Department:	Pharmacy Management	**Original Approval:**	10/26/2006
Policy & Procedure No:	PM553	**Last Approval:**	05/26/2026
Policy and Procedure Title:	Medicare Transition Process Policy and Procedure		
Approved By:	Clinical Services Leadership Team		
Dependencies:	N/A		

Purpose

This policy defines the manner in which Community Health Plan of Washington (CHPW) transitions new members into its Medicare prescription program to ensure continuity of care.

Policy & Procedure

CHPW's Transition Process policy accommodates the immediate prescription needs of qualified members and allows sufficient time to ensure a smooth transition to a therapeutically equivalent medication with the prescriber or the completion of an exception request to maintain coverage of an existing drug based on medical necessity.

Transition Requirements:

The processes in place for transitioning members into the prescription program applies as follows:

- The transition of new enrollees into prescription drug plans following the annual coordinated election period;
- The transition of newly eligible Medicare beneficiaries from other coverage;
- The transition of enrollees who switch from one plan to another after the start of the contract year;
- Members who change in level of care (ex. Home to Long Term Care, Home to Hospital, or Long Term to Home).
- Enrollees residing in LTC facilities; and,
- Current enrollees affected by negative formulary changes from one contract year to the next.

The transition process requirements will be applicable to:

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Part D drugs that are not on the formulary, drugs previously approved under an exception and the exception has expired, and lastly Part D drugs that are on the formulary but require prior authorization, step therapy, or have an approved QL lower than the requested dose, under CHPW's drug utilization rules.

Transitional Supply:

CHPW allows up to a 30-day supply of a non-formulary drug, as well as a formulary drug that remains on formulary but to which new prior authorization or step therapy restrictions have been added, for members who are eligible for transition. The transition supply excludes drugs that are not Part D eligible.

Direct Member Reimbursement (DMR) transition claims:
There is a three-year window for members to submit a DMR claim for reimbursement. Similar to coverage determinations, the PBM will review these requests and send member notifications as appropriate.

Transition Terms

For members who were in the plan last year and aren't in a long-term care facility:
CHPW will cover a temporary supply up to 30-days' supply of medications during the first 90 days of the year for drugs that are newly restricted (non-formulary or step therapy) and in the member's prescription medication list before end of year. This temporary supply will be for a maximum of a 30-day supply (can be one-time fill or multiple fills up to 30-day supply), or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

For members who are new to the plan and aren't in a long-term care facility:
CHPW will cover a temporary supply of the drug one time only during the first 90 days of membership in the plan across contract years if necessary. This temporary supply will be for a maximum of a 30-day supply (one time fill or multiple fills of up to 30-day supply) or less if the prescription is written for fewer days.

For members who are new to the plan and are residents in a long-term care facility:
CHPW will cover a temporary supply of the drug during the first 90 days of membership in the plan, across contract years if necessary. Members are eligible to receive up to a 31-day supply consistent with the dispensing increment in the long-term care setting. If needed, CHPW will cover additional refills during the first 90 days in the plan.

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For those who have been a member of the plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:
CHPW will cover up to a 31-day supply or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply.

Current members who are residents of a long-term care facility may also experience a level of care change (a member changes from one care setting to another, e.g., from a hospital to a long-term care facility) that may result in an unplanned transition periods. Members and providers are able to utilize the exceptions and appeals process to address medication needs as a result of unplanned transitions.

Written Notice
CHPW will provide members with CMS-approved written notice regarding transition process within three (3) business days of adjudication the temporary transition fill. This notice will inform the member of the temporary nature of their transition supply and include instructions for requesting a coverage determination from a variety of mechanisms including phone, fax or by mail.

Transition Extension
It may be necessary for CHPW to extend the transition period for member medications on a case-by-case basis. Specifically in the event that a member appeal or exception request has not been processed by the end of a transition period, CHPW will review the member's request for a transition extension to accommodate the member's immediate need until a decision is made to transition the member to an alternative formulary drug or an exception request is approved.

Member Cost For Transition Fills
Transition fills will be the same cost to the member as though an exception request had already been approved. Low Income Subsidy (LIS) members will not be charged greater than the statutory maximum co-payment for LIS eligible members.

Utilization Management During Transition
During the transition period all non-safety-based utilization management edits will be overridden. Safety based edits (such as quantity limits) will still be applicable where necessary. A prior authorization to determine Part B versus Part D coverage for medications may be applied; however, such an authorization may be overridden at point of sale by the pharmacist if they have sufficient information to determine appropriate coverage.

