

Policy and Procedure

Policy and Procedure Number:	
Policy and Procedure Name:	PH0182 Pharmacy Transition Management
Associated Corporate Policy Name and Number (if applicable):	
Contract or State Reference: (include citation if applicable)	Magellan Complete Care of Virginia, LLC
Responsible Department or Unit:	Pharmacy

Date of Inception:	1/1/2020		
Previous Approval Date:			
Current Approval Date:			
Operational Scope:	Clinical Operations		

Policy and Procedure Approvals

Pamela Mortland	Approval on file	11/20/2019
Sr. Director of Pharmacy, MCC		Date
<NAME>	Approval on file	
Compliance Officer		Date

Business Division and Entity Applicability:

Magellan Healthcare

Magellan Complete Care of Virginia, LLC

Policy and Procedure Purpose Statement

Policy Statement:

Magellan Complete Care of Virginia Medicare’s (MCC of VA (HMO SNP)) Pharmacy Transition Management policy is a written description of the appropriate processes consistent with 42 CFR §423.120(b) (3) for MCC of VA (HMO SNP) enrollees whose current drug therapies may not be included in the MCC of VA (HMO SNP) formulary. Where applicable and as required by the Centers for Medicare and Medicaid (CMS), MCC of VA (HMO SNP) provides transition-eligible Medicare enrollees a temporary supply for eligible medications when the medication meets one or more of the following conditions:

- Not included on the Plan’s formulary; or
- On the Plan’s formulary, but are subject to utilization management rules including, prior authorization required, step therapy, or plan-imposed quantity limits (QL).

The process is intended to afford enrollees and their care team sufficient time to work with their health care providers to switch to a therapeutically appropriate formulary alternative or to request an exception on the grounds of medical necessity.

Policy and Procedure Terms & Definitions

None

Procedure

Procedures:

<p>A. CMS Attestations</p>	<p>1. MCC of VA (HMO DSNP) attests to the following CMS requirements:</p> <p>a. <u>CMS Attestation #1</u> MCC of VA (HMO SNP) will maintain an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how, for enrollees whose current drug therapies may not be included in their new Part D plan's formulary, it will effectuate a meaningful transition for:</p> <ul style="list-style-type: none"> • New enrollees into the prescription drug Plan following the annual coordinated election period. • Newly eligible Medicare beneficiaries from other coverage; • Enrollees who switch from one Plan to another after the start of a contract year; • Current enrollees affected by negative formulary changes across contract years; • Enrollees residing in long term care (LTC) facilities; and • In some cases, enrollees who change treatment settings due to a change in level of care. <p>b. <u>CMS Attestation #2</u> MCC of VA (HMO SNP) submits a copy of its transition policy to CMS and ensures all submissions are per CMS guidelines and that the policy conforms to the requirements of the Prescription Drug Manual, Chapter 6, Section 30.4.</p>
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c. **CMS Attestation #3**

The transition process is applicable to non-formulary drugs, meaning:

- Part D Drugs that are not on the MCC of VA (HMO SNP) formulary;
- Part D Drugs that are on the MCC of VA (HMO SNP) formulary but require prior authorization or step therapy, or that have an approved QL lower than the beneficiary's current dose under MCC of VA (HMO SNP)'s utilization management rules.

MCC of VA (HMO SNP) ensures that its policy addresses procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination. MCC of VA (HMO SNP)'s coverage review and care coordination process addresses this requirement.

d. **CMS Attestation #4**

MCC of VA (HMO SNP) has system capabilities that allow the 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 MCC of VA (HMO SNP) 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.

