

CY 2016 Medicare Part D CMS Transition Process

H0602

Rocky Mountain Health Plans (RMHP) will support the CMS required transition process for enrollees prescribed Part D drugs that are non-formulary or subject to utilization management edits by offering an integrated solution at a retail, home delivery, long term care, home infusion, safety net or ITU pharmacy. RMHP 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 the RMHP Part D formulary, it will effectuate a meaningful transition for:

- New enrollees to the plan at the beginning of the contract year, January 1, 2016, following the annual coordinated election period,
- Newly eligible Medicare beneficiaries who have transitioned from other coverage at the beginning of a contract year
- Enrollees joining the plan from another Part D plan after January 1, 2016,
- Enrollees residing in long-term care (LTC) facilities,
- Current enrollees affected by formulary changes from one contract year to the next,
- In some cases, enrollees who change treatment settings due to a change in level of care.
- In some cases, current enrollees affected by formulary changes from one contract year to the next

RMHP will utilize MedImpact as our claims processor. The medication transition process described below is consistent with the policies of MedImpact and capabilities of their pharmacy claims adjudication system.

During the first 90 days of enrollment beginning on enrollee's effective date of coverage (or during the first 90 days of the new plan year in the case of current enrollees), Rocky Mountain Health Plans will allow enrollees a one-time temporary fill for at least a 30-day supply, unless written for less than a 30 day supply, for all Part D medications that are non-formulary, subject to prior authorization, or subject to step therapy edits. If the prescription is written for less than 30 day supply, refills are allowed to provide up to a total of 30 day supply of medication. After the temporary fill, continuation of drug coverage will be subject to authorization by the health plan. RMHP may continue to provide additional, limited supply of a drug after the transition period has expired in certain cases where the enrollee has a formulary exception request that is still in progress.

For members residing in long term care facilities, the transition supply of medication will be 91 days, 93 days, or 98 days depending upon the dispensing increment (7, 14, or 31 days). Refills will be provided if needed during the first 90 days of a beneficiary's enrollment in the plan to the fully allowed day supply. After the transition period has expired, the enrollee may receive an emergency 31 day supply of non-formulary Part D drugs while an exception or prior authorization is requested. Early refill edits will not be implemented for enrollees entering or being discharged from a long term care facility.

There may be cost sharing for a temporary supply of drugs provided under this transition process. Cost-sharing for a temporary supply of non-formulary drugs or drugs subject to utilization management edits for low-income subsidy (LIS) eligible enrollees will never exceed the statutory maximum co-payment amount for low-income subsidy (LIS) eligible enrollees. For non-LIS eligible enrollees, cost-sharing for a temporary supply of non-formulary drugs will be the same as the plan would charge for non-formulary drugs approved via the formulary exception process. Cost sharing

for a temporary supply of drugs subject to utilization management edits that are provided pursuant to this transition process will be the same copayment that would apply once the utilization management edits are met.

Rocky Mountain Health Plans will ensure the medication transition policy, prior authorization and formulary exception request forms are available to enrollees and prescribing physicians via mail, fax, and email as well as the Rocky Mountain Health Plans website, www.rmhp.org. Enrollees who need extra assistance regarding the medication transition process are contacted. The transition policy will be available to enrollees via link from the Medicare Prescription Drug Plan Finder to sponsor web site including pre-and post-enrollment marketing materials as directed by CMS.

The Transition Process requirements will be applicable to:

- Part D medications that are non-formulary
- Part D medications that are formulary but:
 - Require a Prior Authorization
 - Are a part of a Step Therapy program
 - Require quantity limits

Transition supplies for drugs requiring prior authorization or step therapy will be automatically effectuated and resolved at the point of sale for eligible members receiving transition eligible medications. Utilization management edits that may not occur at the point of sale will only apply in the following cases:

- 1) Edits to determine Part B vs. Part D coverage
- 2) Edits to prevent coverage of non-Part D drugs
- 3) Edits to ensure and promote safe utilization of Part D drugs, including maximum daily dose or quantity that ensures medications are dispensed within FDA labeled safety guidelines

In such case that a transition supply cannot be automatically effectuated due to one of these situations, the RMHP Pharmacy Help Desk will assist the pharmacy in adjusting the claim or by entering an override. Such resolution will then allow the transition supply to adjudicate.

All transition processes will be 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-service.

Notification

Every business day, RMHP will receive a report from MedImpact identifying enrollees that have received a transition supply of medication on the prior business day. This report is used to generate a transition supply notification letter. This letter is mailed by U.S. first class mail, within 3 business days after adjudication of the first temporary fill, to each affected enrollee and his or her prescriber. Long term care residents receiving multiple 14 day or less short cycle fills of a medication, consistent with the requirements under 43.154, will also receive this letter within 3 business days of adjudication of the first temporary fill. This letter explains the transition supply, offers information to enable enrollees to switch to an alternative drug included in the formulary, and provides information

to assist the enrollee in requesting an exception to the RMHP formulary. The letter specifically contains:

- (1) an explanation of the temporary nature of the transition supply an enrollee has received;
- (2) instructions for working with the plan sponsor and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary
- (3) an explanation of the enrollee's right to request a formulary exception and
- (4) a description of the procedures for requesting a formulary exception.