Refills Of Transition Supplies
Multiple fills will be granted during the transition period (up to 30 days' supply total) if a medication must be dispensed at a smaller days' supply due to the requirements of the prescriber, pharmacy supply, safety-based quantity limits, or any other reason. If a medication is pre-packaged in such a way that a single fill will exceed the 30 days' supply limit, one fill will

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be allowed to exceed the limit. In addition, pre-packaged medications where the first fill does not grant the entire 30 days' supply will be granted additional transition fills until the member has received at least 30 days' supply of medication.

Member Access To Transition Information
Members may access this policy via the Medicare Plan Finder or Community Health Plan of Washington Medicare websites. It will be included in pre- and post-enrollment marketing materials. In addition, members may contact CHPW Customer Service for an explanation of their transition rights and to access resources for requesting a coverage determination or communicating with their provider about switching to a preferred alternative.

Administration
The administration of this transition policy, including transition notices to members and physicians, is delegated to CHPW's Pharmacy Benefit Manager (PBM). CHPW will exercise appropriate monitoring and oversight of these functions to ensure member needs are met and contractual obligations are fulfilled.

General Procedures
1. The transition procedures will apply to non-formulary Part D medications and formulary Part D medications that require prior authorization or that are a part of a step therapy program that may also have quality level limit (QL) requirements.
2. Eligible non LTC beneficiaries may receive a single fill or multiple fills up to a 30-day supply unless the prescription is written for a lesser period. LTC beneficiaries are eligible to receive up to a 31 day fill consistent with the dispensing increment in the long-term care setting.
3. For new or returning enrollees, if the prescribed medication is non-formulary or requires step therapy or prior authorization, or is limited due to QLL, PBM will implement soft edits to verify that the new enrollee is in the transition period and allow claims to process without hard edits. The transition period extends for the first 90 days of eligibility in the plan.
4. For current enrollees, PBM's Clinical Program Manager will work with CHPW to develop an annual notice of change file that reflects negative formulary changes (including changes to step therapy and prior authorization requirements) across contract years. This will be completed for purposes of determining transition fill eligibility. The transition period extends for the first 90 days of contract year.
5. At the point of sale on 1/1 of a plan year, PBM's systems identify medications that are affected by the plan's negative formulary changes (changing from formulary status to non-formulary, step-therapy, and/or prior authorization medications) across plan years. Current enrollees who are using medications affected by these formulary changes during the prior year are eligible for transition fills for the affected medications. A brand-new prescription for a non-formulary drug will not be treated any differently than

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an ongoing prescription for a non-formulary drug when a distinction cannot be made at the point of sale for transition claims adjudication.

6. At the time a claim for transition fill is paid, as appropriate, the PBM's messaging will state:
    - Paid under transition fill. Prior authorization required.
    - Paid under transition fill. Non-formulary medication.
    - Paid under transition fill. Other reject.

If and when new HIPPA transaction standards are implemented, PBM will re-assess this messaging protocol, and make any necessary changes to maintain compliance.

1. Once the claim adjudicates, PBM systems trigger the appropriate transition letter to be sent via U.S. first class mail to the beneficiary (or authorized representative) within three (3) business days from adjudication date. The text of the letter will follow the model language provided by CMS or be in the form of a custom letter to include:
    - An explanation that the transition supply provided is temporary and may not be refilled unless a formulary exception is approved;
    - That the beneficiary should work with CHPW as well as his or her health care provider to satisfy UM requirements or to identify appropriate therapeutic alternatives that are on the CHPW's formulary and that will likely reduce his or her costs;
    - That the beneficiary has the right to request a formulary exception, the timeframes for processing the exception, and the beneficiary's right to request an appeal if CHPW issues an unfavorable decision; and
    - CHPW's procedures for requesting a formulary exception.
2. CHPW will submit their standard transition notifications to CMS under the file & use certification process five (5) days before use if the notification is eligible for file and use. If unmodified model language is used, CHPW will submit the notification to CMS for a ten (10) day review. If model language is modified or not used at all, CHPW will submit the notification to CMS for a full forty-five (45) day review.
3. A copy of the transition notice will also be sent to the prescriber of record via U.S. first class mail within three (3) business days of adjudication of a temporary transition fill. The prescriber of record's address will be based on the claim submitted by the pharmacy. The prescriber data source is from the prescriber file loaded in the PBM's adjudication system, based on the prescriber ID submitted by the pharmacy.

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Changes In Level Of Care

A member may have a change in his/her treatment setting due to the level of care required. Such transitions include:

1. Members who are discharged from a hospital to a home;
2. Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to now use their Part D plan;
3. Members who give up Hospice Status and revert back to standard Medicare Part A and B coverage;
4. Members discharged from chronic psychiatric hospitals with highly individualized drug regimens;

For these unplanned transitions, members may need to request an exception or an appeal for continued coverage of their drug. In addition, the PBM will review requests for continuation of therapy on a case-by-case basis for members who have had a change in their level of care and are stabilized on drug regimens that if altered, are known to have risks.

