KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 3.13-P EPSDT Supplemental Services and Targeted Case Management (TCM) has been updated and is provided here for your review and approval.

Reviewer	Date	Comment/Signature
Doug Hayward	6/10/21	
Dr. Tasinga	6/8/2021	
Deb Murr	6/7/2021	
Michael Pitts	4/1/21	
Shannon Miller	4/1/21	

(CEO decision(s))

Board approval required: Yes ___ No ✓ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: EPSDT Supplemental Services and Targeted Case Management (TCM)				POLICY #: 3.13-P	
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 08/1997	Review/Revised Date: 06/10/2021	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief of Health Services

_____ Date _____
Director of Case and Disease Management

_____ Date _____
Director of Utilization Management

POLICY:

KHS is required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under the age of 21, including EPSDT Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist members in gaining access to necessary medical, social, educational, and other services. KHS will ensure that comprehensive case management is provided to each member. KHS must maintain procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside KHS's provider network. If KHS determines that case management services are medically necessary and not otherwise available, KHS will provide, or arrange and pay for, the case management services for its

members who are eligible for EPSDT services (Title 22, CCR, and Section 51340(k)). KHS will ensure the provision and referral of appropriate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) in accordance with the following statutory, regulatory, and contractual requirements:

- Title 22, CCR, Section 51184 and 51340(k)
- DHCS Contract Exhibit A – Attachment 10 Provision 4(F) and Attachment 11 Provision 2
- DHCS APL14-011 Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder
- DHCS APL 20-012 Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under the Age of 21
- Pursuant section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT)
- Section 1374.73 of the Health and Safety Code
- Pursuant to Section 14132.56 of the Welfare & Institutions Code

DEFINITIONS:

EPSDT Case Management Services[2]	Services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services. "Case Management Services" means those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in assisting eligible individuals is set forth in 42 CFR 14 section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h). SA Pg. Pg. 3, para. 1.
EPSDT Diagnosis and Treatment Services[3]	Only those services provided to persons under 21 years of age that: 1. Are identified in section 1396d(r) of Title 42 of the United States Code, 2. Are available under CCR Title 22 Chapter 3 of Division 3 Subdivision 1, ccr.oal.ca.gov without regard to the age of the recipient or that are provided to persons under 21 years of age pursuant to any provision of federal Medicaid law other than section 1396d(a)(4)(B) and section 1396a(a)(43) of Title 42 of the United States Code, and 3. Meet the standards and requirements of CCR Title 22 Sections 51003 and 51303, ccr.oal.ca.gov and any specific requirements applicable to a particular service that are based on the standards and requirements of those sections.
EPSDT Services	EPSDT Services means Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section

	1905(r) of the Social Security Act. (42 U.S.C. §§ 1396a (a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).)
Private Duty Nursing	Private Duty Nursing (PDN) means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)
Home Health Agency	Home Health Agency (HHA) as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.
Individual Nurse Provider	Individual Nurse Provider (INP) means a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.

PROCEDURES:

1.0 PROGRAM DESCRIPTION

The EPSDT benefit provides comprehensive screening, diagnostic, treatment, and preventive health care services for individuals under the age of 21 who are enrolled in Medi-Cal and is key to ensuring that members who are eligible for EPSDT services receive appropriate preventive, dental, mental health, developmental, and specialty services.

Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income individuals under 21 years of age. States are required to provide any Medicaid covered services listed in section 1905(a) of the SSA for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

In accordance with Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c), services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.

The EPSDT benefit is more robust than the Medi-Cal benefit package provided to adults and is designed to ensure that eligible members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

All members under the age of 21 must receive EPSDT screenings designed to identify health and developmental issues, as early as possible. The EPSDT benefit also includes medically necessary diagnostic and treatment services for members with developmental issues, when a screening examination indicates the need for further evaluation of a child's health. The member should be appropriately referred for diagnosis and treatment without delay.

Pursuant to Title 22, CCR, Section 51340, speech therapy, occupational therapy, and physical therapy services are exempt from the benefit limitations set forth under Title 22, CCR, and Section 51304. KHS may not impose service limitations. In addition, KHS is required to provide speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the state plan unless otherwise specified in the applicable KHS contract with DHCS.

2.0 ACCESS

Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services as including the following:

1) Screening services provided at intervals which meet reasonable standards of medical and dental practice and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services must include, at a minimum, a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).

2) Vision services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

3) Dental services provided at intervals which meet reasonable standards of dental practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.

4) Hearing services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

5) Other necessary health care, diagnostic services, treatment, and measures, as described in 42 USC 1396d (a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.

