CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Transition of Care for D-SNP Members	**Policy No.:** HS-RX05
Department: Pharmacy	
Cross-Functional Departments: N/A	
Effective Date: 06/2025	**Last Revision Date:** 07/2025
Director or Officer Signature: Jeff Januska, PharmD Director of Pharmacy Services	**Officer Signature:** Maya Heinert, MD, MBA, FAAP Chief Medical Officer

I. Purpose:

The purpose of this policy is to describe CenCal Health's process for transition of care and ensure that continued drug coverage is provided to new and current CenCal CareConnect members. The transition process allows for a temporary supply of drugs and sufficient time for members to work with their health care providers to select a therapeutically appropriate Formulary alternative, or to request a Formulary exception based on medical necessity. Transition processes will be administered by CenCal Health and its Pharmacy Benefit Manager (PBM) in a manner that is timely, accurate and compliant with all relevant Centers for Medicare & Medicaid Services (CMS) guidance and requirements as per 42 CFR §423.120(b)(3).

While CenCal Health retains ultimate responsibility for the administration and compliance of its transition of care policy, certain operational functions are delegated to its contracted PBM. These delegated functions include, but are not limited to, claims adjudication, point-of-sale logic implementation, and member/provider notification processes. CenCal Health maintains oversight of all delegated activities through formal delegation agreements, performance monitoring, and regular audits to ensure compliance with CMS regulations and internal standards.

II. Policy:

A. CenCal Health's PBM administers a transition process that is in compliance with the established CMS transition requirements.

B. This policy is necessary with respect to:

1. New enrollees into CenCal Health's D-SNP, CenCal CareConnect, 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 the contract year,

4. Current enrollees affected by negative Formulary changes across contract years,
5. Enrollees residing in long-term care (LTC) facilities.

C. CenCal Health will ensure that this transition policy will apply to non-Formulary drugs, meaning both:

1. Drugs that are not on CenCal CareConnect's Formulary, and
2. Drugs that are on CenCal CareConnect's Formulary but require prior authorization or step therapy, or that have an approved quantity limit lower than the beneficiary's current dose, under CenCal Health's utilization management rules.

CenCal Health will ensure that its policy addresses procedures for medical review of non-Formulary drug requests, and when appropriate, a process for switching new CenCal CareConnect enrollees to therapeutically appropriate Formulary alternatives failing an affirmative medical necessity determination.

D. In accordance with CMS requirements, CenCal Health and its PBM ensures that drugs excluded from Part D coverage due to Medicare statute are not eligible to be filled through the transition process.

E. However, to the extent that CenCal Health covers certain excluded drugs under an Enhanced or plan benefit, those drugs should be treated the same as Part D drugs for the purposes of the transition process

III. Procedure:

A. Transition of Care for State Covered Drugs

1. CenCal Health has the option to apply transition of care logic to non-Part D drugs or drugs covered by the state. The logic is similar to the Part D functionality and allows new enrollees a transition fill for a defined period of time (e.g., 90-day minimum) for a specific day supply limit (e.g., 90-day supply) for a specific list of drugs.
2. CenCal Health obtains the transition policy requirements on an annual basis via the Implementation Questionnaire (IQ) with its PBM. The non-Part D drugs will be coded based on CenCal Health's selection on the annual IQ. These transition claims are also included in the daily notification files used for member and prescriber letter generation. Additionally, state requirements for transition time periods are reviewed and implemented if different.

B. Transition Population

1. CenCal Health and its PBM 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 CenCal CareConnect Formulary, it will effectuate a meaningful transition for:

a. new enrollees into CenCal CareConnect following the annual co-ordinated election period,

b. newly eligible Medicare beneficiaries from other coverage,

c. enrollees who switch from one plan to another after the start of a contract year,

d. current enrollees affected by negative Formulary changes across contract years, and

e. enrollees residing in long-term care (LTC) facilities.

C. Transition Period

1. CenCal Health offers the number of transition days as stated in this transition policy, and in accordance with CMS's requirement of a minimum of 90 days from the start of coverage under a new plan. The 90 days are calculated from the member's start date with CenCal CareConnect.

2. CenCal Health 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. CenCal Health may choose to enhance this transition policy to provide coverage beyond the CMS minimum requirements.

3. With the exception of CenCal Health's Transition Across Calendar Years processes described later in this policy, CenCal Health has two options for setting the member's transition start date; utilizing the PBM's system default logic or to continue populating Segment code 5 of the Type 24 file.

4. CenCal Health's default process for setting the transition start date will work with the PBM's Type 23 (member record layout) file, or equivalent file type for Plans that do not utilize the Type 23.

