2019 Medicare Part D Transition Policy

Regulation/ Requirements	• 42 CFR §423.120(b)(3) • 42 CFR §423.154(a)(1)(i) • 42 CFR §423.578(b) • Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4
Purpose	To outline SCAN Health Plan's policy and procedure for complying with Medicare Part D transition requirements for enrollees prescribed Part D drugs that are not on a plan's formulary and Part D drugs that are on a plan's formulary but require prior authorization or step therapy, or that have an approved quantity limits lower than the beneficiary's current dose, under a plan's utilization management requirements. SCAN Health Plan will effectuate a meaningful transition for: (1) new enrollees into prescription drug plans following the annual coordinated election period; (2) newly eligible Medicare beneficiaries from other coverage; (3) enrollees who switch from one plan to another after the start of the contract year; (4) current enrollees affected by negative formulary changes across contract years; and (5) enrollees residing in long-term care (LTC) facilities.
Scope	This policy and procedure document applies to the following SCAN Health Plan Contract numbers: H5425_H5943_H9104
Policy	SCAN Health Plan and Express Scripts, Inc. (ESI), where delegated to manage, will support the Medicare-required transition process for enrollees who are prescribed either non-formulary Medicare Part D drugs or formulary Medicare Part D drugs with step therapy or prior authorization and/or quantity limits requirements.

Definitions	
CMS	Centers for Medicare and Medicaid Services – The United States federal agency responsible for administering the Medicare Health Insurance Program.
ESI	Express Scripts, Incorporated – the Pharmacy Benefit Management organization that is contracted with SCAN Health Plan to provide pharmacy services.
HICL	Hierarchical Ingredient Code List – One of First Data Bank's Smart Key that identifies the chemical ingredient of a drug.
LTC	Long Term Care – A facility that provides long-term care including the dispensing of Part D covered drugs.
MDD	Maximum Daily Dose – The maximum amount of a drug per dosing event as defined by the manufacturer and included on approved drug labeling.
RT	Route of Administration - One of First Data Bank's Smart Keys that identifies how a drug is administered (e.g., oral, injectable, etc.)
RTS	Refill Too Soon – An edit that exists indicating that a drug claim has been presented too early for the pharmacy to dispense to an enrollee.
SCF	Short Cycle Fill – Guidance and related edits pertaining to enrollees receiving certain drugs in a long-term care setting. Brand name solid oral dose drugs subject to short-cycle fill edits were defined by CMS and must be dispensed to patients in increments of 14-days-or-less, consistent with CMS requirements.

General Policy	
Task 1:	**Transition Requirements**
1.1	SCAN Health Plan policy and related processes ensure transition supplies are extended to members in the following scenarios: (1) new enrollees into prescription drug plans following the annual coordinated election period; (2) newly eligible Medicare beneficiaries from other coverage; (3) enrollees who switch from one plan to another after the start of a contract year; (4) current enrollees affected by negative formulary changes across contract years; (5) enrollees residing in long-term care (LTC) facilities; and (6) enrollees who change treatment settings due to a change in their level of care.
1.2	The transition procedures will apply to (1) Part D drugs that are not on a plan's formulary and (2) formulary Part D medications that require prior authorization, or step therapy or that have an approved quantity limits lower than the beneficiary's current dose under SCAN Health Plan's utilization management rules.
1.3	SCAN Health Plan will provide refills for transition eligible 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.
1.4	ESI has systems capabilities that allow 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 the 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.
Task 2:	**Transition Fills and Timeframes**
2.1	SCAN Health Plan provides new enrollees with a 90 day transition window starting on their first day of enrollment into SCAN Health Plan. The window applies for Part D eligible drugs dispensed at retail, home-infusion, long-term care and mail order pharmacies. A transition supply may be provided anytime during an enrollee's 90 day transition window.
2.2	If an enrollee leaves a plan and re-enrolls, the transition period begins again with the new effective date of enrollment, because it is possible that the enrollee's drug therapy changed while the enrollee was not with the plan and that therapy could be potentially interrupted. However, if there is no gap in coverage, there is no new transition period.
2.3	An enrollee who stays with the same contract number but changes PBPs will not be eligible for a transition supply if a plan is able to determine at the POS that there will be no interruption in medication therapy for the member (e.g., the plan is able to determine that the member is not taking a non-formulary medication based on the member's claims history from prior PBP or the formulary has not changed).
2.4	In the retail setting, non-LTC beneficiaries are eligible to receive at least a one-time temporary fill of at least a month's supply of medication (unless the prescription is written for less than a month's supply of medication in which case SCAN Health Plan will allow multiple fills up to a total of one month's supply of medication) anytime during the first 90 days of a beneficiary's enrollment in a plan, beginning on the beneficiary's effective date of coverage. Greater than a month's supply will be provided when the drug is prepackaged and cannot be dispensed at a lower day supply.
2.5	In the long-term care setting, LTC beneficiaries are eligible to receive a one month temporary fill of at least a month's supply (unless the enrollee presents with a prescription written for less), which will 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 in a plan, beginning on the beneficiary's effective date of coverage.
Task 3:	**Transition Across Contract Years**
3.1	For current enrollees whose drugs will be affected by negative formulary changes in the upcoming year, SCAN Health Plan will effectuate a meaningful transition by providing a transition

