| POLICY AND PROCEDURE | |
|---|---|
| **Title:**<br>Part D Transition Claims | |
| **Primary policy owner:**<br>Pharmacy | **Policy #:**<br>PH48 |
| **Impacted/Secondary policy owner:** Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined | |
| 1) ☐All Departments<br>2) ☐Behavioral Health & Social Services (BH/SS)<br>3) ☐ Benefits Administration (BA)<br>4) ☐ Case Management (CM)<br>5) ☐ Claims (CLMS)<br>6) ☐ Community Marketplace & Member Engagement (MAR)<br>7) ☐ Compliance (CMP/HPA)<br>8) ☐ Configuration (CFG)<br>9) ☐ Provider Contracting (CONT)<br>10) ☐ Cultural & Linguistics (CL)<br>11) ☐ Customer Service (CS) | 12) ☐ Facilities (FAC)<br>13) ☐ Finance (FIN)<br>14) ☐ Human Resources (HR)<br>15) ☐ Information Technology / Core Systems (IT)<br>16) ☒ Pharmacy (PH)<br>17) ☐ Provider Networks (PRO)<br>18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM)<br>19) ☐ Utilization Management (UM)<br>20) ☐ Procurement (PRM)<br>21) ☐ Administration (SAF/BC/EM)<br>22) ☐ Medical Management (MM) |
| **Product Type:**<br>☐Medi-Cal<br>☒D-SNP | **Supersedes Policy Number:**<br>NA |

## I. PURPOSE

Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-compliance.

The purpose of this policy is to describe the Health Plan process for transition and ensure that continued drug coverage is provided to new and current Part D members. The transition process allows for a temporary supply of drugs and sufficient time for members to work with their health care providers to select a therapeutically appropriate formulary alternative, or to request a formulary exception based on medical necessity. Transition processes will be administered by MedImpact in a manner that is timely, accurate and compliant with all relevant Centers for Medicare and Medicaid Services (CMS) guidance and requirements as per 42 CFR §423.120(b)(3).

## II. POLICY

A. The Pharmacy Benefits (PBM) supports Health Plan in administering a transition process that is in compliance with the established Centers for Medicare and Medicaid Services (CMS)transition requirements. This policy is necessary with respect to:
   1. New enrollees into Health Plan following the annual coordinated election period;
   2. Newly eligible Medicare beneficiaries from other coverage;
   3. Enrollees who switch to Health Plan after the start of a contract year;
   4. Current enrollees affected by negative formulary changes across contract years; and
   5. Enrollees residing in long-term care (LTC) facilities.

B. The PBM will ensure that its transition policy will apply to non-formulary drugs, meaning both
   1. Part D drugs that are not on Health Plan's formulary, and
   2. Part D drugs that are on Health Plan's formulary but require prior authorization or step therapy, or that have an approved QL lower than the beneficiary's current dose, under Health Plan's utilization management rules.

C. The PBM will ensure that its policy addresses procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D Health Plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

D. Also, in accordance with Centers for Medicare and Medicaid Services (CMS) requirements, the PBM ensures that drugs excluded from Part D

coverage due to Medicare statute are not eligible to be filled through the transition process. However, to the extent that Health Plan covers certain excluded drugs under an Enhanced benefit, those drugs should be treated the same as Part D drugs for the purposes of the transition process.

Transition Population:

A. The PBM will maintain an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how, for enrollees whose current drug therapies may not be included in their new Part D Health Plan formulary, it will effectuate a meaningful transition for:
    1. New enrollees into Health Plan following the annual coordinated election period;
    2. Newly eligible Medicare beneficiaries from other coverage;
    3. Enrollees who switch to Health Plan after the start of a contract year;
    4. Current enrollees affected by negative formulary changes across contract years; and
    5. Enrollees residing in long-term care (LTC) facilities.