The CMS model Transition Notice, via the file and use process, will be used. If the CMS model Transition Notice is not used, a non-model CMS approved Transition Notice will be used. The non-model Transition Notice will be submitted to CMS for approval via the 45 day review process.

Emergency Supply

The transition policy includes an automated process that allows enrollees residing in long-term care facilities an additional transition supply of an eligible drug once they are outside of the transition window if the enrollee did not already receive a transition supply and associated notification while in their transition window. These automated emergency transition supply claims allow up to either a 31 day supply or 14 day supply with refills in the case of short cycle fill drugs. Emergency transition supplies generate both member and prescriber notifications as required for transition supply claims.

Six Classes of Clinical Concern

Per CMS guidance, members transitioning to RMHP while 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 the plan. Utilization management restrictions and/or non-formulary status, which may apply to new members naïve to therapy, are not applied to those members transitioning to RMHP on agents within these key categories. The six classes include:

- 1) Antidepressant;
- 2) Antipsychotic;
- 3) Anticonvulsant;
- 4) Antineoplastic;
- 5) Antiretroviral; and
- 6) Immunosuppressant (for prophylaxis of organ transplant rejection).

Level of Care Changes

When an enrollee has a level of care change (e.g. admitted to LTC facility) they may need additional supplies of their medications. Any time an enrollee is outside of their transition window and present a prescription for a non-formulary drug that is otherwise transition eligible, the claim will hard reject with appropriate rejection codes returned to the pharmacy. There is additional secondary messaging associated in these cases to inform the pharmacy to contact the RMHP pharmacy help desk if a level of care change has occurred for the enrollee. If RMHP determines that the member has experienced a level of care change (including admission to or discharge from a nursing facility, hospital, or long-term care facility) then the pharmacy will be provided a code to place on the claim and the pharmacy is asked to resubmit. Upon resubmission with the override code, the claim will pay and be marked as a transition supply. Early refill edits will not be used to limit appropriate and necessary access to Part D benefits for enrollees being admitted or discharged from a Long Term Care facility.

Medical Review

Rocky Mountain Health Plans exceptions process takes into account special circumstances to ensure that enrollees have access to non-formulary medications. Through our PBM, MedImpact, there are appropriate systems capabilities that allow provision of a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow RMHP and the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of a formulary exception request to maintain coverage of an existing drug based on medical necessity. If clinically necessary, arrangements will be made to continue to provide 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 final decision on drug therapy is made (either through a switch to an alternative formulary drug or an approved formulary exception request).

Medical review of formulary exceptions requests is performed by appropriately credentialed M.D.'s and Pharm.D.'s at the health plan. Requests for exception to the formulary is performed according to evidence based clinical criteria established by the RMHP Pharmacy and Therapeutics Committee.

If the formulary exception request does not meet established criteria for medical necessity, the prescriber is notified and advised that one of the previously communicated therapeutic alternatives should be prescribed. A notice of denial is sent to the beneficiary and prescribing provider, informing both of appeal rights and instructions regarding appeal.

IMPLEMENTATION STATEMENT

The following is a detailed description of how the transition process will work in the RMHP contracted adjudication system for each of the enrollee categories, the transition pharmacy notification processes, and the process pharmacies follow to resolve transition medication edits

- A retail, mail order, or long term care pharmacy receives a prescription request for a non-formulary drug, or a drug that requires prior authorization, step therapy, or quantity limits
- The claims adjudication system verifies that the enrollee is a member in RMHP Part D plan
- The claims adjudication system verifies that the enrollee is within the transition window of time by querying the eligibility system
- The claim adjudication system verifies the drug submitted qualifies for a transition supply based on the rejection message that would otherwise occur
- The transition eligible categories include:
 - a. Non-formulary
 - b. Prior authorization required
 - c. Step therapy rules apply
 - d. Quantity limits apply (for non-drug safety reasons)
- The system determines the allowable days supply for a transition fill
- The system verifies that the enrollee is eligible for a transition supply of the drug, requiring that the date of service on the claim falls within the transition window.
- A long term care enrollee who is outside the transition window and has no claim history within the same plan year that matches the new drug request is eligible for an emergency transition supply.
- The system will allow refills on transition claims up to the point where the transition day supply obligation has been met or exceeded by the last fill
- RMHP will ensure that refills are provided under this transition policy for prescriptions dispensed for less than the written amount due to quantity limits for safety concerns or due to constraints associated with approved product labeling
- If a previous transition supply of the same drug was already dispensed within the same transition window, the system will verify whether a refill is allowable based on the previous day supply already dispensed.
- If a required full transition supply was found to have already been provided to the enrollee while in the transition window, the system will hard reject the claim and return an IF LEVEL OF CARE CHANGE message to the pharmacy with instruction to contact the RMHP pharmacy help desk to determine if the enrollee is eligible for a transition supply.
- The system will calculate cost-sharing for the transition supply. Formulary drugs that require prior authorization, step therapy, or quantity limits will be priced within the copayment tier on which the drug resides. This ensures the temporary supply of drugs provided will be subject to the same copayment as would be charged once the utilization management edits are met. When a temporary supply of non-formulary drug is provided, copayment will be the

same cost sharing that applies to drugs approved via the formulary exception request. Any transition supply for a LIS eligible enrollee will have cost sharing apply that never exceeds the statutory maximum amounts for LIS enrollees.