Early refill edits will not be used to limit appropriate and necessary access to Part D benefits for members admitted to or discharged from a LTC facility. Enrollees shall be allowed to access a refill upon admission or discharge from a LTC facility.

Edits For Transition Fills

The PBM applies drug utilization management edits (including during transition periods) in its system for member safety purposes. The PBM will ensure that it has automated system capabilities in place to override non-formulary Part D drugs, step therapy, and prior authorization edits during transition fills at point of sale, with the following exceptions:

1. Edits to determine Part A vs. Part B vs. Part D coverage
    - Edits to promote safe utilization of a Part D drug, (e.g., quantity limits based on FDA maximum recommended daily dose; early refill edits)
    - The PBM will provide refills for transition prescriptions dispensed for less than the written amount due to quantity limits for safety purposes or drug utilization edits that are based on approved product labeling.

2. Edits to promote drug optimization
    - To the extent that the dose optimization edits require a change in the prescription that is not authorized by the prescriber or otherwise cannot be resolved at the point of sale, the PBM will allow a transition process as described above.

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Emergency Supplies For Long-Term Care (LTC) Residents
If additional time is needed to process formulary or prior authorization exceptions, CHPW will cover an emergency supply of non-formulary drugs or formulary drugs with step therapy or prior authorization requirements for enrollees in long-term care facilities who are beyond their 90-day transition period. In such instances, the lesser of a thirty-one (31) day supply or the prescribed amount of medication will be dispensed following the end of the transition period. This process is delegated to PBM and will be managed by PBM's prior authorization advocates.

Transition Period Extensions
In accordance with the applicable Medicare regulations, CHPW will, on a case-by-case basis, extend the transition period and continue to provide necessary Medicare Part D drugs to a beneficiary if the beneficiary's prior authorization or formulary exception requests or appeals have not been processed by the end of the minimum transition period. The extension will last until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on a prior authorization or exception request). This process is managed by PBM prior authorization advocates where PBM manages prior authorizations on behalf of CHPW.

Requests For Exceptions Or Prior Authorization
PBM processes exception requests made by the beneficiary, a beneficiary's authorized representative, a prescribing physician, or another prescriber, and will determine whether to approve or deny the request. Should PBM deny the request, the enrollee may appeal the decision.

CHPW shall make the Transition Policy available via:

1. Link to the company website from Medicare Prescription Drug Plan Finder (www.medicare.gov)
2. CHPW website (https://medicare.chpw.org)
3. Inclusion in pre- and post- enrollment marketing materials as directed by CMS

CHPW will also make available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms including mail, fax, e-mail and the CHPW website (https://medicare.chpw.org).

Cost Sharing For Transition Refills
There may be patient cost sharing for a temporary supply of drugs provided under this transition process. 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, cost-sharing for a temporary supply of drugs will be based on approved cost-sharing tiers and consistent with cost-sharing that the plan would charge for non-

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formulary drugs approved under a coverage exception. Appropriate cost-sharing will be calculated based upon IT logic that assesses the beneficiary's status.

Procedure For Transition Letter Generation

PBM will automatically generate CMS approved letters to beneficiaries within three (3) business days from the date of adjudication of a temporary transition fill. If the enrollee completes his or her transition supply in several fills, CHPW will only send a transition letter with the first fill only. For LTC beneficiaries, transition letters will be generated within three (3) business days of the first 14-day fill during the transition period.

The letters must include (1) an explanation that the transition supply provided is temporary and may not be refilled unless a formulary exception is approved; (2) that the beneficiary should work with CHPW as well as his or her health care provider to identify appropriate therapeutic alternatives that are on the CHPW's formulary and that will likely reduce his or her costs; (3) that the beneficiary has the right to request a formulary exception, the timeframes for processing the exception, and the member's right to request an appeal if CHPW issues an unfavorable decision; and (4) CHPW's procedures for requesting a formulary exception.

The transition letter program will run daily to identify non-formulary, step therapy, prior authorization and QL requirements.

A notification will also be sent to the prescribing physician of the temporary transition fill.

Monitoring

CHPW will direct their PBM account team to assure that CHPW's transition policy is set up appropriately per the benefit set up and the formulary submitted to CMS by CHPW. The maximum days supply set up in the CHPW's Part D benefit design will be used as the basis for the transition supply but only if equal to or longer than the minimum transition period required by CMS. All Part D benefits will be thoroughly validated during the PBM testing process which will include validation of the benefit design for new implementations and all changes to benefits for existing clients.