Transition Period:

A. Health Plan chooses the number of transition days offered under this transition policy.
    1. Centers for Medicare and Medicaid Services (CMS) requires a minimum of 90 days from the start of coverage under Health Plan.
        i. The 90 days are calculated from the Health Plan start date.
    2. Health Plan will extend its transition policy across contract years should a beneficiary enroll in a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.
    3. Health Plan may choose to enhance this transition policy to provide coverage beyond the Centers for Medicare and Medicaid Services (CMS) minimum requirements.
B. Health Plan has two options for setting the member's transition start date; utilizing the PBM's system default logic or continue populating Segment Code 05 of the Type 24 file.
    1. The PBM's default process for setting the transition start date will work with the PBM's Type 23 (member record layout) file, or equivalent file type if Health Plan does not utilize the Type 23.
        i. Whenever the Type 23 loads or its equivalent file loads, the transition start date default process will run simultaneously

and analyze the member's group number assignment and the member's effective date within that group.

ii. For members that are new to Health Plan or that are re-enrolling but had a break in coverage, the PBM's default process will set the transition start date to match the member's effective date within the group.

iii. For existing (non-new) members that are assigned to a new group within the same Health Plan, the PBM's default process will analyze the change in group number assignment to determine if it results in a new Centers for Medicare and Medicaid Services (CMS) contract and/or plan assignment.

iv. If the change in group number resulted in a new Centers for Medicare and Medicaid Services (CMS)contract assignment, the member's transition start date will be updated to mirror the effective date of the group change.

v. If the change in group number did not result in a new Centers for Medicare and Medicaid Services (CMS) contract assignment, the member's transition start date will remain as is and will not be updated.

vi. If the change in group number resulted in a new plan assignment and new formulary ID, the member's transition start date will be updated to mirror the effective date of the group change.

vii. If the change in group number did not result in a new plan assignment or new formulary ID, the member's transition start date will remain as is and will not be updated.

2. The PBM's default logic aligns with guidance issued by Centers for Medicare and Medicaid Services (CMS) stating Health Plan must effectuate transition for members that change either Centers for Medicare and Medicaid Services (CMS)contract or plan, irrespective of whether or not the change resulted in a new Part D formulary assignment.
3. If Health Plan utilizes Segment Code 05 of the Type 24 for setting member's transition start date, then Health Plan is ultimately responsible for indicating which of the members should be in a transition period.
    i. Health Plan must place the members into a transition period by populating the appropriate Member plan Part D Start Date in Segment Code 05 of the Type 24 File (Member Attribute Load File).

ii. The transition period (90-day minimum) is then calculated from the Member plan Part D Start Date with Health Plan.

C. The PBM will ensure that it will apply all transition processes to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

Implementation Statement:

A. Claims Adjudication System: The PBM has systems capabilities that allow the PBM to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow Health Plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.
B. Pharmacy Notification at Point-Of-Sale: MedImpact utilizes the current NCPDP Telecommunication Standard to provide POS messaging. The PBM reviews NCPDP reject and approval codes developed during the External Codes List (ECL) process. Pharmacy messages are modified based on industry standards.
C. Edits During Transition**:** The PBM will only apply the following utilization management edits during transition at point-of-sale: edits to determine Part A or B versus Part D coverage, edits to prevent coverage of non-Part D drugs, and edits to promote safe utilization of a Part D drug. Step therapy and prior authorization edits must be resolved at point-of-sale.
    1. The PBM will ensure that the transition policy provides refills for transition prescriptions dispensed for less than the written amount due to quantity limit safety edits or drug utilization edits that are based on approved product labeling.
    2. As outlined in 42 CFR §423.153(b), the PBM has implemented Point-of-Sale (POS) PA edits to determine whether a drug is covered under Medicare Parts A or B as prescribed and administered, is being used for a Part D medically accepted indication or is a drug or drug class or its medical use that is excluded from coverage or otherwise restricted under Part D (Transmucosal Immediate Release Fentanyl (TIRF) and Cialis drugs as an example).
D. Pharmacy Overrides at Point-Of-Sale**:** During the member's transition period, all edits (with the exception of those outlined in section II(K)) associated with non-formulary drugs are automatically overridden at the point-of-sale. Pharmacies can also contact the PBM's Pharmacy Help Desk directly for immediate assistance with point-of-sale overrides. The

PBM can also accommodate overrides at point-of-sale for emergency fills as described in section II(M-Q). Please see section II(U-X) for specific information for the processing of non-formulary drugs in the Six Classes of Clinical Concern.