- The system will successfully adjudicate the claim and message the pharmacy with a paid response of either "transition fill" or "emergency supply" depending on the type of adjudication which was completed.
- The required member and prescriber notifications are mailed within three business days of the first fill of a transition supply (mail notifications for refills of a transition supply are not generated).
- The adjudication system described above which supports transition supply requirements from CMS will automatically pay a claim barring certain instances where a hard reject is returned that requires the pharmacy to take action before resubmitting the claim and achieving a paid transaction.
- Whenever an edit is in place that triggers the hard reject of a transition eligible claim for a transition eligible member, the pharmacy is required to take steps in order to achieve the paid transaction. The steps required by the pharmacy are included in the associated messaging returned at the point-of-sale. The hard reject messaging conditions that may be triggered during adjudication of a transition supply eligible claim are:
 - a. Plan Limitations Exceeded
 - i. 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 be marked as a transition supply.
 - b. If Level of Care Change, Call Help Desk
 - i. When this message is returned, the pharmacy is required to contact the pharmacy help desk. If the help desk determines that the member has experienced a level of care change (including admission to or discharge from a nursing facility, hospital, or long-term care facility) then the pharmacy will be provided a code to place on the claim and the pharmacy is asked to resubmit. Upon resubmission with the override code, the claim will pay and be marked as a transition supply.
 - c. Maximum Daily Dose Exceeded
 - i. For patient safety reasons, the recommended maximum daily dose will not be exceeded when dispensing a transition supply of a drug. When this message is returned, the pharmacy is required to modify the submitted quantity to be equal to or less than the number included in the message. Upon resubmission, these transition supply claims then automatically pay and will be marked as a transition supply.
 - d. Refill too soon
 - i. To limit inappropriate or unnecessary access to part D drugs, an early refill edit will trigger a hard reject for a transition eligible drug during an enrollee's transition period. The adjudication system 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 "refill too soon" at point-of-sale but must limit the override use to two for each of the following reasons within 180 days

1. therapy change
 2. vacation supply
- e. Medication B vs D determination required
- i. If a drug cannot be determined as Part D at the point-of-sale, the pharmacy must call the pharmacy help desk for a coverage determination. If the drug is determined to be Part D, an override will be placed so the claim can adjudicate. If the drug is determined to be Part B, an override will be placed so the drug can adjudicate with the appropriate part B flag.
- f. Short Cycle Fill
- i. To comply with CMS guidance related to the long-term care pharmacy requirement to dispense certain Part D drugs in small increments, various edits exist that may trigger a hard reject for an enrollee during a transition period. All short cycle fill related hard rejects occur prior to transition supply processing and are required to be cleared by the long-term care 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 two paid claim messages, "transition fill" or "emergency supply".

Additional steps for current enrollees across plan year:

In order to provide a transition process consistent with the transition process required for new enrollees beginning in the new contract year the following steps are taken:

- Rocky Mountain Health Plans will ensure that an ANOC is sent to members reflecting all changes in the formulary
- A current enrollee is provided with a 90 day cross plan year transition window at the beginning of each contract year. During this time, a current enrollee will be provided with a transition supply of an eligible drug any time there is evidence of prior utilization of the drug within a 120 day look back window. A look back window begins on the last day of the previous plan year and extends 120 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 within the same CMS contract ID for the same HICL and Route Code. Lacking prior utilization within the look back window will preclude a transition supply from being extended to a current enrollee during their cross plan year window.

Additional steps for current enrollees that enrolled late in the previous plan year

For enrollees that joined RMHP in the last months of the previous contract year, the transition process ensures appropriate treatment of those members with respect to a transition supply and a window that crosses the contract year. These enrollees are ensured a full 90 day transition window. During the first 90 days of enrollment these beneficiaries are treated as new enrollees and afforded a transition supply according to the RMHP transition policy for new enrollees as described in this document. Once these enrollees cross into the new contract year, the transition process will ensure that the member continues to be treated as a new enrollee for purposes of transition eligibility, or, in the case where the transition eligible drug claim encounters a new or different transition category in the new plan year, an additional, full transition supply will be provided even though the member

may have received either a full or partial transition supply of the same drug in the previous year though for a different transition category. This transition policy will extend across contract years should a beneficiary enroll in the plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply of medication. This transition process ensures that members enrolling late in the plan year, November or December, are afforded a full 90 day transition eligible window that crosses into the new plan year.