5. Whenever the Type 23 loads or its equivalent file loads, the transition start date default process will run simultaneously and analyze the member's group number assignment and the member's effective date within that group.

   For members that are new to CenCal CareConnect or that are re-enrolling but had a break in coverage, the PBM's default process will set the transition start date to match the member's effective date within the group.

6. CenCal Health ensures that the PBM's default logic aligns with guidance issued by CMS stating that CenCal Health must effectuate transition for members that change either CMS contract or plan, irrespective of whether or not the change resulted in a new Part D Formulary assignment.

7. CenCal Health may continue to utilize Segment 05 of the Type 24 for setting member's transition start date and, in these cases, will ensure it indicates which CenCal CareConnect members should be in a transition period.

8. CenCal Health will ensure the process to place CenCal CareConnect members into a transition period by populating the appropriate Member plan CenCal CareConnect Start Date in Segment Code 5 of the Type 24 File (Member Attribute Load File), or indicate a preference to utilize the Part D Transition of Care start date. If

using the CenCal CareConnect start date indicated in Segment Code 5 of the Type 24 file, the transition period (90-day minimum) is then calculated from the CenCal CareConnect Start Date with the plan.

9. CenCal Health will ensure application of 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.

D. Implementation Statement

1. Claims Adjudication System: CenCal Health delegates the implementation of claims adjudication and temporary drug supply functionality to its PBM. However, CenCal Health ensures through oversight mechanisms that the PBM maintains system capabilities that comply with CMS requirements and support timely access to non-Formulary Part D drugs during the transition period. This includes systems capabilities that allow the PBM 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 CenCal Health 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 Point-Of-Sale: CenCal Health ensures its PBM utilizes the current NCPDP Telecommunication Standard to provide point-of-sale (POS) messaging. The PBM reviews NCPDP reject and approval codes developed during the External Codes List (ECL) process. Pharmacy messages are modified based on industry standards.

3. Edits During Transition: CenCal Health ensures its PBM will only apply the following utilization management edits during transition at point-of-sale: edits to determine Part A or B versus Part D coverage, edits to prevent coverage of non-Part D drugs, and edits to promote safe utilization of a drug. Step therapy and prior authorization edits must be resolved at point-of-sale.

4. CenCal Health 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.

5. CenCal Health ensures its PBM has implemented Point-of-Sale (POS) PA (Prior Authorization) edits to determine whether: 1) a drug is covered under Medicare Parts A or B as prescribed and administered, 2) is being used for a Part D medically accepted indication, or 3) is a drug or drug class, or its medical use, is excluded from coverage or otherwise restricted under Part D (Transmucosal Immediate Release Fentanyl (TIRF) and Cialis drugs as an example)

E. Transition Fills for New Members in the Outpatient (Retail) Setting

CenCal Health 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 CenCal Health will 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.

1. 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).
2. If a generic medication is being filled under transition, the previous claim can be either brand or generic (based on NSDE marketing status).

F. Transition Fills for New Members in the LTC Setting

CenCal Health will ensure 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
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.
4. When an enrollee presents with a prescription written for less than 31 days for an emergency supply in the LTC setting, CenCal Health will accommodate the prescribed amount and allow additional fills as clinically appropriate.

G. Emergency Supplies and Level of Care Changes for Current Members

1. An Emergency Supply is defined by CMS as a one-time fill of a non-Formulary drug that is necessary with respect to current members in the LTC setting. Current members that are in need of a one-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.

2. CenCal Health ensures its PBM can also accommodate a one-time fill in these scenarios via a manual override at point-of-sale.

3. 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 point-of-sale edits. In this instance, CenCal Health will not enter a point-of-sale override.

H. Transition Across Contract Years

1. For current enrollees whose drugs will be affected by negative Formulary changes in the upcoming year, CenCal Health will effectuate a meaningful transition by either: (1) providing a transition process at the start of the new contract year or (2) effectuating a transition prior to the start of the new contract year.

2. The PBM's POS logic is able to accommodate option 1 by allowing current members to access transition supplies at the point-of-sale 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. To accomplish this, POS looks for claims in the member's claim history that were approved prior to January 1 of the new plan year, and that have the same Hierarchical Ingredient Code List (HICL) 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 drug classification). If a generic medication is being filled under transition, the previous claim can be either brand or generic (based on NSDE (National Drug Code Structured Product Labeling Data Elements) drug classification).

