Transition Policy 2018

Purpose:

Provide members who are new to the plan or transitioning to or from a LTC, hospital or other health care setting/benefit (i.e. hospice), to obtain a temporary supply of medications to allow for continuity of care.

Scope:

MMP

Policy Statement:

Neighborhood Health Plan works with our , Pharmacy Benefit Management to provide an appropriate transition process with regard to (1) the transition of new enrollees into prescription drug plans following the annual coordinated election period; (2) the transition of newly eligible Medicare beneficiaries from other coverage; (3) the transition of enrollees who switch from one plan to another after the start of the contract year; (4) enrollees residing in long-term care (LTC) facilities; (5) enrollees who change treatment settings due to changes in level of care; and (6) current enrollees affected by negative formulary changes across contract years, consistent with the requirements set forth in Centers of Medicare and Medicaid Services (CMS) guidance for participation in the Medicare Part D Drug Program. Neighborhood Health Plan and our Pharmacy Benefit Management will also provide an appropriate transition process that meets the criteria set forth above and any other criteria established by a state and CMS.

This transition process is applicable to Non-Formulary drugs, which includes Non-Formulary Part D drugs and Non-Formulary non-Part D drugs covered under the Medicare-Medicaid Plan (MMP) Financial Alignment Demonstration (Demonstration). This process applies to drugs that are (1) Part D drugs that are not on our formulary, (2) drugs previously approved for coverage under an exception once the exception expires, and (3) Part D drugs that are formulary but require prior authorization, or that have an approved quantity limit (QL) lower than the beneficiary's current dose. Members receiving a STEP therapy drug during the transition period will be grandfathered in. For non-Part D drugs this transition process applies to non-Part D drugs that are on Neighborhood's formulary but require prior authorization or have a quantity limit. Neighborhood covers all state covered non-Part D drugs.

Minimum Part D Drug Transition Requirements for Rhode Island MMPs (applicable to non-formulary Part D drugs)		
New Member Transition	**LTC**	**Non-LTC**
Transition Period	Within the first 90 days of membership	Within the first 90 days of membership
Temporary Supply Amount	98 days	30 days
Current Member Transition	**LTC**	**Non-LTC**
Transition Period	90 days of calendar year	90 days of calendar year
Temporary Supply Amount	98 days	30 days

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	
Temporary Supply Amount	90 days	

Definitions:

Level of Care Change: Occurs when an Enrollee 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.

Network Pharmacy: A licensed pharmacy that is under contract with Neighborhood Health's Pharmacy Benefit Management to provide covered Part D drugs to neighborhood members.

PBM (Pharmacy Benefit Manager): The PBM manages the pharmacy claims process and the Transition Process for Neighborhood.

Transition Procedure:

This procedure is delegated to our PBM. What follows is the PBM procedure.

Implementation Statement
The claims processing system performs an initial qualification review before determining a claim may be transition eligible. After this initial validation, if the claim is not denying for A or B versus D, CMS Excluded, and/or unit dose, then the claim is transition eligible and continues in Part D transition logic. The claims processing system uses new member logic to determine if a member should be considered new. If the claim meets all conditions, the member is considered new and the claim moves directly to initial eligibility and bypasses further existing member evaluations. If the claim does not meet any one of the conditions, then the claim will exit the new member eligibility and will continue in the existing member logic. To qualify as an existing member, the member must have historical usage of a drug. If the claims processing system can determine adequate historical usage, then the normal initial eligibility transition period applies.

If a claim does not proceed to Part D transition logic, it may process under non-Part D transition logic. If the claim does not fall into one of the following categories, then the claim is transition eligible and will continue to non-Part transition logic: Part D claims, claims with no denying errors, Protected Class claims, and claims paid by Prior Authorizations. The claims processing system uses new member logic to determine if a member should be considered new. If the claim meets all conditions, the member is considered new and the claim moves directly to initial eligibility and bypasses further existing member evaluations. If the claim does not meet any one of the conditions, then the claim will exit the new member eligibility and will continue in the existing member logic. To qualify as an existing member, the member must have historical usage of a drug. If the claims processing system can determine adequate historical usage, then the normal initial eligibility transition period applies. When a claim processes under non-Part D transition, the claims processing system

will not distinguish long-term care (LTC) and non-LTC claims.