Logging/Tracking/Reporting/Training

1. Daily and monthly reports of transition fills, notices, and rejects will be reviewed and analyzed by PBM's transition team. Monthly reports of transition fills and notices will be shared with CHPW. Daily and weekly reject reports are provided to CHPW for oversight. These reports will demonstrate that CHPW's current and new beneficiary transition process is working appropriately within CHPW's benefit plans. Should additional ad-hoc reporting be required by CMS, PBM will develop such reporting.
2. PBM will document its transition processes annually and make such report available upon request to the account team.

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3. On an annual basis, PBM will provide relevant training to the PBM teams responsible for implementing this transition policy and procedure.
4. The PBM system will generate a member notification within 3 (three) business days and corresponding physician notification of the processing of the transition claim as described in Figure 1.

PBM Oversight

On a weekly basis, CHPW will retrieve and review a PBM generated report documenting the turnaround-time for transition letters sent to members. CHPW will review a sample of the letters sent to ensure CMS requirements are met. See *DP 122 – Medicare Formulary Admin Oversight Process* for more information.

List of Appendices

A. Detailed Revision History

Citations & References

CFR	42 CFR 423.120b	
WAC		
RCW		
LOB & Contract Citation	☐ **WAHIMC**	
	☐ **BHSO**	
	☐ **Wraparound**	
	☐ **SMAC**	
	☐ **HH**	
	☐ **AHE**	
	☒ **MA/DSNP**	Medicare Prescription Drug Benefit Manual Chapter 6, § 30.4 et.seq; Transition
	☐ **CS**	
Other Requirements		
NCQA Elements	UM11	
References		

Revision History

SME Review:	10/26/2006; 06/25/2008; 01/12/2009; 09/01/2009; 09/10/2009; 04/21/2010; 04/12/2011; 03/26/2012; 02/21/2013; 03/24/2014; 04/20/2015; 03/11/2016; 03/01/2017; 03/02/2018; 03/12/2019;

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	08/29/2019; 02/25/2020; 02/22/2021; 03/03/2021; 02/22/2022; 01/31/2023; 02/19/2024; 01/22/2025; 06/24/2025; 05/26/2026
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Appendix A: Detailed Revision History

Revision Date	Revision Description	Revision Made By
10/26/2006	Original	Pharmacy Mgmt
06/25/2008	Content changes	Rachel Koh
01/12/2009	Review for style and formatting	Sunny Otake
09/01/2009	Content Update	Rachel Koh
09/09/2009	Approval	MMLT
09/10/2009	Reviewed for clarity; updated formatting	Jennifer Carlisle
04/21/2010	Content Update – PBM Oversight	Eric Guyette
04/30/2010	Approval	MMLT
04/12/2011	Content Update	Maria Chan
05/25/2011	Approval	MMLT
03/26/2012	Content Update on “day supply” to meet CMS requirement	Maria Chan
04/04/2012	Approval	MMLT
02/21/2013	Content Update	Maria Chan
04/19/2013	Approval	MMLT
03/24/2014	Content update	Annie Lam
04/23/2014	Approval	MMLT
04/20/2015	Content update	Lauren Pope
04/23/2015	Approval	MMLT
03/11/2016	Content update to reflect Ch 6 updates	Mary Eckhart
03/18/2016	Approval	MMLT
03/01/2017	Moved to new template	Mary Eckhart
03/14/2017	Approval	MMLT
03/02/2018	Moved to new template. Minor text updates.	Mary Eckhart
03/13/2018	Approval	MMLT
03/12/2019	Reviewed, no changes	Erin Riddle
03/13/2019	Approval	MMLT
08/29/2019	Content & Citation Updates	Erin Riddle
02/25/2020	Citations table updated	Rebecka Braband
03/05/2020	Reviewed	Omar Daoud
03/10/2020	Department Approval	Yusuf Rashid
03/27/2020	Approval	CMO Cabinet
2/22/2021	Reviewed. No changes	Omar Daoud
03/01/2021	Approval	Yusuf Rashid

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03/02/2021	Approval	CMO Cabinet
03/03/2021	ESI updates added	Cindy Bush/Omar Daoud
03/10/2021	Approval	Yusuf Rashid
03/10/2021	Approval	CMO Cabinet
02/22/2022	Reviewed, no changes. Departmental approval	Omar Daoud
02/23/2022	Approval	CMO Cabinet
01/31/2023	Reviewed , no changes	Omar Daoud
02/13/2023	Approval	Clinical Services Leadership Team
02/19/2024	Reviewed no changes	Omar Daoud
02/21/2024	Approval	Clinical Services Leadership Team
01/22/2025	No changes	Omar Daoud
01/24/2025	Approval	Clinical Services Leadership Team
06/24/2025	Reviewed , no changes	Omar Daoud
07/01/2025	Approval	Clinical Services Leadership Team
05/26/2026	Reviewed, no changed	Omar Daoud
05/26/2026	Approval	Clinical Services Leadership Team

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