	process at the start of the new contract year.
3.2	The transition period for current enrollees extends for the first 90 days of the contract year. During this time, a current enrollee will be provided with a transition supply of an eligible drug anytime there is evidence of prior utilization of the drug within a 270-day look back window, unless the drug was previously filled as a transition supply. A look-back window begins on the last day of the previous plan year and extends 270 days prior. Prior utilization is confirmed based on the HICL and Route of Administration code associated with the drug on the incoming claim to any claim that paid for the enrollee for the same HICL and RT code. If the member is lacking utilization within the look-back window, this will preclude a transition supply from being extended to a current enrollee during their cross-plan year window as that member is not transition eligible.
3.3	SCAN Health Plan extends its transition policy across contract years should a beneficiary enroll in a plan with an effective enrollment date of November 1 or December 1 and need access to a transition supply. Special handling is in place to ensure appropriate treatment of those members with respect to a transition supply and a window that crosses a contract year. These new enrollees are ensured a minimum 90 day transition window under this across plan year transition process.
Task 4:	**New Prescriptions Versus Ongoing Drug Therapy**
4.1	A 270 day look-back is used by SCAN Health Plan to establish ongoing drug therapy. SCAN Health Plan 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.
4.2	Part D sponsors will not implement PA or ST requirements that are intended to steer beneficiaries to preferred alternatives within Protected Drug classes (six classes of clinical concern) for enrollees who are currently taking a drug. This is applicable to those beneficiaries already enrolled in the plan as well as new enrollees who were actively taking drugs in any of the six classes of clinical concern prior to enrollment into the plan. If a plan is unable to determine at the point of sale whether an enrollee is currently taking a drug (e.g., new enrollee filling a prescription for the first time), the plan will treat such enrollee as currently taking the drug.
Task 5:	**Emergency Supply for Long-Term Care Residents**
5.1	In the long-term care setting, after the transition period has expired, SCAN Health Plan's transition policy provides for a 31-day emergency supply of non-formulary Part D drugs or formulary Part D drugs that require prior authorization, or step therapy and/or have quantity limits (unless the enrollee presents with a prescription written for less than 31 days) while an exception or prior authorization is requested. Greater than a 31-day supply will be provided when the drug is prepackaged and cannot be dispensed at a lower day supply. Multiple 14-day or less supplies will be dispensed for brand name solid dose drugs consistent with SCF guidance to meet a minimum of a 31-day emergency supply requirement. The emergency supply process is automated in the ESI's adjudication system on SCAN Health Plan's behalf. Appropriate transition notifications will be generated for both enrollee and prescriber.
Task 6:	**Level of Care Changes**
6.1	For enrollees whose transition window has expired or for enrollees who are still within their transition window who have already received full transition supply and who present a drug claim that is otherwise transition eligible, the claim will reject with an appropriate reject code returned to the pharmacy. There is an "IF LEVEL OF CARE CHANGE, CALL HELP DESK" secondary messaging associated in these cases to inform the pharmacy to contact the ESI's help desk if a level of care change (e.g., discharge from a hospital to the home, etc.) has occurred for the enrollee. The ESI's help desk attendant provides an override code to the calling pharmacy to dispense the allowable transition supply. Appropriate transition notifications will be generated for both enrollee and prescriber.
Task 7:	**Edits for Transition Fills**
7.1	The ESI transition process will automatically effectuate a transition supply where appropriate for

