Transition Policy 2019

Purpose:

To provide members with a temporary supply of medications in certain circumstances that would not otherwise be covered. The intent of this supply is to allow for continuity of care so that members can work with their prescribers to switch to a covered formulary alternative or initiate a coverage determination for the prescribed drug.

Scope:

MMP

Policy Statement:

Neighborhood Health Plan works with its PBM to provide an appropriate transition process for members with ongoing therapy for certain medications that are not covered or are restricted in coverage.

Transition conditions: Member circumstances

The process applies to (1) the transition of new enrollees into Neighborhood's MMP following the annual coordinated election period; (2) the transition of newly eligible MMP members from other coverage; (3) the transition of members who switch from one plan to another after the start of the contract year; (4) members residing in long-term care (LTC) facilities, including members being admitted or discharged; (5) members who changed treatment settings due to changes in level of care; and (6) current members affected by negative formulary changes across contract years.

For new members, if a distinction cannot be made between a brand-new prescription and ongoing prescription therapy, the transition process will be applied.

Neighborhood will extend transition eligibility across contract years if a member enrolls in its MMP with an effective enrollment date in either November or December and needs access to a transition supply.

Transition conditions: Medication coverage status

The transition process applies to medications with the following status:

(1) Part D drugs that are not on formulary
(2) Part D drugs that are on formulary but require prior authorization, or that have an approved quantity limit (QL) lower than the prescription quantity being submitted; and
(3) Non-Part D drugs that are on formulary but require prior authorization or have a quantity limit. Neighborhood covers all state covered non-Part D drugs.

Members receiving STEP therapy drugs during their transition period will be grandfathered in.

Transition eligibility timing and days' supply

Members are eligible for transition fills as described in Tables 1 and 2, below.

Table 1

Minimum Part D Drug Transition Requirements for Rhode Island MMPs (applicable to Non-formulary Part D and UM Drugs)	
New Member Transition	**Non-LTC**
Transition Period	Within the first 90 days of enrollment effective date
Transition Supply Amount	Lesser of 30 days supply or prescribed quantity
Current Member Transition	**LTC**
Transition Period	First 90 days of plan year OR of change in level of care
Transition Supply Amount	Lesser of 31 days supply or prescribed quantity

Table 2

Minimum non-Part D Drug Transition Requirements for Rhode Island MMPs (applicable to non-formulary non-Part D drugs that the state will cover)	
New Member Transition	**LTC and Non -LTC**
Transition Period	Within the first 90 days of membership
Transition Supply Amount	Lesser of 90 days supply or prescribed quantity

Refills of transition supplies are allowed, up to a total of 30 days' supply for non-LTC members and 31 days' supply for LTC members, for prescription fills that are not limited in quantity due to safety edits based on FDA-approved labeling.

Exceptions to the above eligibility conditions

An extension for a transition supply may be authorized when a transition has not been made (either through a switch to an appropriate formulary drug or a coverage determination) by the time the 30 (non-LTC) or 31 (LTC) day duration of the transition supply has been exhausted. Provision of a transition supply will be extended until a transition has been made.

In addition to transition supplies as indicated above, LTC residents are allowed an emergency supply of the lesser of 31 days or prescribed quantity for transition-eligible drugs while an exception or prior authorization request is being processed, regardless of whether they are within their 90-day transition period.

Even in situations described above, transition fills are not allowed in the following circumstances:

(1) Prior authorization requirements designed to determine Part A or Part B versus Part D coverage;

(2) Non-Part D drugs that are not covered by the state of Rhode Island; and

(3) Prior authorization requirements or other UM rejections designed to promote safe

use of a drug

Transition process parameters

Within three business days of the adjudication of a temporary transition fill, a written notice will be sent via U.S first class mail to the member. The notice will include (a.) an explanation of the temporary nature of the transition supply a member has received; (b.) instructions for working with Neighborhood or Neighborhood's delegated PBM and their prescriber to request a coverage determination or to identify an appropriate therapeutic alternative that is on Neighborhood's formulary; (c.) an explanation of the member's right to request a formulary exception; and (d.) a description of the procedures for requesting a formulary exception. For LTC residents dispensed multiple supplies of a Part D drug in increments of 14 days or less, the written notice will be provided within 3 business days after adjudication of the first temporary fill only. Neighborhood's PBM will make reasonable efforts to provide notice of transition to prescribers to facilitate transitioning of Members.

Neighborhood makes general transition process information available to its members via the Medicare Prescription Drug Plan Finder link to Neighborhood's web site as well as in formulary and pre- and post-enrollment materials.

To the extent possible, the transition process for renewing members whose drugs will be affected by negative formulary changes in the upcoming Contract Year will begin prior to the beginning of the new Contract Year.

Definitions: (All defined words in this document are displayed with initial capitals, except for acronyms.)

1. **Additional Demonstration Drugs (ADD):** Drugs (prescription and over the counter) and durable medical equipment not covered by Medicare Part D and covered by Medicaid. Each state involved in a MMP Demonstration separately defines the drugs covered by its Medicaid benefit and the drugs included on its ADD file.
2. **Annual Notice of Change (ANOC)**: The CMS required document that must be sent to all current Members annually in accordance with CMS directions, and that describes changes to existing benefits that are expected for upcoming new Contract Year.
3. **Applicable Month's Supply**: CMS required transition supply for Part D drugs, as a minimum (unless prescriptions are written for fewer days); the supply is determined as the number of days submitted on the applicable Plan Benefit Package (PBP) submitted to CMS for the relevant plan year. CMS approval determines the approved month's supply for Members in both the non-LTC and LTC settings. Multiple fills up to a total month's supply are allowed to accommodate fills for amounts less than prescribed.
4. **Member**: An individual enrolled in a Delegated PBM Sponsor's MMP, also known as an Enrollee or Member.
5. **Biosimilars:** A biological product submitted to the FDA for approval via the biological abbreviated pathway created by Affordable Care Act. These products must demonstrate that they are highly similar to the reference (originator) products; i.e.: there are no clinically meaningful differences between the biological product and the reference product in terms of safety, purity, and potency. Biosimilars have allowable differences because they are made of living organisms.

