice improvement plan.
5. In the following situations, in addition to the other measures applicable to S3/P3 cases, immediate referral will be made to the CMO for consideration of the need for immediate follow-up and potential rapid escalation to the Credentials Committee, Board of Commissioners, Medical Board of California or other regulatory agency, and/or law enforcement agencies, depending the severity of the concern:
   a. actions or omissions constituting unethical or unprofessional conduct;
   b. sexual misconduct with or sexual harassment of a patient;
   c. discriminatory actions or behavior towards a patient based on race, gender, gender identity,

religious beliefs, disability status, socioeconomic status, or other factors generally viewed as constituting unfair bias.

6. Any POC has the right to request a Fair Hearing for certain adverse actions as outlined in Partnership policy MPCR601 Fair Hearing Process for Adverse Actions. This policy also describes reporting requirements to the Partnership Board of Commissioners.
7. A report is filed per policy MPCR601 Fair Hearing and Appeal Process for Adverse Action and MPCR602 Reporting Actions to Authorities as required by Section 805.01 of the California Business and Professions Code. Pursuant to Section 805.01, when a peer review body makes a final decision following a formal investigation of one of the categories of misconduct identified below, it must file a report with the Medical Board of California and proposed action must be given to the practitioner within 15 days after the peer review body makes the recommendation or final decision. A similar approach is applied to all clinical professionals credentialed by Partnership with a report filed with the appropriate professional licensing agency. The investigation findings trigger reporting obligations when the following "may" have occurred:
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
   b. The use of, or prescribing for or administering to themselves of any controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate's ability to practice safely is impaired by that use;
   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.
8. All PRC/Credentials Committee recommendations and necessary attachments are forwarded to the CMO for coordination of any recommended action. If a quality issue has multiple clinicians or providers involved in care who are separately evaluated by a clinical reviewer or the PRC, determinations of severity ratings will not be final until all involved clinicians have been assigned final severity ratings. If any data is pending before making a final determination for one involved clinician, the others clinicians' determinations will be pending and notifications will not be made until all determinations are complete.
9. For contracted providers who are not individuals (e.g., hospitals, skilled nursing facilities, community clinics), where a final determination is an S1, S2, or S3, the case will be referred in writing to the quality assurance committee, Medical Director or other designated authority of the facility involved. This referral will request acknowledgement that the issue has been reviewed and assurance that action has or will be taken to prevent similar system issues in the future. These system issues will be tracked and reviewed at the time of the facility's re-contracting. If the CMO or PRC determines that the system issue at a facility places Partnership members at risk of adverse health outcomes, they may recommend that the contract with this facility be suspended or terminated.
10. The Partnership Board of Commissioners has the ultimate authority for final decisions regarding credentialing and appeals. Credentials Committee recommendations for adverse action are forwarded to the next regularly scheduled Board of Commissioners meeting for a final decision.

D. OPPORTUNTITIES FOR DISCUSSION BY THE CLINICIAN OR PROVIDER OF CONCERN (POC)
   1. The POC will be notified of concern depending on the severity level assigned. The

notification will include the following:
   a. patient name and demographics;
   b. brief statement explaining the purpose of quality review activities;
   c. brief summary of the background of the case;
   d. confidentiality statement; and
   e. CMO/physician designee signature.
2. The POC will be given an opportunity to discuss the case by one of these methods: written, telephonic, in-person, or by encrypted e-mail. The POC will have 14 calendar days to respond.
3. If the POC fails to provide additional information within the required timeframe, the Investigator will send reminder notification with an immediate response required. If no response is received, the CMO or designee may choose to level the case using the information on hand. If an individual clinician is a member of a contracted medical group, the Director of the Quality Assurance (QA) department and/or Medical Director of the group will also be sent a copy of the request for additional information. In addition to the content in the original notification, the following will be included:
   a. A reminder that the organization's Partnership contract requires them to adhere to Partnership policies and procedures, which includes timely response to potential quality incidents; and
   b. An additional 14 calendar days deadline for response.
4. If there is no response from the POC following the second request, the CMO or designee may contact the POC to ensure the notification was received and request a response.
5. When additional information is received from the POC, the CMO or designee may refer the case to the PRC, a physician on the PRC with the same or a similar specialty, or to an outside physician with the same specialty. The original reviewer should be among those who review the additional information. In all such cases, the initial physician reviewer will conduct final review and recommend a level, which is then presented to the PRC for final determination.
6. The POC will receive a final determination notification that will include the following:
   a. a summary of the case findings, including a preferred or required course of action;
   b. final severity level and any actions to be taken;
   c. a statement of opportunity to provide any additional information;
   d. confidentiality statement; and,
   e. CMO/physician designee signature.
7. Phone conversations between a POC and a peer reviewer or the CMO/physician designee will be documented with written notes, which will be entered into the peer review file and sent to the clinician in a subsequent peer review notification, to offer the opportunity to make corrections.