	members, except where the following edits apply to the claim: (1) edits to determine Part A or B versus Part D coverage; (2) edits to promote safe utilization of a Part D drug (e.g., a beneficiary-level opioid claim MME edits, a 7-day supply hard edit to limit initial opioid prescription fills in the opioid naïve patients, quantity limits based on FDA maximum recommended daily dose such as APAP; early refill edits – RTS edits, etc.); (3) edits to prevent coverage of non-Part D drugs (e.g., drugs that can be used for Medicare Part D excluded indication, or drugs that may be dispensed for an indication that is not medically accepted). Secondary messaging is sent to the pharmacy to further inform the pharmacy on the reason for the edit and additional required action. Step therapy and prior authorization edits will be resolved at point-of-sale.
7.2	For enrollees 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 enrollees are allowed to access a refill upon admission or discharge (e.g., early refill edits can be overridden at POS upon these enrollees' admission or discharge).
Task 8:	**Cost-Sharing Considerations**
8.1	SCAN Health Plan ensures that appropriate cost-sharing amounts are applied to the transition supply claims. Cost-sharing for a temporary supply of drugs will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible beneficiaries. For non-LIS eligible beneficiaries, SCAN Health Plan will apply the same cost sharing for non-formulary Part D drugs provided during the transition that would apply for non-formulary drugs approved through a formulary exception in accordance with §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.
Task 9:	**Transition Notices**
9.1	ESI will send written notice via U.S. first class mail on the SCAN Health Plan's behalf to the SCAN's enrollee within three (3) business days of a first temporary transition fill adjudication consistent with CMS transition requirements. The letter will include: (1) An explanation of the temporary nature of the transition supply an enrollee has received; (2) Instructions for working with SCAN Health Plan and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the SCAN Health Plan's formulary; (3) An explanation of the enrollee's right to request coverage determination, including an exception; (4) A description of the procedures for requesting coverage determination, including an exception.
9.2	SCAN Health Plan will also ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice. A notification will be sent to the prescriber via fax, followed by mailing of a written notification if fax is not successful. The notifications are typically sent within five (5) business days of the temporary transition fill adjudication. The prescriber notification utilizes a separate letter template notifying them of the type of transition supply obtained by the member.
9.3	In circumstances where valid prescriber information is not available in national prescriber databases, SCAN Health Plan makes additional efforts to obtain correct contact information for those prescribers identified on the prescriber transition drop letter report, which is generated each business day by ESI, via reaching out to the network pharmacy, requesting prescriber contact information from the SCAN Health Plan Network Management Department, or other means consistent with Section 30.4.10.1 of Medicare Part D Manual, Chapter 6. After obtaining valid contact information, SCAN Health Plan notifies the prescriber directly of the enrollee's

	transition fill adjudication via any of the following communication channels: by phone call or by fax or by mailing the transition prescriber letter depending on which valid contact information was obtained through additional outreach efforts. In circumstances where prescribers have a transient relationship with a beneficiary; e.g., a hospital-based physician, or in situations where the transition claim has been reversed prior to the notice being issued, the prescriber transition notifications will not be generated.
9.4	ESI protects against Personal Health Information being released inappropriately through a series of edits that are employed prior to all member and prescriber mailings on SCAN Health Plan's behalf.
Task 10:	**Public Notice of Transition Policy**
10.1	SCAN Health Plan will make the Transition Policy available to the SCAN Health Plan enrollees via link from Medicare Prescription Drug Plan Finder to SCAN Health Plan web site and include in pre-and post-enrollment marketing materials as directed by CMS.
Task 11:	**Transition Period Extensions**
11.1	On a case-by-case basis, a transition period extension will be granted to provide necessary Medicare Part D drugs to a beneficiary if the beneficiary's 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).
11.2	This process will be managed by ESI's prior authorization representatives on SCAN Health Plan's behalf.
Task 12:	**Requests for Exceptions**
12.1	SCAN Health Plan has procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination, as described below.
12.2	ESI will process exception requests consistent with CMS requirements outlined in the Medicare Part D Manual, Chapter 18 on SCAN Health Plan's behalf made by a beneficiary, a beneficiary's authorized representative, a prescribing physician, or another prescriber for medical review of non-formulary drug requests and to determine whether to approve or deny the request, if appropriate, based on the exception criteria established for the non-formulary drugs.
12.3	Should ESI deny an exception request, the beneficiary and the prescriber will receive a notice that includes the information regarding the appeal rights and the description upon which the denial decision was based, including any specific formulary criteria/therapeutically appropriate formulary alternatives that must be satisfied for approval. A member may switch to these therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.
12.4	SCAN Health Plan will make available prior authorization or exceptions request forms upon request to beneficiaries, authorized representatives, and prescribing physicians. This will be accomplished via a variety of mechanisms, including mail, fax, email, and on SCAN Health Plan's website.
Task 13:	**Transition Process Oversight and Monitoring**
13.1	SCAN Health Plan oversees and monitors the Transition Supply process to ensure that its enrollees have access to necessary drugs as required by CMS guidance. Reporting is made available to show paid and rejected transition supply claims and member and prescriber communication mailings.
Task 14:	**Transition Policy Submission**
14.1	SCAN Health Plan will submit a copy of its transition policy to CMS consistent with CMS guidance.