6. **Capitated Financial Alignment Initiative (or "Demonstration"):** A model where a State, CMS, and a health plan ("Sponsor") enter into a Three-way Contract and the health plan receives payment to provide comprehensive care.
7. **CMS:** Centers for Medicare and Medicaid Services.
8. **Contract:** Also referred to as the Three-way Contract. This is the participation agreement that CMS and a State have with a Sponsor specifying the terms and conditions pursuant to which a Sponsor may participate in the Capitated Financial Alignment Initiative.
9. **Contract Year:** The period for which a particular plan benefit package applies. Also known as the "plan year." In the case of the transition period for current Members across contract years in non-calendar plans, the term "contract year" refers to the calendar year for which the new formulary is effective.
10. **Customer Care:** Delegated PBM's member service call center
11. **Delegated PBM:** The pharmacy benefit management company (PBM) which manages the pharmacy claims process, coverage determinations and the Transition Process for Neighborhood.
12. **DUR:** Drug Utilization Review that does not allow override of select DUR safety edits which are set up to reject at point of sale.
13. **Food and Drug Administration (FDA):** A government agency, under the U.S. Department of Health and Human Services.
14. **Generic Product Identifier (GPI):** A 14-character hierarchical classification system created by Medi-Span. It identifies drugs available with a prescription in the United States to a manufacturer and pill level.
15. **Level of Care Change:** Occurs when an member changes from one treatment setting to another. Examples include entering a long-term care facility from an acute-care hospital; being discharged from hospital to home; ending a Part A skilled nursing stay with reversion to Part D coverage; giving up hospice status to revert to standard Part A and Part B benefits; ending a long-term care facility stay and returning to the community; and being discharged from a psychiatric hospital.
16. **Long-term Care** (**LTC):** Long-term care refers to facilities or institutions, such as nursing homes and skilled nursing facilities that provide healthcare to people who are unable to manage independently in the community. This care may represent custodial or chronic care management or short-term rehabilitative services.
17. **Low-income Cost-sharing Level III (LICS III):** Designation provided by CMS. The CMS LICS III eligibility designation plus the pharmacy submitted codes are evaluated for a claim to be eligible for LICS III benefits.
18. **Low Income Subsidy (LIS):** Subsidized premiums, deductibles, and copayments for which Eligible Members may be qualified. Also referred to as Extra Help.
19. **Medicaid:** State programs of public assistance for eligible persons, whose income resources are insufficient to pay for health care under the Social Security Act.
20. **Medicare Part D (Part D):** Medicare Prescription drug benefit under Part D of the Social Security Act.
21. **Medicare-Medicaid Plans (MMP):** A product offering sponsored by both the Federal and State governments that combines the current Medicare and Medicaid programs into a single benefit offering for dually eligible individuals.
22. **MME:** Morphine Milligram Equivalent

23. **Multi-Ingredient Compound (MIC):** referring to the logic for the determination of reimbursement and coverage of a claim that consists of multiple ingredients which are manually assembled and dispensed by a pharmacy.
24. **National Council of Prescription Drug Programs (NCPDP):** An American National Standards Institute (ANSI) accredited group that maintains a number of standard formats for use by the retail pharmacy industry, some of which have been adopted as Health Insurance Portability and Accountability Act (HIPAA) standards.
25. **National Drug Code (NDC):** The National Drug Code is a unique, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act.
26. **Non-formulary Part D and/or UM Drugs**: Includes (a.) Part D drugs that are not on formulary; and/or (b.) Part D drugs that are on the formulary but require UM (Prior Authorization, step therapy, or approved quantity limit edits).
27. **Non-formulary Medicaid benefit Drugs:** This means drugs on the ADD file that require Prior Authorization, step therapy, or quantity limit edits under Neighborhood's utilization management edits.
28. **Non-formulary MMP Drugs:** This means both Non-formulary Part D Drugs and Non-formulary Medicaid benefit Drugs.
29. **P&T Committee:** Pharmacy and Therapeutics committee, which is a committee that, among other things, evaluates available evidence regarding the relative safety, efficacy, and effectiveness of prescription drugs within a class of prescription drugs and reviews recommendations for the development of formularies. The committee meets at least quarterly.
30. **PAMC:** Prior Authorization/Medical Certification Code. This is a field on the standardized pharmacy adjudication layout for entry of an authorization code provided by the processor.
31. **Patient Location Code (PLC):** RxClaim adjudication legacy system value that crosswalks from the Pharmacy Service Type and Patient Residence Type Code.
32. **PCD:** Protected Class Drug
33. **Point of Sale (POS):** A capability of retail pharmacies to electronically access plan design and eligibility information to process and transmit drug claims data at the time of purchase.
34. **Print Fulfillment:** Delegated PBM business unit(s) that are responsible for the print fulfillment of some Member notifications including transition fill notifications to Members and prescribers.
35. **Prior Authorization (PA):** An evaluation of the drug's prescribed use against a predetermined set of criteria in order to determine whether the drug/drug class will be covered by the Member's insurance plan.
36. **RxClaim:** Delegated PBM information technology system that serves to process and adjudicate Part D claims; otherwise known as the "system," "platform," or "system platform."
37. **Sponsor: Neighborhood Health Plan of Rhode Island (NHPRI),** a MMP Sponsor that contracts with Delegated PBM for pharmacy benefit management services including implementation of its transition process. Also known as the Plan, Plan Sponsor or Client.
38. **Submission Clarification Code (SCC):** NCPDP data element indicating that the pharmacist is clarifying the claim submission.
39. **TF Window:** The Member TF Window or timeframe during which Member transition benefits apply is 90 days.
40. **Transition:** a process that provides a temporary supply of MMP drugs (includes both TF and

TOC).

41. **Transition Fill - Medicare (TF):** A temporary supply of a Part D covered drug per CMS Part D requirements paid under the benefit of the MMP product. TF is part of a MMP's transition process (transition) for Members.

