POLICY AND PROCEDURE	
Title: Pharmacy Network	
Primary policy owner: Pharmacy	**Policy #:** PH50
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 meets network adequacy requirements, in compliance with federal and state regulations, in managing the Pharmacy Network of the Medicare line of business.

II. POLICY

A. Health Plan's Pharmacy Network must be maintained and managed by the Pharmacy Benefit Manager (PBM).
B. Health Plan Pharmacy Network:
    1. In urban areas, there must be a network pharmacy located within, on average, 2 miles of, at least, 90 percent of Medicare beneficiaries.
    2. In suburban areas, there must be a network pharmacy located within, on average, 5 miles of, at least, 90 percent of Medicare beneficiaries.
    3. In rural areas, there must be a network pharmacy located within, on average, 15 miles of, at least, 70 percent of Medicare beneficiaries.
    4. Includes a network of home infusion pharmacies that meet adequacy requirements for its members.
    5. Includes a network of Indian Health Service/Tribal/Urban Indian Health (I/T/U) pharmacies that meet adequacy requirements for its members.
C. Health Plan may supplement its network with non-retail pharmacies including pharmacies offering home delivery via mail-order and institutional pharmacies.
D. Health Plan must allow any pharmacy that wishes to participate in the network, provided it accepts the PBM's standard terms and conditions and meets the PBM's contracting and credentialing standards.

III. PROCEDURE

Contracting

A. The PBM:
    1. Contracts with the network pharmacies.

2. Reviews all pharmacy requests to join the network within seven calendar days from receipt.
3. Receives a full contract that includes standard terms and conditions as well as credentialing requirements.
4. Is subject to initial credentialing within 180 days of contracting and re-credentialed every three years.
5. Provides Health Plan with a monthly electronic file listing the pharmacies in the network, as well as any changes to the network.
6. Reviews the Office of Inspector General (OIG) and Medi-Cal sanction lists monthly to identify any sanctioned pharmacies in the network.
7. Ensures pharmacies sanctioned under or expelled from participation in the Medicare program are removed from the network.

Reporting

B. The PBM:

1. Informs Health Plan, as soon as possible, of any change in the pharmacy network affecting Health Plan members' access to a pharmacy or pharmacies. Such notification, via relevant reports, shall include reason for change, as well as any member impact.
2. On a quarterly basis, provides Health Plan reports of network pharmacy auditing activity results.
3. At least annually, provides Health Plan GeoAccess reports demonstrating the pharmacy network is compliant with the Centers for Medicare & Medicaid Services (CMS) access standards and requirements.
4. Annually, provides Health Plan its retail network pharmacy contract templates so Health Plan can ensure compliance with CMS requirements and minimum pharmacy practice standards established.
5. Annually, provides Health Plan its annual Pharmacy Network CMS reporting document.
6. Annually, ensures it submits timely and accurate, new benefit year pricing and pharmacy network data, for posting on the

Medicare Plan Finder (MPF) site based on the CMS published calendar for the year.

IV. ATTACHMENT(S)

A. Glossary of Terms Link

V. REFERENCES

A. 42 CFR §423.120: Access to covered Part D drugs.
B. 42 CFR §423.505(b)(17): Contract Provisions
C. CMS Readiness Checklist – issued annually by CMS before the beginning of the benefit year
D. Medicare Prescription Drug Benefit Manual (MPDBM) Chapter 5: Benefits and Beneficiary Protections, section 50: Access to Covered Part D Drugs
E. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)
F. State Medicaid Agency Contract (SMAC)

VI. REVISION HISTORY

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

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	
	Chief Executive Officer	

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