Transition system capabilities are provided through MCC of VA (HMO SNP)'s pharmacy benefit manager (PBM), Magellan Rx (MRX), and are outlined in Procedures.

e. **CMS Attestation #5**

MCC of VA (HMO SNP) ensures that in the retail setting that enrollees are provided at least a one-time, temporary fill of at least a month supply of medication (unless the enrollee presents with a prescription written for less than a month's supply in which case the Part D sponsor must allow multiple fills to provide up to a total of a month's supply of medication) anytime during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage.

f. **CMS Attestation #6**

MCC of VA (HMO SNP) ensures that cost-sharing for a temporary supply of drugs provided under MCC of VA (HMO SNP) transition process never exceeds the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-

LIS enrollees, MCC of VA (HMO SNP) charges 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 42 CFR § 423.578 (b) and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply if the utilization management criteria are met.

g. **CMS Attestation #7**

MCC of VA (HMO SNP) ensures that in the long-term care setting: (1) the transition policy provides for a one time temporary fill of at least a month's supply (unless the enrollee presents with a prescription written for less) which should be dispensed incrementally as applicable under 42 CFR §423.154 and with multiple fills provided if needed during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage

(2) after the transition period has expired, the transition policy provides for a 31-day emergency supply of non-formulary Part D drugs (unless the enrollee presents with a prescription written for less than 31 days) while an exception or prior authorization is requested and

(3) for enrollees being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge.

- For an emergency supply for LTC enrollees outside of their transition period, an automated process is in place so that an enrollee residing in an LTC is allowed an additional transition supply of an eligible drug once they are outside of their transition period. These automated emergency transition supply claims provide up to a thirty-one (31) day supply, unless the prescription is written for less than thirty-one (31) days while an exception or prior authorization request is in process. Supplies are provided in appropriate increments in the case of a short cycle fill (SCF) or prepack drugs. Appropriate CMS model transition notifications are generated for both the enrollee and the prescriber.

h. **CMS Attestation #8**

MCC of VA (HMO SNP)'s transition process automatically effectuates a transition supply when appropriate for enrollees, except when the following edits apply to the claim:

- Determination process Part A or Part B versus Part D coverage;

- Edits to prevent coverage of non-Part D drugs;
- Edits to promote safe utilization of a Part D drug;

Secondary messaging is sent to the pharmacy to further inform the pharmacy of the reason for the edit and the additional required action on the part of the pharmacy to ensure eligible enrollee's transition fills of needed medications are appropriately dispensed. In the case of Part A, or B, versus D overlap drugs, or non-Part D drugs, a coverage determination is required prior to payment. Step therapy and prior authorization edits are resolved at the point of sale (POS) through system logic. MCC of VA (HMO SNP) conducts oversight to assure the prescriber's respond to coverage review requests for an enrollee's access to needed medications.

i. **CMS Attestation #9**

MCC of VA (HMO SNP) ensures that the transition policy provides refills for transition prescriptions dispensed for less than the written amount due to quantity limit safety edits or drug utilization edits that are based on approved product labeling. The enrollee is allowed refills up to the days' supply allowed in the benefit.

j. **CMS Attestation #10**

MCC of VA (HMO SNP) will ensure that it will apply all transition processes to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

Because new and refilled prescriptions for on-going therapy for a transition eligible drug cannot always be distinguished at POS, the transition process assumes the drug is ongoing therapy. In addition, the system does not limit a transition supply to one (1) fill if the enrollee has not received the full transition supply. The process allows for refills of a transition eligible drug at the point of sale to ensure enrollees receive at least a thirty (30) day supply of a transition eligible drug. The system allows for refills of a transition eligible drug at POS to ensure enrollees receive at least a thirty (30) day supply of a transition eligible drug. In some cases, more than a thirty (30) day supply can be extended when the drug is prepackaged and cannot be dispensed at a lower day supply.

k. **CMS Attestation #11**

MCC of VA (HMO SNP) sends a written notice via USPS First Class mail to the enrollee within three (3) business days of

adjudication of a temporary transition fill. The notice includes:

- An explanation of the temporary nature of the transition supply an enrollee has received;
- Instructions for working with MCC of VA (HMO SNP) and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on MCC of VA (HMO SNP)'s formulary;
- An explanation of the enrollee's right to request a formulary exception; and
- A description of the procedures for requesting a formulary exception.