6) Blood Lead Screening Requirements

Federal law requires states to screen children enrolled in Medicaid for elevated blood lead levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Accordingly, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin in November 2016 that provides an overview of blood lead screening requirements for children enrolled in Medicaid. In addition, KHS is contractually required to cover and ensure that network providers provide blood lead screening tests in accordance with the California Code of Regulations (CCR).

The CCR imposes specific responsibilities on doctors, nurse practitioners, and physician's assistants conducting periodic health assessments (PHAs) on children between the ages of six months and six years. The California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) issues guidance for all California providers pursuant to the CCR.6 The CLPPB sets forth required blood lead standards of care, including Blood Lead and Anticipatory Guidance developed by the Department of Health Care Services (DHCS) related to children enrolled in Medi-Cal.

In accordance with APL 20-016, KHS will ensure that their contracted providers (i.e. physicians, nurse practitioners, and physician's assistants), who perform periodic health assessments on children between the ages of six months to six years (i.e. 72 months), comply with current federal and state laws and industry guidelines for health care providers issued by CLPPB, including any future updates or amendments.

KHS will ensure that their contracted providers:

1) Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.8 This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.

2) Order or perform blood lead screening tests on all child members in accordance with the following:
   a) At 12 months and at 24 months of age.
   b) When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
   c) When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
   d) At any time a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
   e) If requested by the parent or guardian.

3) Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

Network providers are not required to perform a blood lead screening test if either of the following applies:

1) In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
2) If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

Network providers must document the reason(s) for not performing the blood lead screening test in the child member's medical record. In cases where consent has been withheld, KHS must ensure that the network provider documents this in the child member's medical record by obtaining a signed statement of voluntary refusal. If the network provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent declines to sign or is unable to sign (e.g., when services are provided via telehealth modality), the network provider must document the reason for the not obtaining a signed statement in the child's medical record. KHS will consider these documented efforts that are noted in the child's medical record as evidence of compliance with blood lead screening test requirements.

Current CLPPB-issued guidelines include minimum standards of care a network provider must follow when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. KHS must ensure network providers follow these CLPPB-issued guidelines. According to current CLPPB guidelines, blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. All confirmatory and follow-up blood lead level testing must be performed using blood samples taken through the venous blood sampling method. While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a provider may determine additional services that fall within the EPSDT benefit are medically necessary. KHS must ensure that members under the age of 21 receive all medically necessary care as required under EPSDT.

In addition to ensuring network providers meet requirements for testing, follow-up care, and documentation, as described above, KHS is required to identify, on at least a quarterly basis all child members between the ages of six months to six years (i.e. 72 months) who have no record of receiving a blood lead screening test required by Title 17 CCR section 37100. KHS must identify the age at which the required blood lead

screenings were missed, including children without any record of a completed blood lead screening at each age. KHS must notify the network provider who is responsible for the care of an identified child member of the regulatory requirements to test that child and provide the required written or oral anticipatory guidance to the parent/guardian of that child member. KHS must also maintain records, for a period of no less than 10 years, of all child members identified quarterly as having no record of receiving a required blood lead screening test and provide those records to DHCS, at least annually as well as upon request, for auditing and compliance purposes.

2.1 Medical Necessity Standards

Specifically, for members under the age of 21, KHS is required to provide and cover all medically necessary services with the following exceptions:

A. Dental services provided by dental personnel covered by the Medi-Cal Denti-Cal Program (Policy Letter 13-002);
B. Non-medical services provided by Regional Centers (RCs) to members with developmental disabilities, including, but not limited to, respite, out-of-home placement, and supportive living. However, KHS will monitor and coordinate all medical services with RC staff;
C. Alcohol and substance use disorder treatment services available under the Drug Medi-Cal Program and outpatient heroin detoxification services, including all medications used for treatment of alcohol and substance use disorder covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through Medi-Cal fee-for-service (FFS);
D. Specialty mental health services listed in Title 9, CCR, Section 1810.247 for members that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, 1830.205, or 1830.210, which must be provided by a mental health plan (APLs 13-018 and 17-018);
E. CCS services not included in the KHS capitated rate. The EPSDT services determined to be medically necessary for treatment or amelioration of the CCS-covered condition, including private duty nursing related to a CCS-eligible condition, must be case managed and have obtained prior authorization by the CCS program (on a FFS basis) (Title 22, CCR, Section 51013);8
F. Services for which prior authorization is required but are provided without obtaining prior authorization; and
G. Other services listed as services that are not "Covered Services" under KHS's Contract with DHCS, such as Pediatric Day Health Care services.