Implementation Statement	
This document provides the following information: • A detailed explanation of the Express Scripts processes in support of transition supply requests within its adjudication system on SCAN Health Plan's behalf; • How a network pharmacy is notified when a transition supply is processed at the point of sale; • A description of the edits and an explanation of the process pharmacies must follow to resolve edits at the point of sale during the adjudication of a transition supply.	
I. The Express Scripts adjudication process that supports Transition Supply requirements operates as follows:	
1.	A Retail/ Mail-order/ Long Term Care (LTC) pharmacies receive a prescription request from: • An enrollee who is new to a CMS Plan and within their first 90 days of enrollment or • An existing enrollee at the beginning of a plan year who is established on a drug that has become transition eligible or • An enrollee who has experienced a Level of Care change or • An LTC resident enrollee in need of an emergency supply
2.	The pharmacy submits the prescription request and the drug is either non-formulary or formulary but with utilization management edits.
3.	ESI system verifies enrollment in the plan based on the eligibility set up requirements and files sent by the plan.
4.	ESI system verifies that the enrollee is within the transition period by interrogating the enrollee's available plan's eligibility history.
5.	ESI system verifies that the drug submitted qualifies for a Transition Supply based on the reject messaging about to occur. The rejects indicate one of the four transition eligible categories: Non-Formulary, Prior Authorization Required, Step Therapy and Quantity Limits rules.
6.	ESI system determines the allowable day supply for a Transition Fill.
7.	ESI system verifies that the enrollee is eligible for a transition supply of the drug based on the date of service on the claim falling within their Transition eligibility period.
8.	If an LTC enrollee is outside of a Transition Window and presents a transition eligible prescription drug request, an Emergency Transition Supply of up to 31 days will be paid automatically.
9.	A current enrollee is eligible for a Transition Supply when a paid claim is found within the last 270 days of the previous plan year for the same transition eligible drug (defined by HICL and Route of Administration) where the history claim did not pay under Transition logic.
10.	Using the submitted day supply from the claim, ESI system will verify that the claim is within the Transition Day Supply Plan Limit or has remaining transition day supply to be dispensed. • When greater than the Transition Day Supply Plan Limit is submitted, the claim will reject and a message will be returned to the pharmacy noting the allowable Day Supply/Quantity for a Transition Fill. The pharmacy is then notified to resubmit the claim within the limits presented in the message. • A greater than the Transition Day Supply Plan Limit will be provided if the drug is prepackaged and cannot be dispensed at a lower day supply.
11.	Daily monitoring is completed to ensure the members are receiving fills of the transition eligible drugs. The Pharmacy outreach is conducted for a resolution of transition rejects at point of sale, if

