

<b>POLICY AND PROCEDURE</b>	
<b>Title:</b> Part B Medications Prior Authorizations and Utilization Management Committee	
<b>Primary policy owner:</b> Pharmacy	<b>Policy #:</b> PH44
<b>Impacted/Secondary policy owner:</b> Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) <input type="checkbox"/> All Departments 2) <input type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input type="checkbox"/> Benefits Administration (BA) 4) <input type="checkbox"/> Case Management (CM) 5) <input type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input type="checkbox"/> Configuration (CFG) 9) <input type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input type="checkbox"/> Information Technology / Core Systems (IT) 16) <input checked="" type="checkbox"/> Pharmacy (PH) 17) <input type="checkbox"/> Provider Networks (PRO) 18) <input type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input type="checkbox"/> Medical Management (MM)
<b>Product Type:</b> <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> D-SNP	<b>Supersedes Policy Number:</b> 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 review Part B medications in compliance with federal and state regulations and other program requirements.

## II. **POLICY**

- A. Health Plan must establish a Utilization Management (UM) Committee that is led by Health Plan's Medical Director.
- B. The UM Committee must:
  - 1. At least annually, review all UM policies to ensure consistency with Medicare coverage requirements, including current National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
  - 2. review and approve all UM policies, including those related to Part B drugs, before implementation.
  - 3. review and approve step therapy policies for Part B drugs, ensuring appropriate and cost-effective use.
  - 4. ensure that UM policies are not more restrictive than fully established Medicare existing coverage criteria.
  - 5. for off-label drug use, evaluate coverage based on compendia, authoritative medical literature, and accepted standards of medical practice when there is no NCD or LCD.
- C. Requests for Part B medications must be reviewed within the timelines established by Center for Medicare and Medicaid Services (CMS), as follows:
  - 1. Standard organization determinations: 72 hours, Expedited organization determinations: 24 hours.
  - 2. Standard reconsiderations: 7 days, Expedited reconsiderations: 72 hours.
  - 3. Extensions of these processing timeframes for Part B drug requests are not permitted.
  - 4. Enrollees and prescribers must be notified of the review decision expeditiously and within the timeframes specified above.
- D. Health Plan must provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment enrolls into Health Plan. Health Plan must not disrupt or require reauthorization for

an active course of treatment for new plan enrollees for a period of at least 90 days.

### III. PROCEDURE

- A. Health Plan has established a UM Committee based on CMS' latest requirements by 4<sup>th</sup> Quarter 2025.
- B. The UM Committee:
  1. Reviews all UM policies as well as Part B medication policies to ensure consistency with Medicare coverage requirements, including current NCDs and LCDs prior to the launch of the Health Plan Advantage Dual-Special Needs Plan (D-SNP) on January 1, 2026.
  2. Meets, no less than quarterly, to review and approve new Part B medication authorization criteria.
- C. Beneficiaries joining Health Plan receive a minimum of 90 days of appropriate Part B covered therapy to ensure continuity of care.
- D. Health Plan is available to receive Part B medication authorization requests every day including weekends and holidays.
- E. Health Plan Advantage D-SNP's Pharmacy Department reviews the Part B medication authorizations within the timelines established by CMS (see Policy Section G) and notifies the members and providers as expeditiously as possible.
- F. In reviewing the prior authorization requests, Health Plan Advantage D-SNP complies with NCD, LCD, and general coverage and benefit conditions included in Traditional Medicare regulations.
- G. When CMS coverage criteria are not available, Health Plan Advantage D-SNP creates internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers.
- H. Health Plan Advantage D-SNP do not require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days.

### IV. ATTACHMENT(S)

- A. [Glossary of Terms Link](#)

**V. REFERENCES**

- A. 42 CFR 422.101 [https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.101#p-422.101\(b\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.101#p-422.101(b))
- B. [42 CFR 422.112\(b\)\(8\) – Continuity of Care](#)
- C. 42 CFR 422.137 <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.137>
- D. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
- E. Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans, Updated August 2022
- F. CMS CY 2025 Part D DMP Guidance – Section 40
- G. Medicare Coverage Database website: <https://www.cms.gov/medicare-coverage-database/search.aspx>
- H. Medicare Part D Final Rule: <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f>
- I. State Medicaid Agency Contract (SMAC)
- J. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

**VI. REVISION HISTORY**

Version*	Revision Summary	Date
001		
002		
003		
004		
<b>Initial Effective Date: 09/24/2025</b>		
<b>Published Date:09/29/2025</b>		

**VII. Committee Review and Approval To Be Completed by Compliance**

Committee Name	Version	Date

Compliance Committee	001	09/24/2025
<ul style="list-style-type: none"> <li>Privacy &amp; Security Oversight Committee</li> </ul>		
<ul style="list-style-type: none"> <li>Program Integrity Committee</li> </ul>		
<ul style="list-style-type: none"> <li>Audits &amp; Oversight Committee</li> </ul>		
<ul style="list-style-type: none"> <li>Policy Review Committee</li> </ul>		
Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> <li>Quality Operations Committee</li> </ul>		
<ul style="list-style-type: none"> <li>Grievance Committee</li> </ul>		

**VIII. REGULATORY AGENCY APPROVALS**

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



**IX. Approval signature\***

<b>Signature</b>	<b>Name Title</b>	<b>Date</b>
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

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