Part D Transition Process (CMS Approved)

Last Revision/Review Date: 8/1/2019
P&P #Phrm.735 (v4)

Applicable to

Entity	☐ QHBPC[i]	☒ QHPC[ii]	☒ QHPMC[iii]	☐ QHIC[iv]	☐ QTZ[v]	☐ If other, please specify.
State	☒ Iowa	☒ Illinois	☒ Minnesota	☒ Wisconsin		☐ If other, please specify.
Product Line	☐ All Insured Product Lines (Does not include UWA or self-funded)				☐ Self-Funded	☐ UWA[vi]
	☐ Commercial HMO	☐ Individual ACA Exchange			☒ Medicare Advantage	
	☐ Commercial PPO	☐ Individual ACA Non-Exchange			☐ Medicare Select	
	☐ Commercial POS	☐ Individual Grandfathered			☐ Medicare Supplement	
	☐ FEHB	☐ Medicaid			☐ State/Local	

Enforcement

Employees who violate this policy will be subject to disciplinary actions, up to and including termination of employment. Employees have a duty to report suspected or actual noncompliance. Failure to do so may result in disciplinary action leading up to and including termination.

Review, Revision and Distribution

This policy and any material revisions to this policy require the approval of **Pharmacy Director of Government Programs, the plans Pharmacy and Therapeutics Committee, and Centers for Medicare and Medicaid (CMS)**.

External requests for access to this P&P (from network partners, sister companies, etc.) should be directed to **Pharmacy Program Director**.

This document will be updated periodically to reflect changing business and technology requirements or at least annually, whichever is sooner. All change requests should be directed to the document owner.

Document Logistics & Revision History

Document Owner: Pharmacy Manager of Government Programs
Next Review: May 2020

Description of Changes	Name, Title, or Committee	Date
Creation	Anessa Suhr, Pharmacy Manager of Govt. Programs	11/1/2018
Reviewed/Revised	Jeremy Fejfar, Pharmacy Director Govt. Programs	6/1/2019
Approved	CMS Approved August 2019; Quartz P&T Committee	11/19/2019
Note: Only keep the initial creation, last revision, and last approval dates. Previous versions must be archived for 10 years.		

Policy

Senior Preferred, Medicare Advantage with Part D product, has established a procedure for appropriate processing of Part D transition claims. This is highly relevant during the beginning of the plan year for non-formulary Part D eligible drugs or those requiring utilization management per plan benefits. This will be done to ensure that all guidelines and regulations from Centers for Medicare & Medicaid Services (CMS), will be met with respect to this work by the plan sponsor.

Definitions

Term A	Definition A
Term B	Definition B

Related Documents

Transition of Care from Pharmacy Benefit Manager (PBM)

Transition Process Requirements for Medicare Part D.v12 (PBM)

HPMS Attestation for Transition policy

Requirements

CMS Prescription Drug Manual, Chapter 6, Section 30.4

Federal Register 423.120

Procedure

To comply with the CMS requirements as outlined in 42 CFR 423.120(b)(3), the plan sponsor will apply appropriate transition processing with respect to:

- New members enrolled in a Part D plan through annual enrollment periods
- Newly eligible Medicare beneficiaries from other coverage
- Individuals switching from one plan to another after the start of the contract year
- Current members who remain in the plan and experience negative impact by formulary changes, such as non-formulary drugs, non-formulary drugs previously approved by exception process after the exception process expires, prior authorization, step therapy, and approved quantity limits below FDA maximum dosing or approved quantity limits lower than the members current dosing. The transition process for current members will be consistent with that of a new member.
- Members who enroll with a date of November or December 1st and require a span across contract years for the transition period.

This policy will ensure the following requirements apply for transition processing for the above mentioned beneficiaries:

1. Ensure that there is access to a temporary supply of Part D eligible drugs within the first 90 days of coverage under a new plan. This will be available at retail, home infusion, and long-term care pharmacies.

2. The temporary fill during the 90 day timeframe will be allowed for non-formulary drugs or formulary drugs that have a plan benefit restriction, such as prior authorization, step therapy, or that have an approved quantity limit lower than the member's current dose, under the plan's utilization management rules.

3. All transition policy processes will be extended to members who have an effective date of either November 1st or December 1st and require a needed temporary supply of medications.