Where another entity—such as a local education agency (LEA), RC, or local governmental health program—has overlapping responsibility for providing services to a member under the age of 21, KHS will assess what level of medically necessary services the member requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that KHS and the other entities are not providing duplicative services.

KHS has the primary responsibility to provide all medically necessary services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements

regarding provision of services. KHS should not rely on a LEA program, RC, CCS, Child Health and Disability Prevention Program, local governmental health program, or other entities as the primary provider of medically necessary services. KHS is the primary provider of such medical services except for those services that have been expressly carved out. KHS is required to provide case management and coordination of care to ensure that members can access medically necessary medical services as determined by the KHS provider. For example, when school is not in session, KHS will cover medically necessary services that were being provided by the LEA program when school was in session.

3.0 REPORTING

According to the November 2016 CMS informational bulletin, there is concern that not all blood lead screening tests are coded correctly to be included in Medicaid screening data. Network providers, including laboratories, should utilize appropriate Common Procedure Terminology coding to ensure accurate reporting of all blood lead screening tests.

In order to comply with Health Insurance Portability and Accountability Act requirements, KHS must utilize the CMS-1500/UB-04 claim forms, or their electronic equivalents (837-P/837-I), to report confidential screening/billing to DHCS.

DHCS currently utilizes encounter data submitted through national standard file formats (837-P/837-I) for tracking the administration of blood lead screening. KHS is required to submit complete, accurate, reasonable, and timely encounter data consistent with our DHCS contract and APLs 14-019 and 17-005.12 Additionally, KHS must ensure that blood lead screening encounters are identified using the appropriate indicators, as outlined in the most recent DHCS Companion Guide for X12 Standard File Format, which can be obtained by emailing the Encounter Data mailbox at: MMCDEncounterData@dhcs.ca.gov.

California law requires laboratories performing blood lead analysis on blood specimens drawn in California to electronically report all results to CLPPB. This reporting must include specified patient demographic information, the ordering physician, and analysis data on each test performed. KHS must ensure that network providers are reporting blood lead screening test results to CLPPB, as required.

4.0 MONITORING

KHS will provide training to ALL laboratories and health care providers performing blood lead analysis and monitor through quarterly reporting reconciliation for members less than 6 years of age. Providers will be notified of compliance with this requirement through various communication channels and ongoing auditing of screenings performed.

5.0 PRIVATE DUTY NURSING

As outlined in DHCS APL 20-012 and the I.N. Settlement Agreement, KHS is required to provide Case Management Services as set forth in its Medi-Cal contract to all plan enrolled Medi-Cal beneficiaries who are EPSDT eligible and for whom Medi-Cal Private Duty Nursing services have been approved, including, upon a plan member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the plan member, even when the Plan is not financially responsible for paying for the approved Private Duty Nursing services. Medi-Cal Private Duty Nursing services include Private Duty Nursing

services approved by the California Children's Services Program (CCS).

KHS shall use one or more Home Health Agencies, Individual Nurse Providers, or any combination thereof, in providing Case Management Services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when the Plan is not financially responsible for paying for the approved Private Duty Nursing services.

When KHS has approved an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, KHS has primary responsibility to provide Case Management for approved Private Duty Nursing services. When CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, the CCS Program has primary has primary responsibility to provide Case Management for approved Private Duty Nursing services.

Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be KHS, CCS, or the Home and Community Based Alternatives Waiver Agency) to request Case management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

KHS's obligations to enrolled EPSDT eligible members who are approved to receive Private Duty Nursing services who request Case Management Services for their approved Private Duty Nursing services include, but are not limited to:

a) providing the member information about the number of Private Duty Nursing hours that they are approved to receive;
b) contacting enrolled Home Health Agencies and enrolled Individual Nurse Providers to seek approved Private Duty Nursing services on the member's behalf;
c) identifying and assisting potentially eligible Home Health Agencies and Individual Nurse Providers with navigating the process of enrolling to be a Medi-Cal provider;
d) working with Home Health Agencies and enrolled Individual Nurse Providers to jointly provide Private Duty Nursing services to the member as needed.

The California Code of Regulations (CCR) further clarifies the parameters of California's implementation of the EPSDT program. Pursuant to Title 22 of the CCR, Section 51184(a)(3), screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition. Screening services must identify developmental issues as early as possible.

KHS is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary services that KHS is responsible for

providing, including carved out services, pursuant to the contract with DHCS.