For long-term care residents dispensed multiple supplies of a Part D drug in increments of fourteen (14) days or less consistent with the requirements under 42CFR 423.154(a)(1)(i),. The written notice must be provided within 3 business days after adjudication of the first temporary fill. For long-term care residents and other beneficiaries dispensed multiple supplies of a Part D drug, the initial prescription initiates the required CMS model notification. Per CMS guidance, additional duplicate notifications for drugs dispensed in frequent increments may confuse enrollees and their providers. MRX only triggers the required CMS transition notices for the initial transition fill of the prescription; however, if the transition criteria for the drug changes between fills, an additional letter with the new criteria is generated even if the claim is a refill.

MCC of VA (HMO SNP) submits the transition notice to CMS and the State for marketing review via the file and use process or as a non-model transition notice subject to a forty-five (45) day review. MRX sets up the required CMS model notifications on behalf of MCC of VA (HMO SNP), if delegated per the MRX Part D marketing materials campaign process.

Once MCC of VA (HMO SNP)'s transition process is implemented and the plan is live for the Plan Year, MRX's system interrogates the daily claims data to identify enrollees who received a transition supply of a drug for the first time on the prior business day. That information is used to generate a notification to the enrollee about the transition supply. The notification includes information to enable the enrollee to switch to a formulary product, and as an alternative, provides information to assist the enrollee in requesting an exception in order to allow the enrollee to continue receiving coverage of the existing drug.

MCC of VA (HMO SNP) ensures that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice.

MRX sends prescriber notifications with a fax notification, followed by mailing a written notification if faxing is not successful. Typically the letter is sent within five (5) business days of the adjudication date of a transition supply dispensed to the patient. The prescriber notification utilizes a separate letter for the prescribing physician notifying the prescriber of the transition supply obtained by the enrollee.

There are circumstances in which notifications cannot be mailed to an enrollee nor a prescriber nor faxed to a prescriber. Those circumstances include enrollees for whom neither MCC of VA (HMO SNP), nor MRX, has an approved USPS mailing address on file, or valid prescriber information in MRX's database or MCC of VA (HMO SNP) contracted provider files. In these situations, MRX produces both member and prescriber drop files each business day to facilitate MCC of VA (HMO SNP) action and outreach. MCC of VA (HMO SNP) has a daily process for reviewing the drop files, contacting the member and prescriber for the correct address information, and resending the letter or fax within 3 business days. Prescribers that have a transient address, or situations where the transition claim has been reversed prior to the notification being generated, would not result in a transition claim notification being sent. Monitoring of the daily reject reports and letters reports support the enrollee experience for this potential circumstance.

i. CMS Attestation #12

Enrollees and prescribers may call MCC of VA (HMO SNP) Client Service lines and request prior authorizations or exceptions request forms and have the forms sent via a variety of mechanisms, including mail, fax, or email. The enrollee or prescriber may also download a form from MCC of VA (HMO SNP)'s website, or submit a request electronically.

m. CMS Attestation #13

MCC of VA (HMO SNP) extends the transition policy across contract years should an individual 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 enrollees with respect to a transition supply and a window that crosses a contract year. These new enrollees are ensured a 90 day transition window under this across plan year transition process.

n. CMS Attestation #14

MCC of VA (HMO SNP) makes the transition policy available to enrollees via a link from Medicare Prescription Drug Plan Finder

	<p>to the plan’s website. The policy is also included in pre-and post-enrollment marketing materials as directed by CMS.</p> <p>o. CMS Attestation #15 MCC of VA (HMO SNP) continues to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, or when the enrollee’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 through either a switch to an appropriate formulary drug or a decision on the exception request.</p> <p>p. CMS Attestation #16 For current enrollees whose drugs can be affected by negative formulary changes in the upcoming year, MCC of VA (HMO SNP) effectuates a meaningful transition by either:</p> <ul style="list-style-type: none"> • Providing a transition process at the start of the new contract year or; • Effectuating a transition prior to the start of the new contract year. <p>Systems ensure 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 is provided with a transition supply of an eligible drug unless the drug was previously filled as a transition supply.</p> <p>The system queries the current enrollee’s previous utilization through a look-back window that begins on the last day of the previous plan year and extends through a period of 120 days. If the enrollee had previous utilization, the enrollee is eligible for a transition fill if the medication’s coverage status changed across the plan year. If the enrollee is lacking utilization within the look-back window, this will preclude a transition supply from being extended to a current enrollee during the cross-plan year window, as that enrollee is not transition eligible. This is 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 RT code.</p>
<p>B. Pharmacy & Therapeutics Committee</p>	<p>1. MRX is delegated the activities of the Pharmacy and Therapeutics (P & T) Committee. The P&T Committee performs the following functions relative to the Transition Supply process:</p> <ul style="list-style-type: none"> a. Reviews and approves the Medicare Transition policy as outlined in this document on an annual basis; and b. Per CMS guidance, ensures that transition decisions appropriately address situations involving enrollees stabilized on drugs that are not on MCC of VA (HMO SNP)’s formulary.