Procedures:

1. Neighborhood's transition program is implemented by Delegated PBM according to the following parameters:
   a. Transition supplies are provided at POS as appropriate to eligible Members who are coded as the following:
      i. New Members in the MMP following the annual coordinated election period
      ii. Newly eligible MMP Members switching from other coverage
      iii. Members who switch from another MMP plan after the start of a Contract Year
      iv. Current Members affected by negative formulary changes across Contract Years
      v. Members residing in LTC facilities
      vi. Members experiencing level of care changes
   b. Transition supply limits applicable to Non-formulary Part D and UM drugs are defined as days supplies calculated on Generic Product Identifier (GPI) 14 and are not based on number of fills. Transition supply limits applicable to Non-formulary Medicaid benefit Drugs are defined as below and calculated on GPI 14. See Implementation Statement 16.a for additional information.
   c. Transition-eligible claims submitted for LICS III Members are processed according to Member's LICS Level and pharmacy submitted codes to determine if the claim received will be processed as non-LTC, LICS III or LTC.
2. Delegated PBM will maintain a MMP transition process policy and procedure, and review (and revise if needed) the document at least annually and as needed when processing changes occur.
3. Non-formulary Drugs
   a. Procedures to apply the transition policy to Non-formulary MMP Drugs are to code the P&T Committee approved formulary and UM edits into the adjudication system to therefore identify TF eligible claims at POS so that they will be paid as transition fills.
   b. Since CMS has issued guidance stating that it does not expect Part D sponsors to include expiring formulary exceptions in their transition policies, Delegated PBM will not apply its transition policy to expiring formulary exceptions unless and until CMS issues guidance requiring otherwise.
   c. Procedures for medical review and identifying Formulary Alternatives are as follows:
      i. Information regarding therapeutically appropriate formulary alternatives is made available to Members and prescribers failing an affirmative medical necessity determination.
      ii. Members who contact Customer Care and Pharmacies that contact the Pharmacy Help Desk are provided with information regarding available formulary alternatives when requested and as appropriate for Members' care.
      iii. Neighborhood delegates administration of coverage determinations and exceptions to its Delegated PBM. Included in the delegated responsibilities is the review of the procedures for coverage determinations and exceptions that in some cases may result

in the need for transitioning a Member to a therapeutically appropriate formulary alternative.

4. POS transition fill processing is supported by the Delegated PBM and there are procedures in place for transition extensions and overrides, if needed, through the Pharmacy Help Desk and Customer Care. Transition POS messaging to pharmacies applies as follows:
   a. The Delegated PBM adjudication system automatically processes and pays transition-eligible claims and for Part D transmits POS messaging that the claims are paid under transition rules.
   b. Part D transition messaging to pharmacies is consistent with current National Council of Prescription Drug Programs (NCPDP) Telecommunication claim standards (at the time of this publication, the current standard is D.0 and hereafter referred to as "Current NCPDP Telecommunication Claim Standards"). Pharmacies are not required to either submit, or resubmit, a Prior Authorization/Medical Certification Code (PAMC), or other transition-specific code for MMP transition-eligible claims to pay.
   c. Transition processing applies to both new and ongoing prescriptions at POS and through the Pharmacy Help Desk for Members who are new to a plan.
   d. Communication and educational outreach to network pharmacies is ongoing throughout the year to provide information and instructions regarding transition policies and claim processing. At least annually, and more often as needed, transition pharmacy communications are distributed through the pharmacy network department.
5. Transition for New or Renewing Members in the Non-LTC setting
   a. In a Non-LTC setting, the Delegated PBM adjudication system automatically processes and pays transition-eligible claims for new Members for up to a 30 day supply (with multiple fills up to a 30 day supply allowed to accommodate fills for amounts less than prescribed) for Non-formulary Part D and UM drugs and Non-formulary Medicaid benefit drugs.
   b. Pharmacies are not required to either submit, or resubmit a PAMC, or other transition-specific code for transition-eligible claims to adjudicate and pay.
   c. Transitions are available at POS through this functionality during the TF window.
   d. Non-LTC Level of Care Change
      i. For non-LTC residents, a transition may be provided automatically at POS, if the adjudication process indicates a Level of Care change from LTC to non-LTC. Otherwise, the pharmacy will call the Delegated PBM Pharmacy Help Desk in order to obtain an override to submit a Level of Care transition request.
6. Delegated PBM will adjudicate a $0 cost-share for transition fills.
7. Long-term Care Processing
   For LTC transitions, the Delegated PBM adjudication system automatically processes and pays transition-eligible LTC claims and transmits POS messaging that these are paid under transition. Part D LTC Transition Fills are allowed a cumulative 31 day supply, which may include multiple fills for brand oral solids, which are limited to 14 days supply per fill (with exceptions as required by CMS guidance) unless submitted with an SCC 21-36. SCC codes 21-36 indicate LTC dispensing of varying days supply. Multiple fills to provide up to a total of a 31 day supply of medication are allowed consistent with the applicable dispensing increment in the LTC setting. Pharmacies are not required to either submit, or resubmit a PAMC, or other transition-specific code for transition-eligible claims to adjudicate and pay.

a. LTC Transition Fill Emergency Supplies (ES)
    i. To accommodate Part D emergency fills for LTC residents after either the new or renewing transition supply has been exhausted or the TF window expired, and while an exception or Prior Authorization is pending, an SCC is submitted by the pharmacy on POS claims. Emergency Supply transitions for Part D TF are allowed a cumulative 31 day supply [which may include multiple fills for brand oral solids, which are limited to 14 days supply per fill (with exceptions as required by CMS guidance), unless submitted with an SCC 21-36]. These drug claims would otherwise reject for being Non-formulary or formulary with Prior Authorization, quantity limit, or age edits secondary to Members having exhausted new or renewing transition supply and/or being outside the transition eligibility window.
    ii. Part D LTC ES is allowed per calendar day, per Member, per drug, per pharmacy, per plan for the cumulative days supply during a rolling month, limited to one ES per LTC stay.
b. Level of Care Changes
    i. For Part D TFs for a member being admitted to an LTC, an SCC is submitted by the pharmacy to allow transitions and to override transition fill eligible rejects and Refill Too Soon rejects. Transition fills are allowed a cumulative 31 day supply, which may include multiple fills for brand oral solids [which are limited to 14 days supply per fill (with exceptions as required by CMS guidance), unless submitted with an SCC 21-36].
    ii. Level of Care transitions for Part D TF when the member is not being admitted to an LTC are allowed up to at least a cumulative 30 day supply.
    iii. Level of Care Transition Fills are allowed per calendar day, per Member, per drug, per pharmacy, per plan for the applicable cumulative days supply
    iv. For all Members who experience a Level of Care Change, if a dose change results in an "early refill" or Refill Too Soon reject, the pharmacy may call the Pharmacy Help Desk to obtain an override.
c. LICS III Members
    i. LICS III processing logic is allowed on a transition-eligible claim for a LICS III Member with appropriate pharmacy submitted codes.
    ii. Transition eligible LICS III claims are allowed the cumulative days supply allowance of 30 days (or 31 days for LTC residents).

