APPENDIX A

*The National Commmitee for Quality Insurance (NCQA) identified the pharmacy-related **2025 Health Plan Accreditation (HPA)** standards that apply to the state Medi-Cal Rx program and the standards that are the organization's responsibility for accreditation.*

***Table 1a** provides details on impacted pharmacy-related standards; **Table 1b** provides details on Utilization Management (UM) 11. **Table 2** provides details on pharmacy-related standards that are unchanged.*

Table 1a: Pharmacy-Impacted 2025 HPA Standards:

Standard/Element		Met by the State's Medi-Cal Rx Program	Organization Responsibility for Medi-Cal Members
UTILIZATION MANAGEMENT			
UM 1: Program Structure			
A	Written Program Description	✓ (pharmacy benefit)	✓ (medical benefit)
B	Annual Evaluation	✓ (pharmacy benefit)	✓ (medical benefit)
UM 2: Clinical Criteria for UM Decisions			
A	UM Criteria	✓ (pharmacy benefit)	✓ (medical benefit)
C	Consistency in Applying Criteria	✓ (pharmacy benefit)	✓ (medical benefit)
UM 3: Communication Services[1]			
A	Access to Staff	✓ (pharmacy benefit)	✓ (medical benefit)
UM 4: Appropriate Professionals			
A	Licensed Health Professionals	✓ (pharmacy benefit)	✓ (medical benefit)
B	Use of Practitioners for UM Decisions	✓ (pharmacy benefit)	✓ (medical benefit)
E	Practitioner Review of Pharmacy Denials[2]	✓ (pharmacy benefit)	✓ (medical benefit)
F	Use of Board-Certified Consultants	✓ (pharmacy benefit)	✓ (medical benefit)
UM 5: Timeliness of UM Decisions			
C	Notification of Pharmacy Decisions (factors 2, 4, 7, 8)	✓ (pharmacy benefit)	✓ (medical benefit)
D	UM Timeliness Report (factor 3)	✓ (pharmacy benefit)	✓ (medical benefit)
UM 6: Clinical Information			
C	Relevant Information for Pharmacy Decisions[2]	✓ (pharmacy benefit)	✓ (medical benefit)

[1] *Organizations are responsible for communication services if a member has a UM issue with a pharmaceutical covered under a medical benefit.*

[2] *Medi-Cal health plans pull pharmacy files for pharmaceuticals covered under a medical benefit for the applicable the look-back period for the measurement year.*

Standard/Element		Met by the State's Medi-Cal Rx Program	Organization Responsibility for Medi-Cal Members
UM 7: Denial Notices[2]			
G	Discussing a Pharmacy Denial with a Reviewer	✓ (pharmacy benefit)	✓ (medical benefit)
H	Written Notification of Pharmacy Denials	✓ (pharmacy benefit)	✓ (medical benefit)
I	Written Notification of Pharmacy Appeal Rights/Process	✓ (pharmacy benefit)	✓ (medical benefit)
UM 10: Evaluation of New Technology[3]			
A	Written Process (factor 3)	✓ (pharmacy benefit)	NA
B	Description of the Evaluation Process	✓ (pharmacy benefit)	✓ (medical benefit)
UM 11: Procedures for Pharmaceutical Management *(Table 1B)*			
UM 12: UM Information Integrity			
A	Protecting the Integrity of UM Denial Information	✓ (pharmacy benefit)	✓ (Medical benefit)
B	Protecting the Integrity of UM Appeal Information	✓ (pharmacy benefit)	✓ (Medical benefit)
C	Information Integrity Training	✓ (pharmacy benefit)	✓ (Medical benefit)
D	Audit and Analysis – Denial Information	✓ (pharmacy benefit)	✓ (Medical benefit)
E	Improvement Actions – Denial Information	✓ (pharmacy benefit)	✓ (Medical benefit)
F	Audit and Analysis – Appeal Information	✓ (pharmacy benefit)	✓ (Medical benefit)
G	Improvement Actions – Appeal Information	✓ (pharmacy benefit)	✓ (Medical benefit)
MEMBER EXPERIENCE			
ME 2: Subscriber Information			
A	Subscriber Information (factor 2)	✓ (pharmacy benefit)	✓ (Medical benefit)
ME 5: Pharmacy Benefit Information[4]			
A	Pharmacy Benefit Information Website	✓	NA
B	Pharmacy Benefit Information Telephone	✓	NA
C	QI Process on Accuracy of Information	✓	NA
D	Pharmacy Benefit Updates	✓	NA