Emergency Supplies and Level of Care Changes for Current Members:

A. An Emergency Supply is defined by CMS as a one-time fill of a non-formulary drug that is necessary with respect to current members in the LTC setting.
    1. Current members that are in need of a one-time Emergency Fill or that are prescribed a non-formulary drug as a result of a level of care change can be placed in transition via an NCPDP pharmacy submission clarification code.
    2. The PBM can also accommodate a one-time fill in these scenarios via a manual override at point-of- sale.
B. Upon receiving an LTC claim transaction where the pharmacy submitted a Submission Clarification Code (SCC) value of "18", which indicates that the claim transaction is for a new dispensing of medication due to the patient's admission or readmission into an LTC facility, the PBM's claims adjudication system will recognize the current member as being eligible to receive transition supplies and will only apply the point-of-sale edits described in section II(K) of this policy. In this instance, Health Plan does not need to enter a point-of-sale override.
C. For current enrollees whose drugs will be affected by negative formulary changes in the upcoming year, Health Plan will effectuate a meaningful transition by either:
    1. Providing a transition process at the start of the new contract year or;
    2. Effectuating a transition prior to the start of the new contract year.
D. POS logic is able to accommodate option 1 by allowing current members to access transition supplies at the point-of-sale when their claims history from the previous calendar year contains an approved claim for the same drug that the member is attempting to fill through transition and the drug is considered a negative change from one plan year to the next.
    1. To accomplish this, POS looks for Part D claims in the member's claim history that were approved prior to January 1 of the new plan year, and that have the same HICL value as the transition claim.
    2. Additionally, if a brand medication is being filled under transition, the previous claim must also be brand (based on NSDE marketing status).

3. If a generic medication is being filled under transition, the previous claim can be either brand or generic (based on NSDE marketing status).

E. Negative changes are changes to a formulary that result in a potential reduction in benefit to members.
    1. These changes can be associated to removing the covered Part D drug from the formulary, changing its preferred or tiered cost-sharing status, or adding utilization management.
    2. The transition across contract year process is applicable to all drugs associated to mid-year and across plan-year negative changes.

Transition Extension:

A. Health Plan will make arrangements to continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, to the extent that 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). On a case-by-case basis, point-of-sale overrides can also be entered by Health Plan or by the PBM (if authorized by Health Plan to do so) in order to provide continued coverage of the transition drug(s).

Cost-Sharing for Transition Supplies:

A. The PBM will ensure that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees.
B. For non-LIS enrollees, Health Plan must charge the same cost sharing for non-formulary Part D drugs provided during the transition that would apply for nonformulary drugs approved through a formulary exception in accordance with 42 CFR §423.578(b) and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.

Protected Class Drug Transition Process:

A. Members taking a drug within the six classes of clinical concern must be granted continued coverage of therapy for the duration of treatment, up

to the full duration of active enrollment in Health Plan as long as the drug remains on formulary.

B. UM restrictions (Prior Authorization and/or Step Therapy), which may apply to new members naïve to therapy, are not applied to those members transitioning into Health Plan on agents within any of these key six classes/categories:
    1. Antidepressant
    2. Antipsychotic
    3. Anticonvulsant
    4. Antineoplastic
    5. Antiretroviral; and
    6. Immunosuppressant (for prophylaxis of organ transplant rejection).
C. For new members, the protected class drug process will always override transition process logic to process the claim.
D. Additionally, for new members, a 120-day transition period from their member start date with Health Plan is provided.