8. Utilization Management Edits Not Transition Eligible
    a. Delegated PBM codes drug products with the following utilization management edits such that transition overrides are not applied:
        i. Drugs requiring Part A or B vs. Part D coverage determination as identified on the Delegated PBM drug database.
        ii. Drugs excluded from the MMP benefit as identified on the Delegated PBM drug database.
        iii. Edits to support the determination of Part D Drug Status.
        iv. DUR safety edits such as therapeutic duplication, cumulative acetaminophen, morphine milligram equivalent (MME), drug interaction, age alerts are set up to reject.
    b. Step therapy and non-safety quantity limit edits are resolved at POS.
9. Cumulative Days Supply
    a. Transition refills for supplies dispensed at less than amount written, or less than the days

supply available under transition rules are allowed multiple fills up to at least a 30 day (non-LTC) or 31 day (LTC) supply.

b. For DUR edits that are based on an FDA maximum recommended daily dose, Transition Fill claims which are dispensed at less than the written amount due to this edit are allowed refills during the TF Window.
c. Delegated PBM transition cumulative supply accumulates at a GPI 14 level by Member and across plan codes. LTC Emergency Supply and Level of Care Change/New Patient benefits accumulate separately.

10. The Delegated PBM transition process is coded such that if the distinction cannot be made between a brand-new prescription for a MMP transition-eligible Drug and an ongoing prescription for a MMP transition eligible Drug at the POS, the Delegated PBM transition process will be applied to the prescription as if it is ongoing drug therapy. This is referred to as the New Member process.
11. Transition Notices
    a. A written transition notice is mailed via US First Class mail to the Member within three (3) business days after adjudication of a transition fill. For LTC Part D Transition Fills for brand oral solids (which are limited to a 14 days' supply per fill), a transition notice will be sent only after the *first* transition fill.
    b. The Part D transition notice provides:
        i. an explanation of the temporary nature of the transition supply provided to the Member
        ii. instructions for working with Delegated PBM and prescriber to satisfy utilization management requirements or to identify therapeutically equivalent and appropriate formulary alternatives
        iii. an explanation of the Member's right to request a formulary exception
        iv. a description of the procedures for requesting a formulary exception
    c. Delegated PBM supports the use of the current CMS "Model Part D Transition Notice" for notification to Members of the reasons for their Non-formulary Part D and UM transition fills and recommendations for actions. Notwithstanding any reference in this policy to submitting a transition notice that uses the CMS model notice via the file and use system, since CMS has stated that this is not required, the model notice will not be submitted via the file and use process unless and until CMS requires this.
    d. Transition notices to prescribers are provided when a Member's transition notice is produced. The content of this notice is based on the content of the Member's transition fill notice, or CMS model notice if provided. Reasonable efforts are made to deliver the notice to the prescriber.
12. Prior Authorization and exception request forms are available upon request by Member or prescriber via a variety of means including by e-mail, mail, fax, and via forms posted on Delegated PBM websites.
13. The Delegated PBM transition process for new members is coded to apply across Contract Years for Members with an effective enrollment date at the end of the plan year and who need access to a transition supply for a negative formulary change. These Members are eligible for a TF for a negative formulary change from the date they enroll in the current Contract year through the TF window, which starts on January 1 of the next plan year.
14. [Intentionally left blank to maintain consistent numbering between sections.]
15. Transition Extensions

On a case-by-case basis, Delegated PBM Customer Care will provide an extension of the transition period to accommodate Members who continue to await resolution of a pending Prior Authorization or exception request. The extensions are available through the Pharmacy Help Desk or Customer Care and per Sponsor's plan design.

16. Consistent with the transition fill process provided to new Members, Delegated PBM provides transitions (during the TF Window of the new Contract Year) to renewing Members with a history of utilization of impacted drugs when those Members have not been transitioned to a therapeutically equivalent formulary drug; or for whom formulary exceptions/Prior Authorizations are not processed prior to the new Contract Year. This applies at POS to all renewing Members including those residing in LTC facilities.
    a. Renewing Member LTC transitions are available to all Members in LTC settings during the TF Window for Part D TF.
    b. For these Members, the Delegated PBM adjudication system automatically processes and pays transition-eligible claims and transmits POS messaging that these are paid under transition rules.
    c. Additional transition supplies are available on a case-by-case basis through the Pharmacy Help Desk to ensure adequate transition. Pharmacies are not required to either submit, or resubmit a Prior Authorization/Medical Certification Code (PAMC), or other transition-specific code for transition-eligible claims to adjudicate and pay.
17. Transition Program Monitoring & Reporting
    a. Transition processes are monitored both across and within each program area that has responsibility for transition processes. Transition program monitoring is both quantitative and qualitative.
    b. Transition claim adjudication data are used to produce standard paid transition claim and rejected claim reports for quantitative program monitoring. Program performance monitoring includes reporting and monitoring of all transition types: new and renewing Member; and New Patient Admission and LTC Emergency Supply.

Implementation Statement:
The following is a summary statement for how eligible claims process under transition adjudication system rules upon point of sale (POS) and manual submission to allow the override of system edits that would otherwise result in rejected claims. The objective of these transition adjudication system rules is to ensure dispensing of transition-eligible drugs at POS toward the goal of ensuring member access to medications per CMS and state requirements and guidance as part of the Capitated Financial Alignment Initiative.