1. **Transition Process**

Enrollees will be eligible to receive a temporary supply of a Non-Formulary drug anytime from the beginning of the enrollee's effective-date of coverage for the CMS contract year to the end of the MMP required transition period established by CMS and a state. This transition period applies to retail, home infusion, LTC, and mail-order pharmacies. The length of the transition period and day supply for Part D and non-Part D drugs are established for MMPs in the claims processing system in accordance with federal, state, and client-specific requirements.

If our PBM is unable to make a distinction between a brand-new prescription for a Non-Formulary drug and an ongoing drug therapy at the point of sale, The PBM will regard the prescription as ongoing and apply the transition process standards set forth below.

Enrollees are entitled to receive a transition supply from a Network Pharmacy or an out of network (OON) pharmacy. Generally, out of network pharmacies are not permitted to submit online claims to the PBM. The point of sale transition medication edits set forth below cannot be applied to out of network pharmacy claims until after they have been received by the PBM. Therefore, enrollees obtaining covered drugs at an OON pharmacy will be required to pay the OON pharmacy's usual and customary price at the point-of-sale, submit a paper claim to our PBM on Neighborhood's behalf, and wait for reimbursement from Neighborhood, unless the OON Pharmacy accepts thePBS's Network Pharmacy reimbursement rate.

The PBM will ensure that Network Pharmacies can override prior authorization and step therapy edits so that the enrollee is able to leave the pharmacy with a Non-Formulary drug without unnecessary delays. Specifically, the claims processing system is programmed to automatically pay (without pharmacist intervention) for Non-Formulary drug claims that satisfy the transition coding requirements.

a. However, the PBM will still apply the following utilization management edits at the point of sale:

    1) Edits to determine Part A or B versus Part D coverage;

    2) Edits to prevent coverage of non-Part D drugs except non-Part D drugs a state will cover under the Demonstration; and

    3) Edits to promote safe utilization of a Part D drug and a non-Part D drug.

b. Utilization management edits, such as quantity limit safety edits or drug utilization edits based on approved product labeling (such as maximum FDA-recommended dose), may result in less than the prescribed amount being dispensed. In this case, refills will be made during the transition period to provide for at least the minimum state-required day supply in a retail setting and the minimum state-required day supply in the LTC setting, if applicable. For Part D claims, these utilization management edits are subject to the exceptions process.

c. In the outpatient setting, enrollees are eligible for a temporary supply of a Non-Formulary drug for at least the minimum MMP state-required days of medication (unless they present a prescription written for less than the minimum MMP state-required day supply, in which case the PBM will allow multiple fills to provide up to a total of the minimum MMP state-required day supply). Depending on state-specific MMP requirements established by CMS and a state, such a

temporary fill may be a one-time fill only. The PBM will provide enrollees with notice that they must either switch to a drug on the Neighborhood's formulary or get an exception to continue taking the requested drug. If a new enrollee submits a non-formulary exception request and our PBM denies the request for failure to meet the medical necessity rules, the PBM will outreach to the prescriber to suggest switching the enrollee to therapeutically appropriate formulary alternatives.

1) Neighborhood's PBM will ensure that new and continuing enrollees who submit a prescription for a drug that is limited by commercially available package sizes (unbreakable packages), receive as many packages as necessary to meet the minimum MMP state-required day supply even if it results in a days' supply greater than the minimum MMP state-required day supply. The following examples assume the minimum MMP state-required day supply is 30 days of medication:

d. Enrollees who are LTC facility residents are eligible for a 91-98 day temporary supply of a Non-Formulary drug with multiple refills as necessary dispensed in 14-days-or-less increments, during the MMP required transition period established by CMS and a state of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage.

2. <u>Emergency Supplies/Transition Extension</u>

a. The PBM will provide at least a 31-day emergency supply, unless the prescription is written for less than 31 days, of a Non-Formulary drug to enrollees who are LTC facility residents after the transition period has expired, while a prior authorization (including step therapy) or exception request is being processed.

b. The PBM will make arrangements to continue to supply necessary Part D and non-Part D drugs to an enrollee via an extension to the transition period on a case-by-case basis, to the extent that their prior authorization (including step therapy) or exception request has 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), or other such situations that may require an extension of the transition period, such as OON transition claims received after the end of the transition period.