4. For those scenarios that involve a retail or outpatient setting, the plan will allow at a minimum a one-time, temporary 30-day supply anytime during the first 90 day of a member's enrollment which begins on their effective date of coverage. If the prescription is written for less, the processing logic will allow for multiple refills to accommodate up to the 30- day supply of medication.

5. For current members who may experience a negative change to a drug they currently take, such as the drug is removed from formulary, the drug remains on formulary but has a new prior authorization, step therapy restriction or quantity limit below members current dose, and non-formulary drugs that were approved through the exception process and the exception has expired, the plan will allow a meaningful transition by providing a transition process consistent with the those required for a new member during the beginning of a contract year or providing a transition process prior to the beginning of the new contract year.

6. New members will receive transition fill at point of sale for any non-formulary drug to ensure continuity of care. Following this the plan will allow medical reviews for non-formulary drug requests which may be accomplished through the exception process where medical necessity will be determined by a clinical pharmacist. The plan will also facilitate communication, either verbally or written (i.e. fax) with providers and/or members to switch to therapeutically appropriate formulary alternatives, if an adverse medical necessity determination is made in their case. These processes will help ensure the new Part D member has little to no disruption to their medication therapy.

7. For the long-term care scenarios, the temporary supply will allow for 31 days to be consistent with dispensing increments during the first 93 days of enrollment, or less if prescription presented as such. Multiple refills of a medication will process as necessary to meet this timeframe during the first 93 days of a member's enrollment that begins on their effective date of coverage. After the first 93 days when the transition period expires for LTC members, a 31 day emergency fill will be allowed for non-formulary Part D drugs, prior authorization/step therapy required drugs, and non-safety drug utilization review (DUR) reasons to allow for a formulary exception or coverage determination to be requested by the member or prescriber. Also for members who may be impacted by admission or discharge from a LTC setting, the claims processing system will have provisions to prevent early refill edits that would limit access to any Part D eligible medication and/or benefit.

8. Upon each transition fill, a written notice will be generated within three business days after the first temporary claim adjudication to the member and sent to the member via U.S. first class mail by the PBM. Reasonable efforts will be made by the PBM to ensure a copy will be faxed to the prescribing provider. The CMS model letter, which has been approved via the file-and-use process, is used which includes: an explanation of the temporary supply, guidance on working with the plan or prescriber to identify formulary alternatives or how to satisfy any utilization management requirements, member's right to request a formulary exception and a description of how to make such a request. In the case of long-term care situation, a written notice will be sent to the member via U.S. first class mail within three business day after claim adjudication of the first temporary fill when multiple supplies in increments of 14-days or less are dispensed.

9. While the utilization management requirements of prior authorization and step therapy will be resolved at point-of-sale, there may be certain cases where it will be appropriate to continue with pending a drug claim during the

transition period. These are related to steering of appropriate payments and safety concerns. Therefore, only the following utilization management edits will be allowed to prevent a claim from processing via a transition fill:

a. Part A or Part B vs. Part D determinations

b. FDA non-matched NDC's (No RxCUI)

c. Blocking of non-Part D drugs (i.e. excluded drugs)

d. Safety utilization for Part D drugs (i.e. quantity limits, early refills)

10. For CY2019 or CY2020, the plan will not be implementing any step therapy type edits on medical review drugs (Part B) based on recent CMS guidance; therefore, there would be no disruption or need for transition fills.

Senior Preferred is contracted with a PBM who provides a prescription claims processing system that will have all system capabilities to provide temporary supply of any Part D eligible drug regardless of formulary status. The PBM system will allow 30 day transition fills during the first 90 days of a member's enrollment to ensure compliance with this policy and CMS requirements with respect to accommodating the immediate needs of Senior Preferred members, allowing the plan sufficient time to work with prescribers on formulary exception requests or appropriate therapeutically equivalent medication changes as needed. Our plan will delegate the transition logic and processing of prescription claims at point-of-sale to this vendor. The PBM has provided a detailed transition logic document that shows how all requirements of this policy will be met including flowcharts. Periodic audits of any delegated entity will be performed to ensure continued compliance with this policy.

Below are high level summaries of the PBM transition logic with respect to how claims process within their adjudication system; how the pharmacy is notified when transition is processed at point-of-sale; and descriptions of edits and explanation of the process a pharmacy will follow regarding point-of-sale transition claims.

