KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Medicare Part D Transition Process	**Policy #**	13.25-P
Policy Owner	Pharmacy	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	7/28/2025
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

Kern Health Systems (KHS) will maintain an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how it will effectuate a meaningful transition for enrollees whose current drug therapies may not be included in the Kern Family Health Care Medicare (D-SNP)'s formulary:

1. New enrollees at the start of a contract year
2. Newly eligible Medicare beneficiaries from other coverage
3. Enrollees who switch from one plan to another after the start of a contract year
4. Current enrollees affected by negative formulary changes across contract years
5. Enrollees residing in long-term care (LTC) facilities

II. POLICY

KHS administers a transition process that is compliant with the requirements established by the Centers for Medicare and Medicaid Services (CMS).

This policy is necessary with respect to:

1. New enrollees following the annual coordinated election period
2. Newly eligible Medicare beneficiaries from other coverage
3. Enrollees who switch from one plan to another after the start of a contract year
4. Current enrollees affected by negative formulary changes across contract years
5. Enrollees residing in long-term care (LTC) facilities

KHS will ensure that its transition policy will apply to non-formulary drugs, meaning both:

1. Part D drugs that are not on Kern Family Health Care (KFHC) Medicare (DSNP)'s formulary, and

2. Part D drugs that are on KFHC Medicare (DSNP)'s formulary but require prior authorization, step therapy, or that have an approved quantity limit (QL) lower than the beneficiary's current dose, under the plan's utilization management rules.

III. DEFINITIONS

TERMS	DEFINITIONS
Centers for Medicare & Medicaid Services (CMS)	The Federal agency within the Department of Health and Human Services (DHHS) administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations.
Dual Special Needs Plan (D-SNP)	Medicare Advantage coordinated care plans that serve the special needs of those entitled to Medical Assistance under a State Plan under Title XIX.
Emergency Supply	An Emergency Supply is defined by CMS as a one-time transition fill that is necessary with respect to members that are outside of their initial ninety (90) day transition period and that are in the LTC setting.
Exception	Request to obtain a Part D drug that is not included on the Kern Family Health Care Medicare (D-SNP) formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug.
External Code List (ECL)	A list of value codes with descriptions for data elements. All data elements appear in the National Council for Prescription Drug Programs (NCPDP) Data Dictionary. However, values for data elements are not included in the NCPDP Data Dictionary and appear in a separate publication, called the NCPDP External Code List.
Formulary	List of prescription drugs covered under the KFHC Medicare (D-SNP) Plan.
Ingredient List Identifier (ILI)	Identifies a combination of active ingredients irrespective of manufacturer. (Formerly Hierarchical Ingredient Code List Sequence Number or HICL,)
Level of Care Changes	Level of care changes include the following changes from one treatment setting to another: A. Enter LTC facility from hospitals or other settings. B. Leave LTC facility and return to the community. C. Discharge from a hospital to a home. D. End a skilled nursing facility stay covered under Medicare Part A (including pharmacy charges), and revert to coverage under Part D. E. Revert from hospice status to standard Medicare Part A and B benefits F. Discharge from a psychiatric hospital with medication regimens that are highly individualized.