Member Notification:

A. The PBM provides Health Plan (via FTP) with two daily files called the Transition Notification "All" File and the Transition Notification "Print" file.
    1. The "Transition Notification 'All' File" contains claims data and other member information. This file provides Health Plan with all of the information needed to contact members and providers regarding transition fills.
    2. The "Transition Notification 'Print' File" contains necessary member and claims data needed to produce member notices. This file was created to allow the ability to produce one transition notice per member within a 100 day period where the drug, transition type and applicable drug restrictions are the same.
    3. The PBM will send written notices consistent with Centers for Medicare and Medicaid Services (CMS) transition requirements via U.S. first class mail to enrollee within three business days of adjudication of the temporary transition fill.
        i. If the enrollee completes his or her transition supply in several fills, a notice must be sent with the first transition fill only.
        ii. The notice must include:
            a. An explanation of the temporary nature of the transition supply an enrollee has received;
            b. Instructions for working with Health Plan, the PBM, and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate

therapeutic alternatives that are on Health Plan's formulary;
   c. An explanation of the enrollee's right to request a formulary exception; and
   d. A description of the procedures for requesting a formulary exception.
4. For long-term care residents dispensed multiple supplies of a Part D drug in increments of 14-days-or-less, consistent with the requirements under 42 CFR 423.154(a)(1)(i), the written notice must be provided within 3 business days after adjudication of the first temporary fill.
5. The PBM will use the CMS model Transition Notice via the file-and-use process or submit a non-model Transition Notice to Centers for Medicare and Medicaid Services (CMS) for marketing review subject to a 45-day review.
6. The PBM will ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice.
7. Providing written notification to the member and/or provider in accordance with Centers for Medicare and Medicaid Services (CMS) requirements is ultimately the responsibility of the PBM.
8. The PBM's print vendor will receive the Transition of Care Notification File and the PBM will facilitate the fulfillment process of member notifications on Health Plan's behalf.
9. The PBM and PBM's print vendors adhere to all Centers for Medicare and Medicaid Services (CMS) Marketing Guidelines as set forth in Chapter 2 of the Medicare Prescription Drug Benefit Manual.
10. Health Plan will make their transition policy available to enrollees via link from Medicare Prescription Drug Plan Finder to the Health Plan web site and include in pre-and post-enrollment marketing materials as directed by Centers for Medicare and Medicaid Services (CMS).
11. The PBM produces the Prescriber Transition Notification letters to be mailed to the prescriber at the same time the transition letter is mailed to the member.
12. This information is obtained from the existing Transition Notification Files that are sent to Health Plan daily, as described above. The file/letter includes the following:
    i. Prescriber information
    ii. Member information
    iii. Transition claim details

B. The PBM's print vendor will receive the Prescriber Transition Notification Letter File and the PBM will facilitate the fulfillment process of provider notifications on Health Plan's behalf.
C. The Prescriber Transition Notification letter template provides physicians with formulary alternatives.

PDE Reporting:
A. Since this is a Centers for Medicare and Medicaid Services (CMS) required process, any drugs dispensed that qualify under the transition period are reported as covered Part D drugs with appropriate Health Plan and member cost sharing amounts on the Prescription Drug Event (PDE).

Centers for Medicare and Medicaid Services (CMS) Submission:
A. Health Plan will submit a copy of its transition process policy to Centers for Medicare and Medicaid Services (CMS).

Pharmacy and Therapeutics Committee Role:
A. Health Plan delegates the Part D Pharmacy and Therapeutics Committee (P&T) responsibilities to the PBM.
B. The PBM's P&T maintains a role in the transition process in the following areas:
    1. The PBM's P&T committee reviews and recommends all The PBM formulary step therapy and prior authorization guidelines for clinical considerations; and
    2. The PBM's P&T committee reviews and recommends procedures for medical review of non-formulary drug requests, including the PBM exception process.

Exception Process:
A. The PBM follows an overall transition plan for Health Plan's Medicare Part D members; a component of which includes the exception process. The PBM's exception process integrates with the overall transition plan for these members in the following areas:
    1. The PBM's exception process complements other processes and strategies to support the overall transition plan. The exception process follows the guidelines set forth by the transition plan when applicable.
    2. When evaluating an exception request for transitioning members, Health Plan's exception evaluation process considers the clinical

aspects of the drug, including any risks involved in switching, when evaluating an exception request for transitioning members.