	<ol style="list-style-type: none"> 2. Per CMS guidance, the P&T Committee involvement helps ensure that transition decisions appropriately address situations involving enrollees stabilized on drugs that are on the formulary but are subject to prior authorization, step therapy, and quantity limits as part of a plan’s utilization management requirements. <ol style="list-style-type: none"> a. This is accomplished via the P&T Committee review and approval of the appropriate policies and procedures.
<p>C. Oversight & Monitoring</p>	<ol style="list-style-type: none"> 1. MRX oversees and monitors the transition supply process to ensure that enrollees have access to necessary drugs as required by CMS guidance. <ol style="list-style-type: none"> a. MRX reporting is made available to MCC of VA (HMO SNP) to demonstrate the appropriate paid, rejected and transition-related claims. b. Oversight reports are provided to MCC of VA (HMO SNP) to monitor required enrollee notifications and prescriber notifications. c. MRX’s system monitors rejected claims three (3) times a day. d. If action is not taken by a pharmacy to clear a rejected claim and successfully adjudicate the transition eligible claim, MRX outreaches by automated outbound messaging to advise the pharmacy of the concern and the need for actions to have the claim pay. 2. MCC of VA (HMO SNP) Pharmacy staff oversee formulary changes. <ol style="list-style-type: none"> a. Monthly test claims are run to ensure that the formulary changes are adjudicating correctly. 3. MCC of VA (HMO SNP) Pharmacy staff monitors the success of the transition through associate reports, and grievances and appeals issues. <ol style="list-style-type: none"> a. Member Services representatives forward any issues to the pharmacy department for resolution.
<p>D. Staff Education & Training</p>	<ol style="list-style-type: none"> 1. Prior to the start of a new calendar year, MCC of VA (HMO SNP) conducts training that includes all MCC of VA (HMO SNP) Pharmacy department staff and all other MCC of VA (HMO SNP) staff could be involved in the transition process. Refresher classes will be offered for the upcoming new calendar year. This training includes review of : <ol style="list-style-type: none"> a. Medicare and new benefits for the upcoming year; b. Transition policy for the new calendar year for retail members, long term care members, level of care changes, and emergency refills; c. Medications that are covered during the transition period, including those affected by non-formulary, step therapy, prior authorization, etc.; and