Long Term Care (LTC) Facility	A skilled nursing facility as defined in section 1819(a) of the Act, or a medical institution or nursing facility for which payment is made for an institutionalized individual under section 1902(q)(1)(B) of the Act.
National Council for Prescription Drug Programs (NCPDP)	Organization that focuses on improving the quality of health care by facilitating electronic transactions between healthcare providers and payers.
NDC SPL Data Element file (NSDE)	The Food and Drug Administration (FDA) Comprehensive National Drug Code (NDC) Structured Product Labeling Data Elements file. This file is used to provide structured product labeling of Brand and Generic drugs.
Prior Authorization (PA)	The process undertaken to make a benefit determination that is made prior to the intended delivery of the healthcare service, treatment, or supply under review (e.g., a Pre-Service Claim). Prior Authorization includes requests for coverage determination for medications that are designated on the client part D formulary as "Prior Authorization Required," "Step Therapy," "Quantity Restrictions" or for requests for exception for non-formulary medications or co-insurance amount.
Pharmacy Benefit Manager (PBM)	A company that works with Kern Family Health Care Medicare (D-SNP) to manage and administer prescription drug benefits.
Prescription Drug Event (PDE)	File that reports all claim transactions to CMS for inclusion in the annual financial reconciliation between CMS and health plans.
Point-of-Sale (POS)	Prescription transaction processing computer system where the actual retail transaction occurs when the claim is submitted electronically by the pharmacy.
Pharmacy and Therapeutics (P & T) Committee	An independent group of external and internal health care practitioners that are responsible for evaluating the efficacy, safety, and cost effectiveness of medications to determine potential additions, subtractions, and other changes to a formulary.
Utilization Management (UM)	A set of guidelines that can be applied independently or jointly that otherwise restrict access to the dispensing or consumption of prescription drugs. The four basic restrictions are prior authorization (PA), quantity limits (QL), step therapy (ST) and tier placement. UM is a tool used by health plans to ensure safe, efficacious, and cost-effective.

IV. PROCEDURES

A. TRANSITION POPULATION

KHS 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 KFHC Medicare (D-SNP)'s formulary, it will effectuate a meaningful transition for:

1. New enrollees into prescription drug plans following the annual coordinated election period
2. Newly eligible Medicare beneficiaries from other coverage

3. Enrollees who switch from one plan to another after the start of a contract year
4. Current enrollees affected by negative formulary changes across contract years
5. Enrollees residing in long-term care (LTC) facilities

B. TRANSITION PERIOD

In accordance with CMS requirements, KHS offers a ninety (90) day transition period under the transition policy. CMS requires a minimum of ninety (90) days from the start of coverage under a new plan. The ninety (90) days are calculated from the plan start date. If the member disenrolls from KFHC Medicare (D-SNP) and re-enrolls during this ninety (90) day transition period, the transition period begins again with the new enrollment date. KHS will extend its transition policy across contract years should a beneficiary enroll with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.

KHS 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 POS.

C. IMPLEMENTATION STATEMENT

1. Claims Adjudication System: KHS' Pharmacy Benefit Manager (PBM) has systems capabilities that allow it to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

2. Pharmacy Notification at POS: KHS' PBM utilizes the current NCPDP Telecommunication Standard to provide POS messaging. It reviews NCPDP reject, and approval codes developed during the ECL process. Pharmacy messages are modified based on industry standards.

3. Edits During Transition:
   a. KHS' PBM will only apply the following utilization management edits during transition at POS:
      i. Edits to determine Part A or B versus Part D coverage
      ii. Edits to prevent coverage of non-Part D drugs
      iii. Edits to promote safe utilization of a Part D drug

   b. ST and PA edits must be resolved at POS.

   c. KHS will ensure 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.

   d. As outlined in 42 CFR §423.153(b), KHS' PBM has implemented POS PA edits to determine whether a drug is covered under Medicare Parts A or B as prescribed and administered, is being used for a Part D medically accepted indication or is a drug or drug class or its medical use that is excluded from coverage or otherwise restricted

under Part D (Transmucosal Immediate Release Fentanyl (TIRF) and Cialis drugs as an example).

4. Pharmacy Overrides at POS: During the member's transition period, all edits (with the exception of those outlined in section C3 associated with non-formulary drugs) are automatically overridden at the POS. Pharmacies can also contact PBM's Pharmacy Help Desk directly for immediate assistance with POS overrides. KHS' PBM can also accommodate overrides at POS for emergency fills as described in section F.

   Please see section J for specific information for the processing of non-formulary drugs in the Six (6) Classes of Clinical Concern.