1. The Adjudication System ensures that:
    a. Transition-eligible claims for new and ongoing prescriptions automatically adjudicate upon submission at POS for:
        i. New Members in the MMP plan following the annual coordinated election period
        ii. Newly eligible MMP Members from other coverage
        iii. Members who switch from another MMP plan after the start of a Contract Year
        iv. Current Members affected by negative formulary changes across Contract Years
        v. Members residing in LTC facilities
        vi. Members experiencing level of care changes

b. Transition processing is also available via manual overrides through the Pharmacy Help Desk.
c. TF Window is calculated using the member's MMP eligibility start date as provided on Neighborhood's enrollment feed. Transition logic is not invoked if a claim exceeds either the TF Window or cumulative days supply based on Member's eligibility.
d. Transition processing allows for transition supplies of different drug strengths. Transition benefits (including Cumulative Days Supply) are set up based on Drug Generic Product Identifier (GPI) 14 to allow transition processing of different strengths of a drug under transition system rules. This ensures that a Member taking a drug with one strength is able to receive a transition for same drug/different strength if they present with a new prescription within transition-eligible time period.
    i. Transition for dosage escalation is allowed, as appropriate, by manual override via the Delegated PBM Pharmacy Help Desk.

2. This policy and procedure is updated at least annually, and more frequently as needed for additional changes.
3. Claims for MMP Non-formulary Drugs are eligible for "transition fill" processing for valid adjudication under the Delegated PBM transition process.
    a. Members with a current claim for a Part D drug that requires a quantity limit lower than the quantity limit on the member's history dose will be eligible for TF processing.
4. Systems capabilities exist to provide transition supplies at POS. Pharmacies are not required to either submit, or resubmit a PAMC or other transition-specific codes for a transition-eligible claim to adjudicate.
    a. POS Pharmacy Provider Notification
        i. Pharmacies are notified at POS that claims have paid under transition rules, to assist pharmacies with discussing next steps with Members.
        ii. Transition processing information and communications are sent to all network pharmacies. The transition processing information and communications include, though are not necessarily limited to the: Pharmacy Provider Manual and all related updates; and the Medicare Part D Information/Reminders documents that are sent annually to network pharmacies prior to the beginning of each new Contract Year.
        iii. Delegated PBM Pharmacy Help Desk (PHD): Pharmacies contacting the PHD are verbally informed of a Member's transition availability, process, and rights for requesting Prior Authorization and/or exception, and how to submit an automated transition request.
        iv. Auto-pay of transition-Eligible Claims
        When submitted claims are eligible for payment under Part D Transition Fill rules, RxClaim adjudication system logic applies the TF PAMC 22223333444 to the claim, tags the claim as a paid TF, and returns messaging on paid TF claims. Pharmacies are not required to either submit, or resubmit a PAMC or other TF-specific codes for a TF-eligible claim to adjudicate.
    b. There are conditions under which it may be necessary for the Delegated PBM Pharmacy Help Desk or Customer Care to enter a manual transition override. These situations include, but are not necessarily limited to:
        i. Non-LTC Member moves from one treatment setting to another (level of care change), if not identified automatically through the adjudication process
        ii. Member has requested an exception and the decision is pending at the time the

transition period expires, or the transition cumulative days supply is exhausted

iii. Transition for dosage increase is needed

c. When manually entered with the transition PAMC, these transition overrides are adjudicated and tagged via the same processes as automated POS transition(s). The same messaging is returned to pharmacies on manual transition overrides as returned on automated paid transition claims. Transition letters are produced and sent to Member for manual transition overrides same as POS overrides.

5. Transition Supply & Time Period Parameters (and LTC Days Supply for Statement 7)

a.

Description	Transition Days Supply
New & Renewing Members	
	• Part D TF o Non-LTC: cumulative 30 day supply during the TF Window. Multiple fills up to a cumulative 30 day supply are allowed to accommodate fills for amounts less than prescribed. o LICS III: LTC or non-LTC parameters applied as appropriate. o LTC: cumulative 31 day supply during the TF Window. Multiple fills for a cumulative 31 day supply are allowed during the TF Window to accommodate fills for amounts less than prescribed [including brand oral solid supplies which are limited to 14 days per fill (with exceptions as required by CMS guidance), unless submitted with an SCC 21-36]
Non-LTC Resident Level of Care Change	
• Member released from LTC facility within past 30 days • Member with non-LTC related LOC change	• Part D TF o Non-LTC: cumulative 30 day supply; multiple fills up to a cumulative 30 day supply are allowed to accommodate fills for amounts less than prescribed. o LICS III: LTC or non-LTC parameters applied as appropriate. o TF available at POS if identified through adjudication, otherwise through manual override

	via Pharmacy Help Desk on case-by-case basis.
New and Renewing TF Extension	
• New or Existing Members • Outside standard transition days supply or time period parameters • Transition parameters have been reached and Member is still pending exception/coverage determination decision	• These plan limits will be limited by the amount prescribed • Part D TF o Non-LTC: Via manual override, 7 days additional as needed as long as exception or coverage determination decision is pending. o LICS III: 7 days additional as needed as long as exception or coverage determination decision is pending. o LTC: Via manual override, 7 days additional as needed as long as exception or coverage determination decision pending • Either non-LTC, LICS III or LTC parameters are applied according to the LICS level and pharmacy submitted codes.

b. LICS III Member benefit conversion
A LICS III member is identified by the pharmacy submitted codes along with eligibility LICS Level of III.

c. Non-LTC Resident Level of Care Change
   i. For non-LTC residents, a transition may be provided automatically at POS, if the adjudication process indicates a Level of Care change from LTC to non-LTC and the claim is rejecting for Refill Too Soon (R79) or DUR (R88). Otherwise, the pharmacy will call the Delegated PBM Pharmacy Help Desk in order to obtain an override to submit a Level of Care transition request.
   ii. A Level of Care change from LTC to non-LTC is indicated in the adjudication process if the submitted drug matches a claim in the most recent 120 days of history on GPI 14 with a Patient Location Code indicating LTC. For Part D TF, non-LTC residents are allowed cumulative 30 day supply (may include multiple fills to accommodate fills for amounts less than prescribed).