E. TRACK AND TREND REPORTS
1. Track and trend reports by provider and by level of severity are reported to CMO or physician designee every six months. This includes adverse event trend analysis to assess providers and site rates of adverse events over time.
2. The CMO or physician designee may consider a focused review, or other actions as outlined in section VI.C.4 when any practitioner demonstrates performance below acceptable standards of care or if there is evidence of poor quality that could affect the health and safety of Partnership members. The CMO or physician designee will implement a Practice Improvement Plan as needed. This will include specifics regarding the area of focus that requires improvement, timeframes and required documentation of completion.
3. Thresholds for consideration of a focused review:
   a. Two or more P2 or above quality of care scores in the last 24 months; or
   b. Significant trend of service or quality complaints exceeding the established threshold.

F. MEDICAL RECORD REQUESTS

1. Upon determination that medical records and other related documents are required for the case review, the POC is requested to submit documents to the Partnership QI department within 30 calendar days from the date of the request.
2. If the information requested is not received within that timeframe, attempts to contact the facility will be made to follow up on the request. The CMO/physician designee will use all available information to rate the PQI. If the PQI cannot be rated due to the lack of medical records, the PQI may be referred to the licensing body that oversees the clinician or facility for investigation and disposition. Notification will be sent to the CMO of the POC or facility of concern informing them of the lack of response to the information request.

G. CASE COMPLETION
1. All PQI cases will be processed and closed with a final severity level within 120 days from the date the case is received by the QI department. If a PQI investigation cannot be completed within the timeframe, a 30- days extension may be granted with the approval of the CMO/physician designee. The rationale for the extension approval shall be documented in the case file.
2. If the reviews are not completed in a timely manner, the CMO/physician designee will institute plans for compliance with standards for completion and timeliness.
3. While under review, all PQI cases and related documentation, when not in electronic form, are kept in a secure file cabinet in the QI department and only designated personnel have access to these files. Access to the electronic files is password protected and limited only to staff directly involved in the PQI process.

H. REPORTING REQUIREMENTS
1. If a recommendation is made to revoke, suspend, or restrict the privileges of a clinician, or to terminate the provider's contract with Partnership, the following individuals and committees will be notified:
   a. Chief Executive Officer (CEO) of Partnership.
   b. Credentials Committee recommendations are forwarded to the next regularly scheduled Board of Commissioners meeting for final action.
   c. Chief of Staff and Hospital Administrators of facilities where clinician has hospital privileges.
   d. The CEO of the medical group that employs the clinician, if applicable, and/or the Medical Director of the clinic where the clinician is employed.
   e. DHCS requires Partnership to notify them when a provider has been terminated from being a Medi-Cal or Medicare provider and has been placed on the Suspended and Ineligible Provider list. Providers on the Medi-Cal/Medicaid suspended and ineligible provider list cannot participate in the Partnership provider network.
   f. If the provider is a member of a medical group or clinic, a paraphrased summary of the final determinations of levels S1, S2, S3, P1, P2, and P3 will be reported to the supervising Medical Director. If the final determination is an S3, the CEO of the institution may also be notified.

I. INTER-RATER RELIABILITY (IRR)
1. Inter-rater reliability studies will be performed at least twice a year by the CMO or physician designee to ensure cases are appropriately reviewed, to ensure that the reliability of the PQI case scoring process can be evaluated, and, for cases reviewed in PRC, review actions are appropriate and implemented.

J. RECORD RETENTION
1. Please refer to Policy CMP30 Records Retention and Access Requirements.

K. CONFIDENTIALITY
1. Peer review records proceedings as well as records obtained for the quality/peer review process are protected by California Evidence Code § 1157 and are not subject to discovery when confidentiality has been maintained. To maintain confidentiality, peer review records are retained by the Quality department and are not released to anyone for purposes other than peer review.

Records are maintained in secure electronic format or in a locked file cabinet with access restricted to the CMO, Medical Director for Quality, Manager of Member Safety & Quality Investigations, the RN Investigators, the QI Project Coordinator. While records are being reviewed, or during transport to peer review meetings, a QI staff person accompanies them at all times. If a subpoena is served to Partnership regarding a peer review case, the Manager of Member Safety & Quality Investigations may act as the "certifier of the medical records" being requested.

L. SUBCOMMITTEES
   1. Refer to policy MPQP1053 Peer Review Committee.

M. DELEGATION OVERSIGHT AND MONITORING
   1. Partnership may delegate Potential Quality Issue (PQI) investigation including Peer Review Committee activities oversight.
   2. A formal agreement will be maintained and inclusive of all delegated functions.
   3. Partnership will review related policies and procedures and annual summary reports of findings and actions taken as a result of the PQI review process and provide feedback as part of Partnership annual oversight audit.
   4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

Exhibit A, Attachment III, Section 2.2 in the 2024 DHCS Contract

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Quality Investigator RN

X. REVISION DATES:

Medi-Cal 07/01/96; 06/02/97; 10/10/97 (name change only); 01/13/99; 06/16/99; 06/21/00; 05/16/01; 05/15/02; 08/20/03; 04/20/05; 07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16; 06/21/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee meeting date.

PREVIOUSLY APPLIED TO:

Healthy Families
MPQP1016 - 10/19/2011 to 03/01/2013

Healthy Kids (Healthy Kids Program ended 12/01/2016)
07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16 to 12/01/16