[3] *UM 10, Element A, factor 3 is NA for Medi-Cal health plans. The pharmaceutical aspect of Element B is NA for Medi-Cal health plans.*

[4] *This standard is not applicable to Medi-Cal health plans because they are not responsible for administering or managing communication for pharmaceuticals covered under a pharmacy benefit. All Elements will be scored NA.*

Standard/Element		Met by the State's Medi-Cal Rx Program	Organization Responsibility for Medi-Cal Members
DELEGATION[5]			
A	Delegation Agreement	✓ (pharmacy benefit)	✓ (medical benefit)
B	Predelegation Evaluation	✓ (pharmacy benefit)	✓ (medical benefit)
C	Review of Program	✓ (pharmacy benefit)	✓ (medical benefit)
D	Opportunities for Improvement	✓ (pharmacy benefit)	✓ (medical benefit)

Table 1B: Impact of Medi-Cal Rx on UM 11—Procedures for Pharmaceutical Management

Summary of changes (2025):

- Revised the look-back period for UM 11 requirements from "6 months" to "12 months for Elements A, C and E.

UM 11 Requirement	NCQA Guidance
Lookback period	**For Interim Surveys:** Prior to the survey date for all Elements. **For First Surveys:** **6 months for all Elements** **For Renewal surveys:** **Element A:** 12 months. **Element B:** At least once during the prior year. **Element C:** 12 months. **Element D:** At least once during the prior year. **Element E:** 12 months.
Element A: The organization's policies and procedures for pharmaceutical management include the following:	**NCQA reviews** the organization's policies and procedures that govern physician-administered drugs, as outlined below, as applicable.
1. The criteria used to adopt pharmaceutical management procedures.	NCQA acknowledges that pharmaceutical management procedures differ for physician-administered drugs. Policy and procedure requirements that address traditional pharmaceutical management, such as procedures for having an exception process or procedures for generic substitution, therapeutic interchange, and step therapy, may not apply.

[5] *NCQA does not require Medi-Cal health plans to oversee the entity (Magellan Medicaid Administration, Inc.) DHCS contracted with to manage Medi-Cal Rx functions covered under the standards and guidelines.*

	Organizations should present evidence to illustrate how drugs administered in a clinical setting are covered by medical management policies or coverage guidelines. Examples of evidence includes member handbooks or benefit booklets. NCQA does not require procedures to address how drugs administered in a clinical setting are placed on formulary lists.
2. A process to use clinical evidence from appropriate external organizations.	NCQA acknowledges that clinical UM criteria and other clinical evidence govern UM decisions regarding physician-administered drugs. **NCQA reviews** all UM criteria in UM 2. For UM 11, NCQA reviews the aspects of the UM criteria that apply to physician-administered drugs.
3. A process to include pharmacists and appropriate practitioners in the development of procedures.	**NCQA reviews** the organization's policies and procedures that govern physician-administered drugs, such as medical management procedures, to ensure involvement of clinical pharmacists and appropriate practitioners on committees or other decision-making bodies.
4. A process to provide procedures to practitioners annually and when it makes changes.	Factor 4 is NA for Medi-Cal health plans because NCQA evaluates distribution of medical UM criteria to practitioners, upon request, in UM 2.
UM 11 Requirement	NCQA Guidance
Element B: Pharmaceutical Restrictions/ Preferences: Annually and after updates, the organization communicates to members and prescribing practitioners:	**NCQA reviews** distribution of procedures governing coverage of physician-administered drugs that could be included in medical management procedures; this may be the same documentation presented for UM 2. **NCQA reviews** components that apply to physician-administered drugs within medical management procedures in UM 11. **NCQA also reviews** evidence such as member handbooks and benefit booklets that contain coverage information about physician-administered drugs. **NCQA does not review** distribution of procedures governing physician-administered drugs to prescribers. Instead, **NCQA reviews** UM criteria, including those that apply to physician-administered drugs, in UM 2 and ensures that criteria are made available upon request. **NCQA does not review** distribution of the formulary or lists to prescribers and members because Medi-Cal health plans are not responsible for administering a formulary.
1. A list of pharmaceuticals, including restrictions and preferences.	See above. **NCQA reviews** procedures governing coverage of physician-administered drugs and restrictions on these drugs, which may include medical management procedures and criteria that are also presented for UM 2. **NCQA also reviews** evidence such as member handbooks and benefit booklets that contain coverage information about physician-administered drugs. **NCQA does not review** distribution of procedures governing physician-administered drugs to prescribers. Instead, **NCQA reviews** UM criteria, including those that apply to physician-administered drugs, in UM 2 and ensures that criteria are made available upon request.