6. The adjudication system ensures that cost-sharing is always $0.
7. Processing for LTC Setting
   a. The Pharmacy Service Type and Patient Residence Type codes on submitted claims are used to identify the claims as either non-LTC or LTC for purposes of reimbursement and allowed transition days supply.
      i. The values defined as being LTC by Delegated PBM pharmacy network operations are cross-walked internally during RxClaim adjudication to the legacy system value

"Patient Location Code" (PLC) 03.

b. LTC transition cumulative days supply limits are allowed for qualified claims submitted with PLCs designating LTC.
c. LTC Emergency Supply (ES) is allowed after the transition supply parameters are exhausted for new Members and a coverage determination or exception is still pending. The Part D Transition Fill LTC ES transition policy provides for a cumulative 31 days supply [including multiple fills as necessary for brand oral solids, which are limited to 14 days' supply per fill (with exceptions as required by CMS guidance), unless submitted with an SCC 21-36].
d. Transition LTC New Patient Admission/ Level of Care Change and LTC Emergency Supply are automated based upon specific POS claim submission rules. Pharmacies are instructed on how to correctly submit qualifying claims via Provider Manual updates and ongoing network communications so that these claims correctly process as transition under applicable LTC transition conditions.

LTC NEW PATIENT ADMISSION & LTC EMERGENCY SUPPLY	
Description	Transition Days Supply
LTC New Patient Admission/Level of Care Change Member resides in LTC Facility (New Admission)	

• Member admitted to LTC facility within the past 30 days
 	
• New Patient Admission (NP) Level of Care Change (LOC)
	Applicable to Part D TF
	• At POS submitted with:
	  ○ Submission Clarification Code 420-DK Value "18"
	  ○ Patient Location Code identified as LTC
	• Additional fills as needed are available via manual transition overrides through the Pharmacy Help Desk
	• Multiple fills allowed to accommodate LOC changes
	• Only one transition LTC NP is allowed per calendar day, per Member, per drug, per pharmacy, per plan
	• New Members must have transition days supply exhausted, or transition time period expired
	
	Part D TF
	• Cumulative 31 day supply [includes multiple fills for brand oral solids, which are limited to 14 days' supply per fill (with exceptions as required by CMS guidance), unless submitted

	with an SCC 21-36].
LTC Emergency Supply Member resides in LTC facility	
• LTC Emergency Supply (ES)	Applicable to Part D TF • At POS submitted with: o Submission Clarification Code 420-DK Value "7" o Patient Location code identified as LTC • POS automated TF LTC ES is set-up to allow one ES every rolling 30 days, limited to one ES per LTC stay. The adjudication logic looks back 30 days starting the day after the date of fill. • LTC ES is allowed per calendar day, per Member, per drug, per pharmacy, per plan a cumulative days supply during a rolling month or New Members must have TF day supply exhausted, or TF time period expired, and while an exception or Prior Authorization is pending Med D TF • Cumulative 31 days supply, which may include multiple fills for brand oral solids, which are limited to 14 days' supply per fill (with exceptions as required by CMS guidance), unless submitted with an SCC 21-36.

e. LTC New Patient Admission or Level of Care Change for Members being admitted to or discharged from an LTC facility - early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such Members are allowed access to a refill upon admission or discharge.

LTC NEW PATIENT & LTC EMERGENCY SUPPLY (FOR PART D TRANSITION FILL ONLY)
REFILL TOO SOON (RTS) & DRUG UTILIZATION REVIEW (DUR) OVERRIDES

Description	Edit	Reject Code	Point of Sale	Manual Override Available
LTC New Patient	RTS/ Plan Option 15	79	Y	Y (if Drug Qualifies as TF, TF Override used)

LTC Emergency Supply	RTS/ Plan Option 15	79	N	Y (if Drug Qualifies as TF, TF Override used)
LTC New Patient	DUR – Plan Option 30	88	Y	Y (if Drug Qualifies as TF, TF Override used)
LTC Emergency Supply	DUR – Plan Option 30	88	N	Y (if Drug Qualifies as TF, TF Override used)

8. Transition Edits
   a. **Override Edits Not Applied During Transition**
   Transition overrides are not applied at POS, or manually, to drugs with dose limits based on maximum FDA labeling, A or B vs. D drugs requiring coverage determination prior to application of transition benefits, or drugs not covered under MMP program benefits, which include drugs that require a medically accepted indication.
      i. **Refill Too Soon (RTS)**
      Automated transition system logic for new and renewing Members does not allow an override of RTS (except for LTC New Patient Admission or Level of Care Change) edits. Instead, reject 79 (RTS) is returned to pharmacies when submitted claims hit this edit.
      ii. **Drug Utilization Review (DUR) Edits**
      Automated TF system logic for new and renewing Members does not allow override of DUR safety edits that are set up to reject at point of sale. Instead, reject 88 (DUR) is returned to pharmacies when submitted claims hit this edit.
      iii. **Part A or B Only Drugs (for Part D Transition only)**
      Automated TF adjudication logic is not applied to Part A or B only drug claims. All Med A or B 'only' drugs are excluded from TF processes and payment under TF rules and are tagged with an "N" status in the "Med D" status field on the Delegated PBM drug database. Part B only drugs reject using the appropriate reject codes and applicable Current NCPDP Telecommunication Claim Standards structured reject messaging. Part B only claims reject as A5/A6 combo (not D, always B).
      iv. **Part A or B vs. Part D (A or B vs. D) (for Part D Transition only)**
      Part A or B vs. D drugs (formulary drugs with a UM edit) are not provided a TF because coverage is available for the drugs. A determination is needed to identify what coverage will be applied to the drug. Part A or B vs. D drugs reject using the appropriate reject codes and applicable Current NCPDP Telecommunication Claim Standards structured reject messaging. This allows the pharmacy or member to call Delegated PBM for clinical review to determine coverage. The messaging is set up on the RxClaim Prior Authorization table to specify Med A/B/D drugs. Med B v. D claims reject as A6 (B vs. D), A5 (Not D, not B. Not covered under Part D Law) or A4 (This Product May Be Covered Under The Medicare-B Bundled Payment To An ESRD Dialysis Facility), A3 (This Product May Be Covered Under Hospice – Medicare A) as appropriate. Plan-level phone numbers are returned in the reject messaging for formulary drug claims rejecting for A or B vs. D determinations to enable pharmacies to follow-up.
      Once the determination is made, if a drug is determined to be Part D eligible, a PA is entered.