D. TRANSITION FILLS FOR NEW MEMBERS IN THE OUTPATIENT (RETAIL) SETTING

KHS will ensure that in the retail setting, the transition policy provides for a one time temporary fill of at least a month's supply of medication (unless the enrollee presents with a prescription written for less than a month's supply, in which case KHS must allow multiple fills to provide up to a total of a month's supply of medication) anytime during the first ninety (90) days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage. If a brand medication is being filled under transition, the previous claim must also be brand (based on Comprehensive NDC SPL Data Elements File [NSDE] marketing status). If a generic medication is being filled under transition, the previous claim can be either brand or generic (based on NSDE marketing status).

E. TRANSITION FILLS FOR NEW MEMBERS IN THE LTC SETTING

KHS will ensure that in the long-term care setting:

1. The transition policy provides for a one (1) 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 ninety (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 thirty-one (31) day emergency supply of non-formulary Part D drugs (unless the enrollee presents with a prescription written for less than thirty-one (31) days) while an exception or PA is requested.

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

F. EMERGENCY SUPPLIES AND LEVEL OF CARE CHANGES FOR CURRENT MEMBERS

An Emergency Supply is defined by CMS as a one (1) time fill of a non-formulary drug that is necessary with respect to current members in the LTC setting. Current members in need of a one (1) time Emergency Fill or that are prescribed a non-formulary drug as a result of a level of care change can be placed in transition via an NCPDP pharmacy submission clarification code.

KHS' PBM can also accommodate a one (1) time fill in these scenarios via a manual override at POS.

Upon receiving an LTC claim transaction where the pharmacy submitted a Submission Clarification Code (SCC) value of "18," which indicates that the claim transaction is for a new dispensing of medication due to the patient's admission or readmission into an LTC facility, the PBM's claims adjudication system will recognize the current member as being eligible to receive transition supplies and will only apply the POS edits described in section C3 of this policy. In this instance, KHS does not need to enter a POS override.

G. NEGATIVE FORMULARY CHANGES:

Negative changes are changes to a formulary that result in a potential reduction in benefit to members. These changes can be associated with removing the covered Part D drug from the formulary, changing its preferred or tiered cost-sharing status, or adding utilization management.

1. For current enrollees whose drugs will be affected by negative formulary changes in the upcoming year, KHS will effectuate a meaningful transition by either:

    a. Providing a transition process at the start of the new contract year, or
    b. Effectuating a transition prior to the start of the new contract year.

    POS logic is able to accommodate option 1 (one) by allowing current members to access transition supplies at the POS when their claims history from the previous calendar year contains an approved claim for the same drug that the member is attempting to fill through transition and the drug is considered a negative change from one plan year to the next. The POS looks for Part D claims in the member's claim history that were approved prior to January 1 of the new plan year, and that have the same ICI value as the transition claim. Additionally, if a brand medication is being filled under transition, the previous claim must also be brand (based on NSDE marketing status). If a generic medication is being filled under transition, the previous claim can be either brand or generic (based on NSDE marketing status).

2. The transition across contract year process is applicable to all drugs associated to mid-year and across plan-year negative changes.

H. TRANSITION EXTENSION

KHS will make arrangements to continue to provide necessary 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 transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request). On a case-by-case basis, POS overrides can also be entered by KHS or by the PBM in order to provide continued coverage of the transition drug(s).

I. COST-SHARING FOR TRANSITION SUPPLIES

KHS will ensure that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-LIS enrollees, a sponsor must charge 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.

J. SIX CLASSES OF CLINICAL CONCERN

Per CMS guidance, members transitioning to a plan while taking a drug within the six (6) 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 as long as the drug remains on formulary. UM restrictions (PA and/or ST), which may apply to new members naïve to therapy, are not applied to those members transitioning to the Medicare Part D plan on agents within these key categories. The six (6) classes include:

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

For new members, protected class drug logic will always override transition logic to process the claim. Additionally for new members, a 120 (one hundred twenty) day transition period from their member start date is provided.

K. MEMBER NOTIFICATION

KHS' PBM will send written notice consistent with CMS transition requirements via U.S. first class mail to the enrollee within three (3) business days of adjudication of the first temporary transition fill. If the enrollee completes his or her transition supply in several fills, a notification is required with the first transition fill only.