	any. The outreach is intended to achieve a paid transition supply claim for an enrollee.
12.	If a previous Transition Supply of the same drug was already dispensed within the same Transition Window, ESI system will verify whether a refill is allowable based on the previous days supply already dispensed (Refills for prepackaged drugs may exceed a maximum allowable transition day supply if they cannot be dispensed at a lower day supply).
13.	If a required full Transition Supply was found to have already been provided to the enrollee while in their transition window, the system will reject the claim and return an “IF LEVEL OF CARE CHANGE, CALL HELP DESK” secondary messaging to the pharmacy with instructions to contact the pharmacy help desk to determine if the enrollee is eligible for a level of care change Transition Supply.
14.	ESI system will calculate cost-sharing for the Transition Supply. Formulary drugs that require Prior Authorization or have Step Therapy and/or Quantity Limits will adjudicate for a cost-sharing tier on which the drug resides. When a transition supply is provided for a non-formulary drug, the plan will apply the same cost-sharing that the plan charges for non-formulary drugs approved through a formulary exception.
15.	ESI system will successfully adjudicate the claim and the pharmacy receives paid claim messages of either “TRANSITION FILL” or “EMERGENCY SUPPLY” depending on the type of adjudication which was completed.
16.	The required member notifications are mailed within 3 business days of the first fill of a Transition Supply (mail notifications for refills of a Transition Supply are not generated); however, if a transition criteria for the drug changes between fills, an additional letter with new criteria is generated even if the claim is a refill.
17.	The prescriber notifications are sent to the prescriber via fax, followed by mailing of a written notification if fax is not successful. The prescriber notifications are typically sent within 5 business days of the first fill of a Transition Supply (notifications for refills of a Transition Supply are not generated unless the transition criteria for the drug changes between fills).
18.	The Express Scripts adjudication process described above which supports Transition Supply requirements from CMS will automatically pay a claim barring certain instances where a reject is returned that require the pharmacy to take an action before resubmitting the claim and achieving a paid transaction as described below.
II.	Whenever an edit is in place that triggers the reject of a transition eligible claim for a transition eligible member, the pharmacy is required to take steps in order to achieve a paid transaction, if warranted (the steps required by the pharmacy are included in the associated messaging returned at point of sale).
1.	“Plan Limitations Exceeded” When this message is returned, the pharmacy is required to modify the submitted quantity to be equal to or less than the amount included in the point of sale message. Upon resubmission with corrected information, the transition supply claim will pay and be marked as a transition supply. One message text example is: “ALLOW QT nnnn.”
2.	“If Level of Care Change Call Help Desk” When this message is returned, the pharmacy is required to contact the Pharmacy Help Desk. A process is in place with the Help Desk and includes a series of questions that are posed to the pharmacy. If any of the questions are answered with YES, then a level of care change is confirmed. The Help Desk provides an override code to the pharmacy to place on the claim and

	the pharmacy is asked to resubmit. Upon resubmission with an override code, the claim will pay and be marked as a transition supply.
3.	"Refill Too Soon (RTS)" To limit inappropriate or unnecessary access to Part D drugs, an early refill edit will trigger a reject for a Transition eligible drug during an enrollee's Transition Period. The Express Scripts RTS logic considers paid claims, both mail and retail, for the same drug, dispensed in the previous 180 days to calculate an on-hand days' supply. The pharmacy may resubmit a claim with overrides for RTS at point-of-sale but limits the override use to two (2) for each of the following reasons within 180 days: • Therapy change, • Lost or spilled medication, • Vacation supply. The Express Scripts RTS allowance requires that a non-LTC enrollee has consumed at least 70% of their drug on-hand for any medication. The consumption requirement for enrollees in an LTC facility is 50%. This consumption requirement for enrollees in an LTC facility ensures that LTC members have appropriate and necessary access to their Part D benefit.
4.	"Short Cycle Fill (SCF)" To comply with CMS guidance related to the LTC pharmacy requirement to dispense certain Part D drugs in increments of 14-days-or-less, various edits exist that may trigger a reject for an enrollee during a transition period. All SCF related rejects occur prior to Transition supply processing and are required to be cleared by the LTC pharmacy before the claim will automatically pay as a transition supply. Once the rejects are cleared and a paid transition supply claim is adjudicated, the pharmacy receives one of the two paid claim messages of "TRANSITION FILL" or "EMERGENCY SUPPLY".
5.	"Part A vs. B vs. D or Part D vs. non-Part D determination required" Part A vs. B vs. D overlap drugs are excluded from transition supply processing by Medicare law as the determination must be made prior to adjudication for appropriate billing. Part D vs. non Part D drugs, including drugs that may be dispensed for an indication that is not medically accepted, are excluded form transition supply processing as the determination must be made first if a drug will be used for a Part D covered indication or not (e.g., for indication that is excluded from Part D coverage or otherwise restricted under Part D as defined in section 1927(d)(2) or for indication that is not medically-accepted (as defined in section 1860D-2(e)(4) of the Social Security Act).
6.	"Opioid Medication Edits" To comply with CMS requirements and decrease the opioids overutilization, there are safety edits for opioid medications; e.g., beneficiary-level opioid claim MME edits, a 7-day supply hard edit to limit initial opioid prescription fills in the opioid naïve patients, etc. These edits are applied during transition consistent with Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4.8.