	NCQA does not review distribution of the formulary or lists to prescribers and members because Medi-Cal health plans are not responsible for administering a formulary.
2. How to use the pharmaceutical management procedures.	See above. **NCQA reviews** procedures governing coverage of physician-administered drugs, which may include medical management procedures and criteria presented for UM 2.
3. An explanation of limits or quotas.	Factor 3 is NA for Medi-Cal health plans.
4. How prescribing practitioners must provide information to support an exception request.	Factor 4 is NA for Medi-Cal health plans because they are not responsible for administering a formulary.
5. The organization's process for generic substitution, therapeutic interchange and step-therapy protocols.	Factor 5 is NA for Medi-Cal health plans because they are only responsible for physician-administered drugs.
Element C: Pharmaceutical Patient Safety Issues: The organization's pharmaceutical procedures include:	NCQA recognizes that these drugs are often dispensed through clinics, practitioner offices, hospitals, and other facilities, and that plans may have no ability to identify individual batch or lot recalls for drugs covered under the medical benefit unless the drug was removed from the market in its entirety. **NCQA reviews** procedures for notification when a physician-administered drug is completely removed from the market. **NCQA reviews** communication to members and prescribing practitioners for physician-administered drugs that were completely removed from the market, if applicable.
1. Identifying and notifying members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification.	See above.
2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.	See above.
Element D: With the participation of physicians and pharmacists, the organization annually:	
1. Reviews the procedures.	**NCQA reviews** evidence that procedures governing coverage of physician-administered drugs are reviewed annually, which may be in documentation presented for UM 1, Element B.
2. Reviews the list of pharmaceuticals.	**NCQA reviews** evidence of annual review of coverage information about physician-administered drugs, such as member handbooks or benefit booklets that contain coverage information about physician-administered drugs.
3. Updates the procedures as appropriate.	**NCQA reviews** evidence that procedures governing coverage of physician-administered drugs are updated annually, which may be in documentation presented for UM 1, Element B.
4. Updates the list of pharmaceuticals as appropriate.	**NCQA reviews** evidence that coverage information about physician-administered drugs, such as member handbooks or benefit booklets that contain coverage information about physician-administered drugs, are updated as appropriate.

UM 11 Requirement	*NCQA Guidance*
Element E: The organization has exceptions policies and procedures that describe the process for:	This element applies to all pharmaceuticals, whether they are covered under an organization's medical benefit or under its pharmacy benefit, including, but not limited to: • All pharmaceuticals, whether or not they are listed in the organization's formularies; • Pharmaceuticals administered or dispensed in all settings (e.g., inpatient, outpatient, at the pharmacy, at home); and • Customized pharmaceutical management procedures for a distinct set or class of pharmaceuticals, including injectables.
1. Making an exception request based on medical necessity.	
2. Obtaining medical necessity information from prescribing practitioners.	
3. Using appropriate pharmacists and practitioners to consider exception requests.	
4. Timely handling of exception requests.	
5. Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.	

Table 2: NCQA requirements with pharmacy components that are unchanged

Standard/ Element	
PHM 3, Element A: Practitioner or Provider Support	No changes due to pharmacy carve-out
UM 8, Element A: Policies for Appeals	No changes due to pharmacy carve-out
UM 9, Elements A-D: Appropriate Handling of Appeals	No changes due to pharmacy carve-out

HEDIS Pharmacy-Related Measures

Medi-Cal health plans must report HEDIS measures with a pharmacy benefit. NCQA considers the pharmacy data received from the state's PBM for carved out pharmacy benefits to be ancillary provider/Encounter Data rather than supplemental data for reporting purposes. This allows these data to be used when identifying eligible populations. The receipt and handling of these data should be addressed in the HEDIS Roadmap, Section 1 – Table 1.4.