1. To accommodate the immediate need of the member, Senior Preferred will temporarily cover a non-formulary drug, including both Part D drugs that are not on the plan's formulary and Part D drugs that are on the plan's formulary but require prior authorization or step therapy. This will include a review of medically necessary drugs through a formulary exception procedure which will review if all Part D formulary drugs were not as effective and/or would have adverse effects. This process could also address previous trials/failures of formulary alternatives. In addition, the formulary exception process will assist member in switching to therapeutically appropriate formulary alternatives if necessary.
2. In addition, the transition processes will address changes to a members setting of care, such as from their home to an institutional setting or hospital to their home. This will allow uninterrupted access to needed drugs while members have time to discuss alternatives or therapy options with their provider. Or, if needed, allows time for an exception request to maintain coverage of the existing drug. This will include not imposing early refill edits so members are allowed access to refills when admitting or discharging (level of care changes) from one setting to another.
3. Senior Preferred has ensured the logic of the PBM will do the following in determining adjudication at point-of-sale:

    a. An initial qualification review will be done to determine if the claim is transition eligible

b. The adjudication logic will eliminate any non-Part D claims, claims with no errors, Li-net claims, protected class drugs, etc.

c. After the above initial validation check, the logic will ensure the claim has not denied for the following reasons:

i. Part B vs. Part D

ii. CMS Excluded drugs

iii. Unit dose drugs

iv. Patient safety edits, such as overutilization of acetaminophen

4. When all of the above is met, the claim will continue to process through transition. The pharmacy will be provided messaging at the point of sale to identify that a transition fill is applicable for the member.

5. The PBM logic has the ability to do historical look back across plans by using specific member identifiers such as the MBI, HICN, RRB or member ID. This allows for determination regarding prior drug use as it relates to eligibility for a transition fill. Senior Preferred has chosen the PBM options to look back 180 days when determining if the member is still considered new. Senior Preferred will also implement a historical look back through no less than 180 days of claims to determine if a transition fill meets the requirements for previous drug utilization. If this look back still fails to determine whether the prescription is a brand new for a non-formulary drug or an ongoing prescription for a non-formulary drug, all transition processes will apply and the transition fill will be allowed at point-of-sale.

6. If the member is low income subsidy (LIS) eligible, the cost share amounts will never exceed the statutory maximum allowed. For non-LIS members, all transition overrides for a non-formulary drug will have the same cost sharing as would apply if the same non-formulary drug is approved through a formulary exception process. Specifically, their cost sharing would process at the non-preferred drug tier; this is consistent with Senior Preferred policies when a non-formulary drug is approved through an exception and placed on the non-preferred drug tier or Tier 4. For non-LIS members who receive a transition override for a formulary medication that has UM criteria, they will receive the same cost sharing as would apply if the UM was met during a non-transition period.

7. We will utilize methods to notify members of changes between contract years and make efforts to transition a member to a formulary alternative or therapeutically equivalent drug. These tools may include, but are not limited to the following:

a. Annual Notice of Change (ANOC)

b. Member letters

c. Member phone calls

d. Transition policy information will also be made available via a link on the Medicare Prescription Drug Plan Finder with hyperlinks to the Senior Preferred website at www.seniorpreferred.org

e. Transition policy will also be included in pre and post enrollment marketing materials as directed by CMS.

f. Senior Preferred will accept coverage determinations prior to the start of the benefit year to allow for smoother transition for new members and current members impacted by negative year to year changes.

8. If a claim should deny due to a DUR or Safety reason with respect to quantity limits, the prescription will pay if the quantity or days' supply is adjusted to that which is less than the limits for safety purposes and these edits are based upon approved product labeling. Also, plan will allow transition refills of prescriptions when dispensed for less than the written amount in quantity limit or utilization edits and will be based upon approved product labeling.

For those members or providers who require a prior authorization or exception form, Senior Preferred has placed this form on our website at www.seniorpreferred.org/medpa where the users will have the option to submit electronically or may print a different version to mail, fax, or email as needed.

9. Any member with a unique or extenuating circumstance not addressed in the above noted policy and procedure will be reviewed on a case by case basis. Senior Preferred will provide any necessary Part D eligible drugs to member via an extension of the transition period to the extent that the members exception request or appeal have not processed by the end of the minimum transition period or until such time that a transition has been made through a switch to an appropriate formulary alternative or a decision have been rendered on an exception request.