3. Negative changes are changes to a Formulary that result in a potential reduction in benefit to members. These changes can be associated with: 1) removing the covered Part D drug from the Formulary, 2) changing its preferred or tiered cost-sharing status, or 3) adding utilization management. The transition across contract year process is applicable to all drugs associated to mid-year and across plan-year negative changes.

I. Transition Extension

1. CenCal Health will make arrangements to continue to provide necessary 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, point-of-sale overrides can also be entered by CenCal Health or by its PBM (as authorized by CenCal Health) in order to provide continued coverage of the transition drug(s).

J. Cost-sharing for Transition Supplies

1. CenCal Health 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.

2. For non-LIS enrollees, CenCal Health will ensure 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.

K. Six Classes of Clinical Concern

1. Per CMS guidance, members transitioning to a plan 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 as long as the drug remains on Formulary. Utilization management restrictions (PA and/or Step Therapy) which may apply to new members naïve to therapy, are not applied to those members transitioning to the CenCal CareConnect plan on agents within these key categories. The six classes include:

    a. Antidepressant;

    b. Antipsychotic;

    c. Anticonvulsant;

    d. Antineoplastic;

    e. Antiretroviral; and

    f. Immunosuppressant (for prophylaxis of organ transplant rejection).

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

L. Member Notification

1. CenCal Health Responsibilities

    a. CenCal Health will utilize the CMS model Transition Notice to ensure consistency with federal requirements.

    b. CenCal Health, in coordination with its PBM, will make reasonable efforts to notify prescribers of enrollees who receive a transition notice, ensuring timely and appropriate communication.

    c. CenCal Health is responsible for ensuring that written notifications are provided to members and/or providers in accordance with CMS guidelines.

    d. To support timely and accurate member communication, CenCal Health has elected to contract with the PBM's print vendor. This vendor will receive the Transition of Care Notification File and manage the fulfillment and mailing of member notices on CenCal Health's behalf.

2. PBM Responsibilities (as Delegated by CenCal Health)

    CenCal Health delegates the following responsibilities to its PBM:

    a. The PBM will provide (via FTP) two daily files:

        i. Transition Notification "All" File: Contains claims data and other member information necessary for CenCal Health to contact members and providers regarding transition fills.

ii. Transition Notification "Print" File: Includes member and claims data needed to produce member notices. This file is designed to allow the production of one transition notice per member within a 100-day period where the drug, transition type, and applicable drug restrictions are the same.

b. The PBM will send written notice via U.S. first class mail to the enrollee within three business days of adjudication of the temporary transition fill. If the enrollee completes the transition supply in several fills, the PBM is required to send the notice with the first transition fill only. The notice must include:

i. an explanation of the temporary nature of the transition supply the enrollee has received;

ii. instructions for working with CenCal Health and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the Formulary;

iii. an explanation of the enrollee's right to request a Formulary exception;

iv. a description of the procedures for requesting a Formulary exception;

v. for long-term care residents dispensed multiple supplies of a drug in increments of 14-days-or-less, consistent with the requirements under 42 CFR 423.154(a)(1)(i), the written notice must be provided within three business days after adjudication of the first temporary fill.

M. Prescription Drug Event (PDE) Reporting

This is a CMS required process and any drugs dispensed that qualify under the transition period are reported as covered Part D drugs with appropriate Plan and member cost-sharing amounts on the PDE.

N. CMS Submission

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

O. Transition Policy Accessibility and Disclosure

CenCal Health will make the transition policy available to enrollees via link from Medicare Prescription Drug Plan Finder to CenCal Health's web site and include in pre- and post-enrollment marketing materials as directed by CMS.

P. Pharmacy and Therapeutics (P&T) Committee Role

1. Formulary: CenCal Health utilizes the PBM's standard Formulary and delegates the maintenance of clinical guidelines to the PBM's P&T Committee. CenCal Health retains oversight of this process and reviews the PBM's recommendations to ensure alignment with CenCal Health's clinical and regulatory standards. Final accountability for Formulary decisions and exception processes remains with CenCal Health.

2. The P&T Committee reviews and recommends the transition process in the following areas:

    a. All Formulary step therapy and prior authorization guidelines for clinical considerations; and

    b. Procedures for medical review of non-Formulary drug requests, including the exception process.

Q. Exception Process

1. CenCal Health coordinates with its PBM to implement the exception process as part of the overall transition plan for CenCal CareConnect members. While the PBM may process exception requests operationally, CenCal Health retains responsibility for ensuring that all exception decisions are made in accordance with CMS guidelines and that the process is transparent, clinically sound, and member-centered.

