# Medicare Part D – 2016 Transition Rights

The Centers for Medicare and Medicaid Services (CMS) requires that sponsors of Medicare Part D prescription drug plans provide beneficiaries with access to transition supplies of needed medications to protect them from disruption and give adequate time to move over to a drug that is on a plan's formulary (medication list), file a formulary exception request or, particularly for Low Income Subsidy (LIS) recipients, enroll in a different plan.

Transition rules apply to stand-alone Medicare Prescription Drug Plans (PDPs), Medicare Advantage Plans with Prescription Drug Coverage (MA-PDs), and Medicare-Medicaid Managed Care Plans participating in the Dual Eligible Financial Alignment Demonstrations.

Transition rules are particularly important for low income beneficiaries who were automatically reassigned to new plans, which may or may not cover their medications.

In addition, all plans change their formularies each year, so even people who remain in the same plan may find that their plan no longer covers their medications or has newly imposed utilization management requirements.

### *Tell CMS!*

*CMS is serious about transition protections and in recent audits has penalized plans with a pattern of transition violations.*

*Advocates who see violations, particularly several with the same plan, should report them to their CMS regional office even if you can obtain individual resolution with the plan.*

To assist advocates with transition issues, this fact sheet sets out the CMS minimum requirements for all plans.

For further information, contact Georgia Burke, gburke@justiceinaging.org.

## CMS Minimum Transition Requirements

CMS requires Part D plans to establish transition policies to ensure that beneficiaries who are stabilized on a medication are not left without coverage:

- When they first enroll in a Part D plan.
- When they are moving to a new plan that does not cover their current drug, including when that move is mid-year.
- When, at the start of a new plan year, the plan in which they currently are enrolled drops coverage of a drug they are taking or imposes new utilization management restrictions on that drug.
- When they experience a change in level of care (e.g., from hospital to a nursing facility, from a nursing facility to home, or out of hospice status to standard Medicare, etc.).

## For all enrollees:

Plans must provide a one-time fill–**30 day supply** (unless a lesser amount is prescribed)– of an **ongoing** medication within the first 90 days of plan membership.

- Applies both to drugs not on formulary and to those subject to utilization management controls.[1]
- Applies to the first 90 days in the plan, even if enrollment is not at the beginning of the plan year and even if the 90 day period extends over two plan years (e.g., a November enrollment).
- Applies both to new members and to continuing members when a plan has changed formulary.
- Does not cover non-Part D drugs.
- Does not cover multiple prescriptions for the same medication. For example, if a doctor only prescribes a pain medicine in 14 day batches, the transition will only cover one batch.
- Safety edits are permitted (e.g., quantity limits based on FDA recommendations, early refill edits). Edits also are permitted to help determine Part B v. Part D coverage and to prevent coverage of non-Part D drugs (e.g., drugs prescribed for non-compendium off-label uses).

Plans must mail a **written notice** explaining that the transition supply is temporary, including instructions for identifying appropriate substitutes; notice of the right to request a formulary exception; and instructions on how to file an exception request. The notice must be mailed within three business days of the temporary fill.

If, at the point of sale, a plan cannot determine whether a newly written prescription is for ongoing drug therapy or not, the plan must assume that the prescription is ongoing and apply transition policies.

## Residents in a long-term care (LTC) facility or other institution get further protections.

- Plans must provide a 31 day supply during the first 90 days.
- Plans must honor multiple 31 day fills during the first 90 days.

## A change in status brings additional rights.

- Early refill edits may not be used to deny an enrollee access to a refill upon admission or discharge from a facility.
- For members leaving facilities, plans should permit fills of prescriptions in the week before discharge to avoid gaps or delays.
- Extension of transition supplies is required on a case-by-case basis until an "appropriate and meaningful transition can be effectuated."(See box below for fuller details.)

For CMS Guidance on transition drug supplies, go to Medicare Prescription Drug Benefit Manual, Chapter 6 at 30.4 et seq.

### Extending Transition Supplies: Plan Responsibilities

*Prescription Drug Benefit Manual, Chapter 6 at 30.4.4.3*

"A Part D sponsor may need to make arrangements to continue to provide necessary drugs to an enrollee via an extension of the transition period, on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period. It is vital that sponsors give affected enrollees clear guidance regarding how to proceed after a temporary fill is provided, so that appropriate and meaningful transition can be effectuated by the end of the transition period. *Until that transition is actually made, however, either through a switch to an appropriate formulary drug, or a decision is made regarding an exception request, continuation of drug coverage is necessary, other than for drugs not covered under Part D."*

[1] Plans must waive utilization management rules during the transition. However, if a plan limits dosage to, for example, 14 pills, the plan may distribute 14 pills when the enrollee first presents the prescription, but must provide refills until the 30 day transition supply is met.