1. The notice will include:
   a. An explanation of the temporary nature of the transition supply an enrollee has received
   b. Instructions for working with KFHC Medicare (D-SNP) and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the KFHC Medicare (D-SNP)'s formulary
   c. An explanation of the enrollee's right to request a formulary exception, the timeframes for processing the exception, and the member's right to request an appeal if an unfavorable decision is issued
   d. A description of the procedures for requesting a formulary exception.

2. For LTC residents dispensed multiple supplies of a Part D drug in increments of 14 (fourteen) days-or-less, consistent with the requirements under 42 CFR 423.154(a)(1)(a), the written notice will be provided within three (3) business days after adjudication of the first temporary fill.

3. KHS will use the CMS model Transition Notice via the file-and-use process or submit a non-model Transition Notice to CMS for marketing review subject to a 45 (forty-five) day review.

4. KHS will make their transition policy available to enrollees via a link from Medicare Prescription Drug Plan Finder to KFHC Medicare (DSNP)'s web site and include in pre-and post-enrollment marketing materials as directed by CMS.

L. **PROVIDER NOTIFICATION**

KHS will ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice. Reasonable efforts may include, but are not limited to:

1. Providing a copy of the written transition notice labeled as the "Prescriber Copy" directly to the prescriber of record via mail, fax, or electronic means.

2. Notifying the prescriber of record directly of the adjudication of the enrollee's transition fill via a phone call, or individualized or batch fax/electronic notification.

M. PDE REPORTING

Since this is a CMS required process, any drugs dispensed that qualify under the transition period are reported as covered Part D drugs with appropriate KHS and member cost sharing amounts on the Prescription Drug Event (PDE).

N. CMS SUBMISSION

KHS will submit a copy of its transition process policy to CMS.

O. PHARMACY AND THERAPEUTICS COMMITTEE ROLE

The PBM's Pharmacy and Therapeutics (P&T) Committee maintains a role in the transition process in the following areas:

1. The PBM's P&T committee reviews and recommends all KFHC Medicare D-SNP's formulary, step therapy, and prior authorization guidelines for clinical considerations

2. The PBM's P&T committee reviews and recommends procedures for medical review of non-formulary drug requests, including the exception process.

P. EXCEPTION PROCESS

KHS follows an overall transition plan for Medicare Part D members; a component of which includes the exception process. KHS' exception process integrates with the overall transition plan for these members in the following areas:

1. KHS exception process complements other processes and strategies to support the overall transition plan. The exception process follows the guidelines set forth by the transition plan when applicable.

2. When evaluating an exception request for transitioning members, KHS' exception medical review process considers the clinical aspects of the drug, including any risks involved in switching.

3. The exception policy includes a process for switching new Medicare Part D plan members to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

KHS will make available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on KFHC Medicare (D-SNP)'s web sites.

V. ATTACHMENTS

Attachment A:	Appendix A. POS Transition Flow Diagram

VI. REFERENCES

Reference Type:	Specific Reference:
Regulatory	Federal Register, Vol. 76, No. 73, Part II, 42 CFR, §423.120(b)(3), §423.153(b), §423.154
Regulatory	42 CFR §423.120(b)(3)
Regulatory	Medicare Prescription Drug Benefit Manual, Chapter 6, Part D Drugs and Formulary Requirements, January 15, 2016, Section 30.4

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy	Director of Pharmacy

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Legal and Human Resources Officer		
Deputy Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 13.25-P Medicare Part D Transition Process

Last approved version: N/A

Reason for creation: New policy.

Director Approval		
Title	**Signature**	**Date Approved**
Bruce Wearda Director of Pharmacy		
Melissa McGuire Senior Director of Delegation Oversight		
Christine Pence Senior Director of Health Services		
Nate Scott Senior Director of Member Services		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____

Attachment A
POS Transition Flow Diagram

APPENDIX A. POS TRANSITION FLOW DIAGRAM