Non-formulary Drugs in these categories, as a rule, will not be covered under Part A or B or Part D. Therefore, a TF is provided to allow the Member to leave the pharmacy with a temporary supply and work with their prescriber to identify a formulary alternative.

v. **Excluded Drugs-not covered by CMS or the state under MMP program benefits**
CMS requires some drugs to be reviewed to determine the Part D drug status. These drugs will require a medically accepted indication based on the FDA approved label or the CMS approved compendia in determining if it is eligible for Part D coverage. Members can request a formulary exception for these excluded Part D drugs**.** Drugs will only be approved for members with a diagnosis demonstrating that the drug is prescribed for a medically accepted indication. Members who have a coverage determination (Prior Authorization or formulary exception) denied, will receive a denial letter indicating their drug is not a Part D drug. Members will have the right to appeal the decision. If the drug is determined to be for a medically accepted indication and so a Part D drug, but any additional utilization management criteria are not met, then the claim is reviewed for TF eligibility and a PA is entered if appropriate.

b. **Transition-Eligible Edits**
MMP transition days supply and time parameters are applied to submitted claims for:

- Non-formulary Part D and UM Drugs
- Non-formulary Medicaid benefit drugs
- Formulary drugs with Prior Authorization, QL (quantity vs. time), daily dose or age edits. Transition logic will not be applied in situations where the daily dose or age edit is a maximum FDA labeled dosage that should not be exceeded for safety reasons. The following is the order of processing for drugs to which edits are applied: Prior Authorization then Quantity Limits (including daily dose and age).

The unique types of transition conditions are listed below.

i. **Non-formulary (NF)**
Drugs that are not covered on a closed integrated formulary. NF transition overrides a reject code 70 for NDC Not Covered (Plan reject 70).

ii. **Prior Authorization (PA)**
Drugs that are covered on the formulary but require Prior Authorization. PA transition overrides a reject code 75 for Prior Authorization.

iii. **Step Therapy**
Because the transition fill itself would satisfy the step therapy requirements for a step 2 drug, in effect enabling the Member to continue to obtain future fills of that drug without encountering a reject, transition letters will NOT be sent to either Members or prescribers. Step TF overrides reject 76/75.

iv. **Approved Quantity Limits (QLs)**
Quantity vs. Time (QvT) or Maximum Daily Dose (DD)
Drug quantity limits are used to establish the allowed amounts for coverage of selected drugs to specified values over a set period of time. For the purposes of the transition process, a quantity limit is considered a type of transition for drugs that require limited supply of a drug to be dispensed based on days supply or allowed quantity across time or maximum doses per day.

a. Drugs that would otherwise reject for quantity limitations when submitted for

more than the allowed quantity are eligible for transition processing during the transition time period. Transition system logic allows the quantity limit reject to be overridden and the claim to process through transition program logic and to post to history appropriately. If a claim is not eligible for transition override and rejects for quantity limits (i.e. transition days supply exhausted, or transition time period expired), it will continue to reject according to quantity limit parameters using Reject 76. Transition system logic overrides "quantity over time" edits that are set up to either count continuous fill history across Contract Years (quantity "period to date" Type D set-up), or to count fill history beginning January 1 of each Contract Year. QL/QvT transition overrides the reject code 76.

b. In addition to transition for QL/QvT, transition is applicable for DD drug edits. DD and QL/QvT edits are mutually exclusive. Transition for the QL/QvT edits takes precedence over the DD TF. DD transition overrides reject 76. Transition logic will not be applied in situations where the daily dose or age edit is a maximum FDA labeled dosage that should not be exceeded for safety reasons.
c. For QvT transition and Plan Limitations, a QvT set up on drug NDC (Plan Option 10) and/or GPI (Plan Option 11) will override plan limitations that are set up on Plan Options 26.1 and 26.2, Preferred Formulary. Therefore, when transition is allowed for QvT reasons, the Plan Limitations on 26.1 and 26.2 are also overridden. However, cumulative transition days supply does not override either once used/exhausted.
d. For Part D QL changes, the system will look at the QL edit in history and compare it to the current/active QL edit. If the current QL edit is lower than the history edits, the QL edit is overridden and the claim processes through TF program logic.

v. **AG Reject**

An AG Reject is a claim reject due to a days supply limitation. Claims submitted for more than remaining allowed transition Days Supply return an "AG" reject code and message "Resubmit for Remaining Day Supply of XX" with XX being the number of remaining allowed transition cumulative days supply. The "AG" reject code is returned as the primary reject code unless, per current NCPDP Telecommunication Claim Standards, this reject is required to follow either the ADDINS (additional insurance) and/or Brand/Generic Savings messaging when these apply. AG rejects are returned on both initial claims with no prior transition in history, as well as subsequent submissions when cumulative days transition supply has not been exhausted with previous paid transition(s). When a pharmacy reduces the claim days supply and resubmits, transition-eligible claims process via transition rules.

vii. **Unbreakable Pre-packaged Medications for Part D**

Drugs for which the manufactured packaging cannot be split for the dispensing of a prescription may be considered an unbreakable pre-packaged medication for which the pre-packaged medication days supply may be dispensed. The intent of this logic is to ensure a Member receives their entire transition days supply (DS) even though the DS exceeds the maximum benefit due to the type of packaging for the drug. This logic will apply if the pre-packaged medication cumulative DS is less than the required benefit, prior to the current fill. If the pre-packaged medication cumulative DS, including the current fill, quantity exceeds the maximum benefit, and the current fill is

less than or equal to the quantity of a single package of medication, the TF will pay. If the pre-packaged medication cumulative DS, including the current fill quantity, exceeds the maximum benefit, and the current fill quantity exceeds the quantity of a single package of medication, the pharmacy will be messaged to resubmit for a single package of the medication. The claim will retain the messaging and the rejects associated with the processing.

viii. **Member Level / Clinical Prior Authorizations (PA)**
Member level clinical Prior Authorizations will be entered to override all transition-eligible edits. Otherwise, a transition will be allowed for any transition-eligible edit for which the PA has not been entered. When a Member / clinical PA already exists on the Member record to override all transition-eligible edits, transition processing is not applicable. Under this condition, claims do not process as transitions and transition letters are not sent to Members.

c. **Processed without TF for Part D**
   i. **Protected Class Drugs (PCD) Logic**
   The PCD Logic will pay the claim without applying transition logic.
   ii. **Grandfather Drug Logic**
   The Grandfather Drug logic will override the NF, Step and PA edit and pay the claim without TF. TF processing will apply to any TF-eligible edit which the Grandfather Drug logic has not overridden.
   iii. **Type 2 ST-PA Drug Logic**
   Type 2 ST-PA Drug edits are edits submitted to CMS as Step for new starts to therapy only. Delegated PBM adjudication logic uses a 108-day minimum look back period for determining new starts. The Type 2 ST-PA Drug Logic will pay the claim without TF logic, according to the plan criteria.