3. The exception policy includes a process for switching new Health Plan Medicare Part D plan members to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

B. Health Plan will make available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on Health Plan's web site.

## III. PROCEDURE

Transition Claim Adjudication – Retail Setting

A. The PBM adjudicates a temporary supply of non-formulary Part D drugs or formulary Part D drugs with UM edits, within the first 90 days of coverage for new members beginning on the enrollee's effective date of coverage.

B. The PBM adjudicates a temporary supply of a Part D medication to existing members negatively affected by a formulary change from year to year.

C. The temporary fill is up to a one-month (30-day) supply of a medication unless the member presents a prescription written for less than a month's supply in which case multiple fills, provided up to a total of a month's supply (30 days) of medication, must be allowed to process.

D. If a brand medication is being filled under transition, the previous claim must also be brand (based on Comprehensive NDC SPL Data Elements File [NSDE] marketing status).

E. If a generic medication is being filled under transition, the previous claim can be either brand or generic (based on NSDE marketing status).

Transition Claim Adjudication – Long-Term (LTC) Setting

A. The PBM ensures that the transition policy provides for a one time temporary fill of at least a month's supply (unless the enrollee presents with a prescription written for less) which should be dispensed incrementally as applicable under 42 CFR §423.154 and with multiple fills provided if needed during the first 90 days of a beneficiary's enrollment into Health Plan, beginning on the enrollee's effective date of coverage;

B. After the transition period has expired, the transition policy provides for a 31-day emergency supply of non-formulary Part D drugs (unless the

enrollee presents with a prescription written for less than 31 days) while an exception or prior authorization is requested; and

C. For enrollees being admitted to 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 enrollees are allowed to access a refill upon admission or discharge.

Transition Notifications:

A. The PBM provides Health Plan, daily, with three Transition Notification files ("Transition Notification 'All' File" and "Transition Notification 'Print' File" and "Prescriber Transition Notification").
B. The PBM facilitates the transfer of information to the print vendor to produce and mail the transition notices to members and prescribers.
C. The PBM performs quality checks on the files pre- and post-production and share results with Health Plan.
D. The PBM provides Health Plan access to the print vendor's web archive.

## IV. ATTACHMENT(S)

A. Glossary of Terms Link

## V. REFERENCES

A. 42 CFR §423.120(b)(3)
B. 42 CFR §423.154
C. Medicare Prescription Drug Benefit Manual (MPDBM) Chapter 6, Section 30.4
D. Medicare Prescription Drug Benefit Manual Chapter 5: Benefits and Beneficiary Protections, section 50: Access to Covered Part D Drugs
E. State Medicaid Agency Contract (SMAC)
F. Health Plan Contract with Centers for Medicare and Medicaid Services (CMS)

## VI. REVISION HISTORY

| Version* | Revision Summary | Date |
|---|---|---|
| 001 | New Policy that includes updated Transition Claim Adjudication – Retail Setting to address CMS question, Attestation # 5 | 7/3/2025 |

| | | |
|---|---|---|
| 002 | | |
| 003 | | |
| 004 | | |
| **Initial Effective Date: 09/24/2025** | | |
| **Published Date:09/29/2025** | | |

## VII. Committee Review and Approval To Be Completed by Compliance

| Committee Name | Version | Date |
|---|---|---|
| Compliance Committee | 001 | 09/24/2025 |
| • Privacy & Security Oversight Committee | | |
| • Program Integrity Committee | | |
| • Audits & Oversight Committee | | |
| • Policy Review Committee | | |
| Quality Improvement Health Equity Committee (QIHEC) | | |
| • Quality Operations Committee | | |
| • Grievance Committee | | |

## VIII. REGULATORY AGENCY APPROVALS

| Department | Reviewer | Version | Date |
|---|---|---|---|
| Department of Healthcare Services (DHCS) | | | |
| Department of Managed Care (DMHC) | | | |

## IX. *Approval signature**

| Signature | Name<br>Title | Date |
|---|---|---|
| | PRC Chairperson | |
| | Policy Owner | |
| | Department Executive | |
| | Chief Executive Officer | |

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