POLICY AND PROCEDURE	
Title: Drug Management Program (DMP)	
Primary policy owner: Pharmacy	**Policy #:** PH36
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☐ Case Management (CM) 5) ☐ Claims (CLMS) 6) ☐ Community Marketplace & Member Engagement (MAR) 7) ☐ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☐ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☒ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
Product Type: ☐Medi-Cal ☒D-SNP	**Supersedes Policy Number:** *NA*

I. PURPOSE

To ensure Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-

compliance. Health Plan Workforce and Delegates administer a Drug Management Program (DMP) in compliance with federal and state regulations and other program requirements.

II. POLICY

A. Health Plan must implement and run a Drug Management Program to address overutilization of Frequently Abused Drugs (FADs) while maintaining access to such drugs as medically necessary.
B. The DMP must identify Potential At-Risk Beneficiaries (PARBs) and At-Risk Beneficiaries (ARBs) and enroll them in the program.
C. The DMP must conduct Clinical Review and Physician Outreach to evaluate member's risk for misuse or abuse of frequently abused drugs.
D. Members who have a condition that makes them exempt from the program must be excluded from the DMP. The exclusions are:
    1. Member being treated for cancer related pain.
    2. Member receiving hospice care or non-hospice palliative or end-of-life care.
    3. Member residing in a long-term care (LTC) facility or another facility for which FADs are dispensed to residents through a contact with a single pharmacy.
E. The DMP must issue the appropriate notices (first and second) to the member and provider if the member is identified as an ARB and provider approved restriction of FADs if warranted.
F. Health Plan must send the appropriate notification of ARB restriction to Center for Medicare and Medicaid Services (CMS) and complete the necessary information on the Overutilization Monitoring System (OMS) quarterly forms. Health Plan must also provide the appropriate information to a Health Plan Sponsor if the member leaves Health Plan, at the gaining sponsor's request, within 2 weeks of such request.
G. Health Plan must report annually to CMS based on CMS specified guidance and timelines.

III. PROCEDURE

A. Health Plan administers and manages the DMP program.

B. The Heath Plan Pharmacy Team identifies and enrolls in DMP, potential and at-risk beneficiaries, by one of the following ways:
   1. Cases identified by CMS as Potential At-Risk Beneficiaries and provided to Health Plan through OMS Acumen reports (PARB1)
   2. Members meeting minimum Overutilization Monitoring System (OMS) criteria - (see Table 1).
   3. Prior Sponsor Health Plan Identified PARB2 or ARB2: Transaction Reply Code of TRC 376 (New Enrollee CARA Status Notification) from the Daily Transaction Reply.

C. The Heath Plan Pharmacy Team excludes beneficiaries exempt from the DMP.

D. The Heath Plan Pharmacy Team conducts a case management review and physician outreach as follows:
   1. Assess the need to discuss with Provider about implementing a beneficiary-specific point-of-sale edit, or restricted authorization (RA).
   2. Make first outreach to Provider via inquiry letter.
   3. Make subsequent outreach: at least 3 attempts to contact prescribers over 10 business days. The outreach attempts shall be documented for audit review.

E. After completion of required case management, if intention is to limit member's access to FADs, The Heath Plan Pharmacy Team mails an Initial Notice to the member, and shall:
   1. Provide a copy of the initial notice to Prescriber.
   2. Allow 30 days for member or Provider response before next step.

F. If a determination is made that the member is an ARB and a limit to access specific medications should be instituted, The Heath Plan Pharmacy Team sends a Second Notice which explains the details of the restriction:
   1. This notice shall be sent:
      a. No less than 30 days after the date of the Initial Notice; and
      b. No more than the earlier of: within 3 days of the date the relevant determination is made OR 60 days after the date of the initial notice.
   2. A copy of the Second Notice shall be sent to the Provider.

3. The letter shall provide appeal rights.

G. If, upon receipt of additional information, it was determined that the member is not an ARB, an Alternate Second Notice is sent to the member and provider explaining that there shall be no limitations on FADs for the member.

H. If the Heath Plan Pharmacy Team determines that a beneficiary is exempt after sending the Initial Notice, the Alternate Second Notice is provided within 3 days from the date the determination is made.

I. The Heath Plan Pharmacy Team enrolls ARBs into the Medication Therapy Management (MTM) Program by sending requests to the PBM.

J. Heath Plan Pharmacy Team identifies beneficiaries that have an episode of opioid overdose, so the beneficiary is included in the DMP. Health Plan shall use the ICD-10 opioid overdose codes provided by CMS in Overutilization Management System (OMS).

K. Heath Plan Pharmacy Team has access to all prescriber or member outreach communications to perform an audit for selected cases each quarter. The audit includes:
   1. A review DMP activity report to verify that the members included meet the minimum CMS criteria and do not fall into any of the exempted categories.
   2. A review of appropriate written notice to enrollees for at-risk determinations.
   3. Review whether enrollee submitted preferences for prescribers or pharmacies and a review for proper second written notice to the enrollee.
   4. Determined if the enrollee is not an at-risk beneficiary or is exempt. A review for proper alternate second written notice to the enrollee will be determined.

Table 1: OMS Minimum Criteria

MIN 1. Use of opioids with average daily MME > 90 mg for any duration during the most recent 6 months AND either: 3+ opioid prescribers AND 3+ opioid dispensing pharmacies; OR 5+ opioid prescribers (regardless of the number of opioid dispensing pharmacies).

MIN 2. History of opioid-related overdose: A medical claim with a primary diagnosis of opioid-related overdose within the most recent 12 months; AND a Part D opioid prescription [not including Medication-Assisted Treatment (MAT)].

IV. ATTACHMENT(S)

A. Glossary of Terms Link

V. REFERENCES

A. CMS CY 2025 Part D Drug Management Program (DMP) Guidance
B. CMS 2025 Drug Management Program Notices
C. CMS Guidance: Frequently Asked Questions About Drug Management Programs (DMPs) Revised November 18,2024
D. Medicare Part D Reporting Requirements (Effective 2025)
E. State Medicaid Agency Contract (SMAC)
F. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

VI. REVISION HISTORY

Version*	Revision Summary	Date
001		
002		
003		
004		
Initial Effective Date: 09/24/2025		
Published Date:09/30/2025		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee	001	09/24/2025

• Privacy & Security Oversight Committee		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review Committee		
Quality Improvement Health Equity Committee (QIHEC)		
• Quality Operations Committee		
• Grievance Committee		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)			
Department of Managed Care (DMHC)			

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	

Signature	Name Title	Date
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy