Medicare Part DTransition Policy

Capital Health Plan recognizes and works to maintain compliance with the dual goals of the Medicare Transition Program (Program), which are: (1) making certain that eligible Part D members receive their temporary transition supply of non-formulary Medicare Part D drugs, including Part D drugs that are on the Plan's formulary but require Prior Authorization (PA), Step Therapy (ST), and/or Quantity Limits (QL) under the Plan's Utilization Management (UM) rules, and (2) providing Part D members with sufficient time to work with their health care providers to switch to therapeutically-appropriate formulary alternatives or to request a PA or Formulary Exception (FE) on the grounds of medical necessity. Capital Health Plan administers this Program consistent with CMS regulations and manual requirements, as amended from time to time.

This policy addresses the following elements:

- Transition Requirements
- General Transition Process
- New Prescriptions vs. Ongoing Drug Therapy
- Transition Timeframes and Temporary Fills
- Timeframe and Transition Fills in Outpatient Settings
- Timeframe and Transition Fills in LTC Settings
- Transition Extensions
- Transition Across Contract Years for Current Members
- Emergency Supply for Current Members
- Level of Care Changes
- Edits for Transition Fills
- Cost Sharing Considerations
- Transition Notices
- Public Notice of Transition Processes

Eligible members

Affected members whose current drugs may not be included in their new Part D plan's formulary, the plan provides a transition for:

- *New members into prescription drug plans following the annual coordinated election period;*
- *Newly eligible Medicare members from other coverage;*
- *Members who switch from one plan to another after the start of the contract year;*
- *Current members affected by negative formulary changes across contract years; and*
- *Members residing in LTC facilities.*

Applicable drugs

This transition policy applies to non-formulary drugs, including:

- *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, or that have an approved QL lower than the beneficiary's current dose, under the Plan's utilization management requirements.*

This transition policy includes procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan members to therapeutically appropriate formulary alternatives, failing an affirmative medical necessity determination.

New prescriptions versus ongoing drug therapy

The transition processes are applied to a brand-new prescription for a non-formulary drug if a distinction cannot be made between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

Transition Timeframe and Transition Supply

Outpatient Settings (retail, extended supply network [ESN], mail order)

In the retail setting, the Plan's Program provides for at least a month's supply anytime during the first 90 days of a member's enrollment in a plan, beginning on the member's effective date of coverage.

Long-term care (LTC) Settings

In the LTC setting, the Plan's transition program provides:

- A temporary fill of at least a month's supply or a larger days' supply for prescription products that cannot be broken (unless the member presents with a prescription written for less) during the first 90-days of a member's enrollment in a plan, beginning on the member's effective date of coverage.
- After their transition period has expired, a 31-day emergency supply of non-formulary Part D drugs (unless the member presents with a prescription written for less than 31 days), or a larger days' supply for prescription products that cannot be broken to allow time to request an exception or prior authorization.
- For members being admitted or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such members are allowed to access a refill upon admission or discharge.

Transition extension

The Plan makes arrangements to continue to provide necessary Part D drugs to members via an extension of the transition period, on a case-by-case basis, if their exception requests or appeals have not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request has been made).

Transition across contract years for current members

For current members whose drugs will be affected by negative formulary changes from one contract year to the next, our program allows for effectuation by either of the two methods noted below:

- Providing a transition process at the start of the new contract year, if the member has history of paid claim(s) for the drug within a designated lookback period which is a minimum of 108 days;
- Effectuating a transition prior to the beginning of the new contract year.

The Program is extended across contract years, if a member enrolls into a plan with an effective enrollment date of either November 1 or December 1 and needs access to a transition supply.

Emergency supply for current members in the LTC Setting
An emergency supply of non-formulary Part D drugs is supplied for LTC facility residents as part of the Plan's transition program. During the first 90 days after a member's enrollment, the Plan's transition program provides a transition supply.

If a member's transition period has expired and they are in a LTC facility, the member still receives an emergency supply of non-formulary Part D drugs while an exception or PA is requested. These emergency supplies of non-formulary Part D drugs are for at least 31 days of medication.

Treatment of re-enrolled members
In some cases, members may leave one plan for a period of time to enroll in a different plan and then re-enroll in their original plan. As a result, the Program tracks enrollment dates so that these members are treated as new members for purposes of receiving transition benefits. This means, the date of the member's re-enrollment in their original plan is used for purposes of applying the transition benefits.

Level of care changes
Unplanned transitions for current members could occur and prescribed drugs may not be on the Plan's formulary. These circumstances usually involve level of care changes in which a member is changing from one treatment setting to another.
For these unplanned transitions, members and prescribers must use the Plan's coverage determinations and appeals processes.

In order to prevent a temporary gap in care when a member is discharged to home, members are permitted to have a full outpatient supply available to continue therapy once their limited supply provided at discharge is exhausted. This outpatient supply is available in advance of discharge from a Part A stay.

When a member is admitted to or discharged from an LTC facility, and does not have access to the remainder of the previously dispensed prescription, a one-time override of the "refill too soon" edits is processed for each medication which would be impacted due to a member being admitted to or discharged from a LTC facility. Early refill edits are not used to limit appropriate and necessary access to a member's Part D benefit, and such members are allowed to access a refill upon admission or discharge.

Cost Sharing Considerations
The Plan Sponsor verifies that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the maximum co-payment amounts for Low-Income Subsidy (LIS) eligible members. For non-LIS eligible members, the Plan will charge the same cost sharing for non-formulary Part D drugs provided during the transition process that would apply for non-

formulary drugs approved through a formulary exception; and, the same cost sharing for formulary drugs subject to utilization management edits provided during the transition process that would apply if the utilization management criteria are met.

Transition notices

Written notice via U.S. first class mail is sent to the member within three (3) business days of the temporary transition fill submit date.

The notice must include:

- An explanation of the temporary nature of the transition supply a member has received.
- Instructions for working with the plan and the member's prescriber to satisfy utilization management requirements or identify appropriate therapeutic alternatives that are covered on the Sponsor's formulary.
- An explanation of the member's right to request a formulary exception.
- A description of the procedures for requesting a formulary exception.

Reasonable efforts are made to notify prescribers of affected members who receive a transition notice, as noted above. A cover letter and confidential patient profile, which includes the patient's name, address, the drug filled and the reason for notification, are sent directly to the prescriber of record via U.S. first class mail.

Public Notice of Transition Processes

The Plan makes this program description available to members via a link from Medicare Prescription Drug Plan Finder to the Plan's web site and include it in pre-and post-enrollment marketing materials as directed by CMS. The purpose of this information is to reassure members that there are procedures in place to assist them in switching to therapeutic alternatives or in obtaining a formulary exception, as appropriate. In addition, the information may be useful to educate advocates and other parties about Plan's transition processes.

Quality Assurance

Pursuant to CMS guidance, necessary quality assurance checks are performed, such as running test claims for all the types of scenarios on the adjudication system, prior to the start of the plan year. It is the Plan's policy to monitor its computer and software systems continually in order to maintain the timely delivery of transition fills for entitled members. Performance is tracked with regard to transition services, and immediate action is taken when problems are identified related to adherence to this CMS Part D Transition Policy.

For questions about this policy, please contact Capital Health Plan Member Services at 850-523-7441 or 1-877-247-6512, or for TTY users 850-383-3534 or 1-877-870-8943, 8:00 a.m. to 8:00 p.m., seven days a week, October 1 to March 31; and 8:00 a.m. to 8:00 p.m., Monday through Friday, April 1 to September 30. Or, visit our website at www.capitalhealth.com/Medicare.