	<ol style="list-style-type: none"> d. Medications not covered as a transition medication, including non-Part D drugs, Part A or Part B versus part D coverage medications, medications rejecting due to a safety edit. e. Formulary changes for the upcoming calendar year, including formulary enhancements, formulary deletions, and clinical edit changes. <ol style="list-style-type: none"> 2. MCC of VA (HMO SNP) associates are trained through team meetings or one-on-one discussions. <ol style="list-style-type: none"> a. New MCC of VA (HMO SNP) associates are trained on the transition policy during the associate’s initial two week training period.
<p>E. Prescriber & Member Education</p>	<ol style="list-style-type: none"> 1. Annually MCC of VA (HMO SNP) Pharmacy staff perform outreach to prescribers prior to a new plan year to proactively attempt to switch members who will experience cross-year formulary changes. <ol style="list-style-type: none"> a. Members impacted by such changes are identified by MRX. b. Letters are sent to prescribers noting the formulary change and recommended covered alternatives. 2. MCC of VA (HMO SNP) Outreach staff reviews the formulary with each member during the outreach discussion prior to enrollment. <ol style="list-style-type: none"> a. Questions regarding specifics are referred to the Pharmacy department.
<p>F. Implementation Statement</p>	<ol style="list-style-type: none"> 1. The MRX adjudication process that supports transition supply requirements operates as follows: <ol style="list-style-type: none"> a. A pharmacy receives a prescription request from: <ul style="list-style-type: none"> • New enrollees into the prescription drug plan following the annual coordinated election period within their first 90 days of enrollment. • Newly eligible Medicare beneficiaries from other coverage within their first 90 days of enrollment; • Enrollees who switch from one Plan to another after the start of a contract year within their first 90 days of enrollment ; • Current enrollees affected by negative formulary changes across contract years; • Enrollees residing in long term care (LTC) facilities; and 2. In some cases, enrollees who change treatment settings due to a change in level of care. The pharmacy submits the prescription request and the transition process continues if the drug is identified as non-formulary or is identified as on the formulary but with utilization management edits applied based on the plan’s approved formulary submission. 3. The MRX system verifies enrollment in the plan based on the eligibility set-up requirements and the file sent by the plan. 4. The MRX system verifies that the enrollee is within the transition period by reviewing the enrollee’s available plan eligibility history.

5. The MRX 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.
6. The MRX system verifies that the drug submitted qualifies for a transition supply based on the reject messaging triggered.
 - a. The rejects indicate one of the four transition eligible categories:
 - Non-formulary;
 - Prior authorization required;
 - Step therapy rules; or
 - Quantity rules.
7. The MRX system determines the allowable days' supply for a transition fill based on the plan's benefit set-up requirements.
8. The MRX system can determine potential LTC emergency fill scenarios.
 - a. 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 thirty-one (31) days is paid.
9. The MRX system determines if a current enrollee is eligible for transition across plan years when a paid claim is found within 120 days of the previous plan year for the same drug by HICL/RT within the same CMS contract ID and where the history claim did not pay under transition logic.
 - a. Using the submitted days' supply from the claim, the MRX system verifies that the claim is within the transition days' supply limit or has remaining transition day supply to be dispensed.
 - Transition claims are limited to the transition day supply limit established unless it is a prepackaged drug and cannot be dispense lower than the transition day supply.
 - Refills may be allowed on transition claims up to the point where the transition day supply obligation has been met or exceeded by the last fill.
10. Oversight of the transition process includes daily outreach via telephone.
 - a. The outreach is intended to ensure a timely transition supply of needed medication for an eligible enrollee.
 - b. Automated outbound messaging is made to any retail network pharmacy that is not able to resolve hard rejects for a transition eligible claim on their own.
11. If a previous transition supply of the same drug was already dispensed within the same transition period, MRX system verifies whether a refill is allowable based on the previous days' supply already dispensed.
 - a. If a required full transition supply was found to have already been provided to the enrollee while in the transition period, the system hard rejects the claim and returns an IF LEVEL OF CARE CHANGE

- message to the pharmacy with instructions to contact the pharmacy help desk to determine if the enrollee is eligible for a level of care fill.
12. MRX system calculates cost-sharing for the transition supply based on the plan's benefit requirements.
 - a. For plan benefits where the enrollee is low income subsidy eligible, the copay is tiered to Brand or Generic LIC levels, or if specified, the Part D drugs are tiered to \$0 dollar cost sharing in line with the CMS LIC waiver for the plan.
 13. The process successfully adjudicates claims and sends a message to the pharmacy with a paid response of either "TRANSITION FILL" or "EMERGENCY SUPPLY," depending on the type of adjudication which was completed.
 14. The required enrollee notifications are mailed within three (3) business days of adjudication of the first fill of a transition supply; mail notifications for refills of a transition supply are not generated; however, if the transition criteria for the drug changes between fills, an additional letter with the new criteria is generated even if the claim is a refill.
 15. If valid prescriber contact information has been obtained by MRX from a national prescriber database or from the MCC of VA (HMO SNP) provider directory, the required prescriber notifications are mailed within five (5) business days after the first fill of a transition supply; mail notifications for refills of a transition supply are not generated unless the transition criteria for the drug changes between fills.
 16. MRX's adjudication process described above is configured to automatically pay a claim for an eligible medication when an enrollee is in their transition period, as a result of the enrollee needing an LTC emergency fill, or a temporary fill to address a transition of a Level of Care change.
 17. If an enrollee is in need of an extension to the transition fill, the enrollee can reach out to the plan in advance or at the POS to request an extension.
 - a. MRX network pharmacies are aware of the potential need for an extension while the enrollee's prescriber or plan are resolving the exception or prior authorization needed for the medication.
 - b. The network pharmacy may call the help desk to get an override for another thirty-one (31) days' supply in this circumstance.
 - c. This final manual step enables transition eligible non-formulary, step-therapy, and prior authorization edits to be resolved at the POS.
 18. Automated reject, paid claims and transition notification reports are posted to the plan client proprietary website location for oversight of the transition process and for discussion with the plan's account teams about additional care coordination or