3. <u>Level of Care Change</u>

Current enrollees who experience a Level of Care Change are eligible to receive a transition supply of a Non-Formulary drug upon admission or discharge from an applicable setting.

a. The claims processing system compares the enrollee's current "residence" and "place of service" to the enrollee's "residence" and "place of service" for previous claims. If these values are different, it is an indication that the enrollee has experienced a Level of Care Change.

b. Where the new treatment setting can be determined based on location code, the claim will automatically process as a transition claim without pharmacist intervention, and will override

utilization management edits (i.e. prior authorization and step therapy), other than those described under 1.b.

c. The PBM will not apply early refill edits that would limit appropriate and necessary access to Part D Drugs by enrollees who experience a Level of Care Change. These enrollees will be allowed to obtain a refill of their prescription(s) upon admission to or discharge from a LTC facility.

d. Where the new treatment setting cannot be determined based on location code, and the Network Pharmacy is aware that the member's prescription is related to a Level of Care Change, the Network Pharmacy must call the PBM's Provider Helpdesk to request an override of any utilization management and or non-formulary edits other than those described under 1.b.

e. If an enrollee has more than one level of care change in a month, the Network Pharmacy must call the PBM Provider Helpdesk in order to process the override request.

4. <u>Transition Notices</u>

a. Neighborhood will provide the PBM with the approved transition notice for use in this process.

b. The claims processor will provide the PBM daily reports of point-of-sale overrides that indicate that a transition supply was dispensed. These reports will serve as a guide for programming the PBM's coverage determination system. The coverage determination system will then generate the transition notice.

c. The PBM sends the transition notice to the applicable enrollee via U.S. First Class mail, within three (3) business days of the date the transition supply is dispensed. This applies to transition supplies dispensed to long-term care residents who are dispensed multiple supplies of a Part D drug in increments of 14-days-or-less. Our PBM will make reasonable efforts to notify the prescriber of the transition supply for affected enrollees. The prescriber's transition notice will be sent by fax and will only include the drug(s) they prescribed.

d. The notice will include, at a minimum:

1) That the transition supply provided is temporary and may not be refilled unless a coverage determination is approved;

2) That the enrollee should work with the Neighborhood as well as his or her health care provider to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on Neighborhood's formulary and that will likely reduce his or her costs;

3) That the enrollee has the right to request a coverage determination (including a formulary exception), the timeframes for processing the coverage determination, and the member's right to request an appeal if Neighborhood issues an unfavorable decision; and

4) The Neighborhood's procedures for requesting a formulary exception.

e. The PBM makes the prior authorization or exceptions forms available upon request to both enrollees and prescribers through a variety of mechanisms, including mail, fax, and e-mail. Neighborhood posts these forms on their websites and provides the forms to members and prescribers upon request.

f. Network Pharmacies must post and distribute a hard copy of the "Medicare Prescription Drug Coverage and Your Rights" (CMS-1047) standard notice to enrollees in cases when a prescription cannot be filled as written. (See Policy CSCD-3-01 Notice Requirements by Network Pharmacists for Standard Coverage Determinations.)

g. Network Pharmacies are strongly encouraged to provide enrollees with point of sale notification of the transition supply. The PBM ensures that the claims processor provides point of sale messaging to Network Pharmacies that indicates that a particular fill is a transition supply.

5. Cost-Sharing

a. Neighborhood has no cost sharing

6. Transition Across Contract Years

a. In order to prevent coverage gaps, the PBM will provide a transition supply of the requested prescription drug beginning January 1 and provide enrollees with the required transition notice.

b. The PBM will provide a temporary supply of the requested prescription drug (where not medically contraindicated) and provide enrollees with notice that they must either switch to a drug on Neighborhood's formulary or get an exception to continue taking the requested drug. This applies to drugs that were removed from the prior year's formulary as well as drugs that remain on the upcoming year's formulary but include new prior authorization or step therapy requirements.

Our PBM will extend the transition policy across contract years should a beneficiary enroll into a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.

7. Availability of the Transition Policy

This policy will be posted on the Neighborhood Health Plan website. A link to this policy from the Medicare Prescription Drug Plan Finder will be made. Additionally, as applicable pertinent information from this policy will be included in Pre- and Post- enrollment marketing materials as directed by CMS. This will include but not be limited to the member handbook and List of Covered Drugs.

SOURCE DOCUMENTS

42 CFR Parts 400, 403, 411, 417 and 423 – Medicare Prescription Drug Benefit Final Rule
Medicare Prescription Drug Benefit Manual - Chapter 5 - Benefits and Beneficiary 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 Enrollees 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