    CenCal Health coordinates with its PBM on an overall transition plan for CenCal CareConnect members; a component of which includes the exception process. This exception process integrates with the overall transition plan for these members in the following areas:

    The 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.

    When evaluating an exception request for transitioning members, CenCal Health's exception evaluation process considers the clinical aspects of the drug, including any risks involved in switching, when evaluating an exception request for transitioning members

    The exception policy includes a process for switching new CenCal CareConnect plan members to therapeutically appropriate Formulary alternatives failing an affirmative medical necessity determination.

2. CenCal Health 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 CenCal Health's website.

R. Provider Notification

1. CenCal Health Responsibilities

    a. CenCal Health is responsible for ensuring that Prescriber Transition Notification letters are mailed to prescribers at the same time the transition letters are sent to members.

    b. CenCal Health has elected to contract with the PBM's preferred print vendor to manage the mailing process on CenCal Health's behalf.

    c. CenCal Health will utilize the Prescriber Transition Notification letter template and File Specification document provided by the PBM to ensure consistency and

compliance with CMS requirements.

2. PBM Responsibilities (as delegated by CenCal Health)

   a. The PBM will provide a daily file via FTP to support in generation of Prescriber Transition Notification letters to be mailed to the prescriber at the same time the transition letter is mailed to the member.

      This file is obtained from the existing Transition Notification Files that are sent to plans daily, as described above, and includes the following:

      i. Prescriber information

      ii. Member information

      iii. Transition claim details

   b. The PBM has developed a Prescriber Transition Notification letter template and a corresponding File Specification document to assist CenCal Health in producing and distributing the letters. The template includes recommended Formulary alternatives to support prescribers in identifying appropriate therapeutic options.

IV. Definitions:

Centers for Medicare & Medicaid Services (CMS): The Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

CenCal CareConnect: CenCal Health's exclusively aligned enrollment Dual Eligible Special Needs Plan (D-SNP) available to CenCal Health Medi-Cal full benefit dual eligible members.

Formulary: The entire list of drugs covered by a Medicare Part D plan.

HICL (Hierarchical Ingredient Code List): A standardized code used to identify the active ingredient(s) of a drug, regardless of brand or formulation. It supports transition of care processes by enabling recognition of previously used medications for temporary coverage decisions.

Medicare Part D: A voluntary program that helps Medicare beneficiaries cover the cost of prescription drugs. These plans are offered and managed by private insurance companies that have been approved by Medicare.

NSDE (National Drug Code Structured Product Labeling Data Elements): A dataset maintained by the U.S. Food and Drug Administration (FDA) that standardizes and organizes information about drug products marketed in the United States. It supports accurate identification and classification of medications for formulary management and transition of care processes.

Pharmacy Benefit Manager (PBM): A third-party administrator that manages prescription drug benefits for health insurers, large employers, and other payers

V. References:

A. 42 CFR 423.120(b)(3), 42 CFR 423.154(a)(1)(I), and 42 CFR 423.578(b)

VI. Cross Reference: N/A

VII. Attachments: N/A

Administrative Management

Internal and External Oversight	
Line of Business (LOB): Medi-Cal ☐ Dual Special Needs Plan (D-SNP) ☒ N/A ☐	
Regulatory Oversight: CMS ☒ DHCS ☐ DMHC ☐ N/A ☐	
Required for NCQA Accreditation: No ☒ Yes ☐	
Committee Oversight: ☐ Anti-Fraud Committee (AFC) ☐ Board of Directors (BOD) ☐ Community Advisory Committee (CAC) ☐ Customer Experience Committee (CEC) ☒ Compliance Committee (CC) ☐ Delegation Oversight Committee (DOC) ☐ Member Services Committee (MSC) ☐ Network Management Committee (NMC)	☐ Provider Credentialing and Peer Review Committee (PCC) ☒ Pharmacy and Therapeutics Committee (P&TC) ☐ Quality Improvement and Health Equity Committee (QIHEC) ☐ Security Committee (SC) ☐ Utilization Management Committee (UMC) ☐ N/A

Revision History					
P&P Revision Date	**Leader Review and Approval**	**Reason for Revisions**	**Revision Effective Date**	**Regulatory Approval Date**	**Compliance Committee Approval Date**
06/2025	Jeff Januska, Director of Pharmacy Services Maya Heinert, Chief Medical Officer	New Policy	06/2025	TBD	MM/YYYY

07/2025	Jeff Januska, Director of Pharmacy Services Maya Heinert, Chief Medical Officer	Revised policy to address issues identified by CMS	07/2025	TBD	08/20/2025