actions to ensure the transition process is effectuated for the enrollee.

19. As recognized in CMS guidance, certain edits may exist where a hard reject is returned that requires the pharmacy to take action before resubmitting the claim and achieving a paid transaction.
 - a. When an edit is in place that triggers the hard reject of a transition eligible claim for a transition eligible enrollee, the pharmacy is required to take steps in order to achieve a paid transaction.
 - b. The steps required by the pharmacy are included in the associated messaging returned at point of sale.
 - c. Training and documentation on these processes is included in the MRX Network Manual to support timely determinations.
 - d. The hard reject messaging conditions that may be triggered during adjudication of a transition supply eligible claim, other than limited safety editing, are:
 - 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 pays and is marked as a transition supply. One message text example is: "ALLOW QT nnnn."
 - 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 override codes to the pharmacy to place on the claim and the pharmacy is asked to resubmit.
 - Upon resubmission with the override codes the claim will pay and be marked as a transition supply.
 - Refill Too Soon (RTS):
 - To limit inappropriate or unnecessary access to Part D drugs, an early refill edit triggers a hard reject for a transition eligible drug during an enrollee's transition period.
 - The Plans 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:

	<ul style="list-style-type: none"> ❖ Therapy change; ❖ Lost or spilled medication; or ❖ Vacation supply. ➤ The Plan’s RTS allowance requires that an enrollee has consumed 75% of their drug on-hand of an ophthalmic agent as well as at least 75% of any other medication. ➤ The consumption requirement for enrollees in an LTC facility is 75% • <u>Med B/D Determination Required.</u> <ul style="list-style-type: none"> ➤ B/D overlap drugs are excluded from Transition Supply processing by Medicare law as the determination must be made prior to adjudication for appropriate billing. Messaging returned to the pharmacy indicates this need for verification by sending the message: “B/D Determination required”. Training and documentation on these processes is included in the MRX Network Manual to support timely determinations. • <u>Med D/non D Determination Required:</u> <ul style="list-style-type: none"> ➤ D/non-D drugs are excluded from transition supply processing by Medicare law as the determination must be made prior to adjudication for appropriate billing. ➤ Messaging returned to the pharmacy indicates this need for verification by sending the message “Med D/Non-D Determination Req” • <u>Short Cycle Fill (SCF)</u> <ul style="list-style-type: none"> ➤ To comply with CMS guidance related to the LTC 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 SCF related hard 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 SCF edits 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”. ➤ Subsequent transition fills will be allowed up to the days’ supply set by the Plan. • <u>Opioid Medication Quantity Limits:</u> <p>To comply with CMS requirements to limit opioid medications to appropriate quantities, there are hard edits that enforce predetermined quantity limits for opioid medications. A temporary supply of opioids can be provided during transition, as long as the temporary transition fill does not exceed cumulative opioid MME edits, or beneficiary-specific limits.</p>
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	Beneficiary-level opioid point-of-sale claim edits (and cumulative opioid MME edits), are applied during transition.
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Cross Reference(s)

None

Associated Forms & Attachments *(internal link(s) available to Magellan Health employees only)*

None

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