KHS is responsible for determining whether a member requires Targeted Case Management (TCM) services, and refers members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.[4] If members under age 21 are not accepted for TCM services, KHS ensures the member has access to services comparable to EPSDT TCM services.[5] Such services would be provided through the County Health System if not otherwise available.

If a Member is receiving TCM services as specified in Title 22, CCR, Section 51351, KHS is responsible for coordinating the member's health care with the TCM Provider and for determining the medical necessity of covered diagnostic and treatment services recommended by the TCM provider.[6]

Members who are having difficulties in receiving PDN services or are dissatisfied with their case management services may:

a) Contact KHS Member Services at (800) 391-2000;
b) Utilize the member grievance process as outlined in *Kern Family Health Care Policy #5.01Member Grievance and Appeal System;*
c) File a Medi-Cal State Fair Hearing as provided by law;
d) Email DHCS directly at EPSDT@dhcs.ca.gov

Members with questions regarding questions about their legal rights regarding PDN services may contact Disability Rights California at (888) 852-9241.

6.0 DELEGATION

KHS is responsible for ensuring that our delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

REFERENCE:

Revision 2021-03: Revision to Policy updated by Director of Utilization Management to comply with 20-012 language.
Revision 2020-11: Policy updated by Director of Utilization Management to comply with APL 20-016
Revision 2020-07: Policy updated by Director of Utilization Management to comply with APL 20-012 and I.N. Settlement Agreement.
Revision 2018-11: Policy updated by Administrative Director of Health Services to comply with APL 18-017.
Revision 2018-04: Policy updated by Director of Health Services to comply with APL 18-007.
Revision 2016-02: Removed language on the transition from Kern Regional Center**. Revision 2014-11:** Policy updated by Director of Health Services to comply with ABA Autism requirements. **Revision 2014-01:** Revision provided by Director of Health Services. Healthy Families language removed. **Revision 2005-10:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).

[2] CCR Title 22 Section 51184(g)
[3] CCR Title 22 Section 51184(b)
[4] DHS Contract A-11 2
[5] DHS Contract A-11 2
[6] DHS Contract A-11 2

Attachment A

QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT (QI/UM) COMMITTEE MEMBERSHIP

Voting Membership

1	KHS Chief Medical Officer (Chairperson)
2	Participating Primary Care Physicians
2	Participating Specialty Physicians
1	Participating Home Health Representative
1	Kern County Public Health Officer
1	Participating Mid-Level Practitioner
2	Other Participating Ancillary Representatives
1	Participating Hospital Representative (as selected by KHS)
	QI Manager and staff (Committee staff support)

Meeting Schedule

The QI/UM Committee meets at least quarterly, but as frequently as necessary to demonstrate follow-up on all findings and required actions.

Reporting Relationship

QI/UM Committee reports to the Board of Directors at least quarterly.

Attachment B

PHYSICIANS ADVISORY COMMITTEE (PAC) MEMBERSHIP

Voting Members

1 KHS Chief Medical Officer (Chairperson)
2 General/Family Practitioner
1 General Internist
1 Pediatrician
1 Obstetrics/Gynecologist
1 Noninvasive Specialist
1 Invasive Specialist
1 Practitioner at Large

Ex Officio Non-Voting Members:

1 KHS Board Member (Limited to Medical Doctor (MD) or Doctor of Osteopathy (DO))

Attachment C

PHARMACY & THERAPEUTICS COMMITTEE MEMBERSHIP

Voting Membership

1 KHS Chief Medical Officer (Chairperson)
1 KHS Corporate Pharmacist (Alternate Chairperson)
1 KHS Board Member
1 Retail/Independent Pharmacist
1 Retail Chain Pharmacist
1 Geriatric Practice Pharmacist
1 General Practice Medical Doctor
1 Pediatrician
1 Internist
1 Obstetrics and Gynecology
1 Provider at Large

Meeting Schedule

The P&T Committee meets quarterly – Quorum: 4 voting members

Reporting Relationship

Reports to the QI/UM Committee quarterly

Attachment D

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

The Public Policy/Community Advisory Committee (PP/CAC) shall provide public input in the development of policies for KHS. The Public Policy/Community Advisory Committee shall meet quarterly.

Voting Members:

7 Subscribers/enrollees
1 Member of the KHS Board of Directors
1 Participating Health Care Practitioner
1 Kern County Health Officer or Representative
1 Director, Kern County Department of Human Services or Representative
2 Community Representatives

Ex-officio Non-Voting member:
KHS Director of Marketing (Chairperson)