9. Transition Claims History
All history for a drug during the transition time period is counted, regardless of the dispensing pharmacy/network. POS, manually entered, and Member submitted (paper) claims for retail, mail, Long Term Care, and home infusion networks are counted together to determine the total cumulative days supply for a drug. MMP transition days supply limits are defined as cumulative supplies based on Part D days supply requirements to ensure that refills for transition-eligible drugs are available when the transition is dispensed at less than the amount written secondary to quantity limits due to safety, or edits based on approved product labeling; the system automatically "counts" prior related transition claims to allow correct transition days supply accumulation parameters to apply.
10. If the distinction cannot be made at the POS between a brand-new prescription for an MMP Non-formulary Part D or UM Drug and an ongoing prescription, the transition process is applied as if it is a brand-new prescription.
    a. This applies to Members who are new to the plan including: new plan Members at the start of a Contract Year; newly eligible Members from other coverage; and Members who switch from one plan to another after the start of a Contract Year.
    b. Part D Transition Fills are available at POS through transition processing during the Part D TF Window.
    c. Additional transition supplies are available on a case-by-case basis through the Pharmacy Help Desk to ensure adequate transition.
11. Transition Notices

a. Part D TF letters are sent to Members within three (3) business days of the adjudicated TF claim; reasonable and best efforts are also made to identify a current prescriber address/contact information and provide notice of a Part D TF to prescribers to facilitate transitioning of Members. For Part D TF, LTC residents dispensed multiple supplies of a Part D drug in increments of 14-days-or-less as required by CMS guidance, the written notice will be provided within 3 business days after adjudication of only the *first* temporary fill. Part D TF Letters are generated from the Part D TF Claim and Letter Tags which are extracted to the daily Part D TF Letter File.
    i. Daily Part D TF Letter File
        a. Paid TF claims are automatically extracted to a daily TF Claim File. For every paid TF claim, there is either a corresponding record on the correlated daily TF Letter File, or the record is captured on the daily internal exception file with the reason the record is not included on the TF letter file (example: same day paid/reversed).
        b. The contents of the TF Letter file are used to drive production of the appropriate Member and prescriber TF letters.

12. Delegated PBM and neighborhood makes Prior Authorization and exception request forms available upon request to Members, prescribers, pharmacies, and others by a variety of means including mail, fax, email, and with the Sponsor via their plan website. Forms may vary depending on state/MMP regulations.
13. Delegated PBM Part D TF process for new members is applied from the date of enrollment through the TF Window. The enrollment date does not need to be the start of the Contract Year and the transition process may extend across Contract Years where the TF Window extends across Contract Years.
14. [Intentionally left blank to maintain consistent numbering between sections.]
15. Transition extensions are available for new or existing Members, non-LTC or LTC, through the Pharmacy Help Desk or Customer Care when transition parameter limits have been reached and Member is still pending an exception/coverage determination decision.
16. Transition for Current Members
    a. Renewing Members
        i. Renewing Member - transition fills are available to renewing Members who are impacted by a negative formulary change during the TF Window.
        ii. Renewing Members need to have a history of utilization of the Non-formulary MMP Drug(s). History of utilization is based on the following criteria:
            1. History look back 90 days from current date of fill to identify the most recent qualifying history claim
            2. Non-formulary MMP Drug GPI-10 match level
            3. Part D history claim(s) for same drug
                a. not paid as TF(s)
                    i. AND if the incoming claim reject reason is QL, the current QL limit must be lower than the limit on the history claim; or
                b. if only a paid TF is in the Member's history,
                    i. the TF reject reason in the Member's history must not be the same as the incoming claim TF reject reason;
                    ii. or if the history TF reject reason does match the incoming claim TF reject reason AND the NDCs for each claim (claim in history and incoming

claim) must be different for the incoming claim to be evaluated for TF AND the NDC coding on the historical claim and incoming claim are different, or

iii. if the history TF reject reason does match the incoming claim TF reject reason AND the NDCs of each claim is the same AND the reason is QL, the current QL limit must be lower than the history limit.

4. For instances where the Member receives a partial Part D Transition Fill, the system logic will ensure that a renewing Member's remaining TF days supply is Transition Fill eligible during the TF Window. New Member LTC ES and LTC NP & Member PA (reason TF) paid TF claims are not included in the look back calculation to determine if the renewing Member received a partial fill and has remaining days supply.
5. Part D Renewing Member system logic has the following hierarchy: Transition Fill reject reason comparison, then look back calculation for remaining days supply.

c. The Delegated PBM Pharmacy Help Desk is instructed to provide transition supplies to renewing Members who were on medications in the prior Contract Year using the parameters delineated above.
d. On a case-by-case basis, Delegated PBM Customer Care may provide extensions to accommodate Members who continue to await resolution of a pending Prior Authorization or exception requests.

SOURCE DOCUMENTS

42 CFR Parts 405, 417, 422, 423, 460, and 498-- Medicare Prescription Drug Benefit Final Rule, published 4/16/18 (CMS-4182-F)
42 CFR Parts 400, 403, 411, 417 and 423 – Medicare Prescription Drug Benefit Final Rule
Medicare Prescription Drug Benefit Manual - Chapter 5 - Benefits and Member Protections, Rev. 9/30/2011.
Medicare Prescription Drug Benefit Manual - Chapter 6 - Part D Drugs and Formulary Requirements, Rev. 1/15/2016.
Medicare Prescription Drug Benefit Manual - Chapter 18 - Part D Members Grievances, Coverage Determinations, and Appeals, Rev. 5/12/2014.
CMS Part C & D User Call (December 11, 2013 3:30 PM ET), Transcript (pages 12, 15-16)
Memorandum of Understanding Between the Centers for Medicare & Medicaid Services And The State of Rhode Island (pages 100-101)
Contract Between United States Department of Health of Human Services, Centers for Medicare and Medicaid Services, In Partnership with the State of Rhode Island and Providence Plantations Executive Office of Health and Human Services and Neighborhood (page 95-96), July 13, 2016