Department: Pharmacy	Effective Date: 1/1/2024
Policy and Procedure Title: Part B Drug Transition Period	Most Recent Revision Date: 12/19/2025
Approved by: Utilization Management Committee	Applies to: ☑ GlobalHealth Holdings, LLC ☑ GlobalHealth, Inc.

POLICY

The minimum 90-day transition period prohibits a Medicare Advantage (MA) plan from disrupting or requiring preauthorization for an active course of treatment for new plan enrollees for a period of at least 90-days (or the course of treatment has concluded, whichever comes first). The MA plan cannot deny coverage of active courses of treatment on the basis that the active course of treatment did not receive prior authorization (or was furnished by an out-of-network provider) but may review the services furnished during the active course of treatment against permissible coverage criteria when determining payment.

PURPOSE

To ensure that GlobalHealth is in compliance with all regulations for the 90-day transition period for medications requested to be covered under a new enrollee's medical benefit (Part B) as defined by Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS) Final Rule (CMS-4201-F).

REFERENCES

- Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS) Final Rule (CMS–4201-F)
- Medicare Advantage and Part D Drug Pricing Final Rule (CMS-4180-F) 42 CFR Parts 422 and 423
- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective November 18, 2024)
    - Section 10.5: Adjudication Requirements
    - Section 20: Representatives
    - Section 40: Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations
    - Section 80: Reopening and Revising Determinations and Decisions.
- Program Audit Protocol and Data Request, Part C Organization Determinations, Appeals, and Grievances (ODAG) OMB Approval 0938-1395 (Expires 01/31/2027)
- HPMS Memo: Release of Medicare Advantage and Prescription Drug Plan Appeals Guidance (2/22/2019)
- CMS HPMS Memo: CY 2022 Parts C & D Dismissal and Withdrawal Q's & A's, December 9, 2021
- Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE) (CMS-4208-F)
- 42 CFR 422.566 Organization Determinations
- 42 CFR 422.138(c) Prior Authorization – Effect of prior authorization, pre-service, or concurrent approval.
- 42 CFR 422.568(b)(3) Requests for a Part B drug
- 42 CFR 422.572(a)(2) Timeframe and notice requirements for expedited organization determinations – Requests for a Part B drug
- 42 CFR 422.112(b)(8) Continuity of Care

DEFINITIONS

1. Active Course of Treatment: a course of treatment in which a patient is actively seeing the provider and following the course of treatment.
2. Course of Treatment: a prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan.
3. Expedited Organization Determination for Part B Drugs: An enrollee, or any physician, may request an expedited organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. The determination must be rendered as expeditiously as the enrollee's health condition might require, but no later than twenty-four (24) hours after receiving the enrollee's request.
4. MR4: Platform used by PBMs for clinical and utilization management, providing care management and regulatory compliance for risk-taking health plans, pharmacy benefit managers (PBMs), and provider organizations.
5. Organization Determination: Any determination made by a health plan regarding any of the following:
    a. Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
    b. Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered, should have been furnished, arranged for, or reimbursed by the health plan.
    c. The health plan's refusal, pre or post-service or in connection with a decision made concurrently with an enrollee's receipt of services, to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the health plan.
    d. Reduction, or premature discontinuation of a previously authorized ongoing course of treatment.
    e. Failure of the health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.
6. Pre-Service Organization Determination: GlobalHealth's determination regarding the items and/or services a member is entitled to receive under their benefit plan when a request for the provision of health services is received prior to the service being delivered by a Provider. Some healthcare services are required to be pre-authorized (evaluated and approved by GlobalHealth prior to being accessed by the member in order for payment to be rendered).
7. Prior Authorization: A utilization management requirement under which an enrollee (or their provider) must obtain approval from GlobalHealth before the plan will cover a specific service, item, or benefit. The process ensures that the service meets the plan's coverage criteria and is medically necessary according to CMS standards.
8. Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence, and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits, or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.

9. Reliable evidence: means evidence that is relevant, credible, and material.
10. Similar fault: means to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim as defined in part 411 of Title 42 Chapter IV, Subchapter B.
11. Standard Organization Determination for Part B drugs: A decision to authorize or deny a pre-service request for authorization of specific inpatient or outpatient medical services that must be rendered as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours after the date GlobalHealth receives the request.

PROCEDURES

A. Transition
   1. Overview:
      a. GlobalHealth does not disrupt or require preauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days, when enrollee currently undergoing treatment switches to a new MA plan, even if the course of treatment was for a service that commenced with an out-of-network provider.
      b. The 90-day transition period begins the day enrollment in the new plan becomes effective,
      c. Who is eligible for a Part B drug transition: all new enrollees* who are undergoing an active course of treatment —including where the active course of treatment is taking a physician-administered drug covered under Part B.
         i. New Enrollees are those:
            - New to an MA coordinated care plan having either been enrolled in a different MA plan with the same or different parent organization, or;
            - An enrollee in Traditional Medicare and joining an MA coordinated care plan.
            - Beneficiaries new to Medicare and enrolling in an MA coordinated care plan.
         ii. An active course of treatment is one in which a patient is actively seeing the provider and following the course of treatment. (§ 422.112(b)(8)(ii)(B))
      d. After 90 days GlobalHealth will reassess medical necessity through a prior authorization and apply out-of-network limits in accordance with plan benefits and other relevant requirements as appropriate.
      e. If the above information is received to confirm active treatment, the Pharmacy Administrative Coordinator will upload the document as an attachment to the authorization request in MR4. The Pharmacy Administrative Coordinator will then proceed with the approval of the Part B Drug transition fill for up to a maximum of 90 days of treatment within the member's first 90 days of transition.
   2. Effect of prior authorization, pre-service, or concurrent approval
      a. After approving a covered item or service through prior authorization or pre-service determination of coverage or payment, or a concurrent determination made during the enrollee's receipt of inpatient or outpatient services, GlobalHealth does not deny coverage later on the basis of lack of medical necessity and does not reopen such decision, except for good cause or if there is reliable evidence of fraud or similar fault.
      b. Approval of a prior authorization request for a course of treatment is valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation.
   3. Training:
      a. New hires are trained during orientation and through peer training.
      b. Staff is notified of updates and changes to policy through departmental meetings and/or email notification with additional training provided as needed.

RELATED GH POLICIES AND PROCEDURE(S)

N/A

ATTACHMENTS(S)

N/A

POLICY AND PROCEDURE REVIEW & REVISIONS:

DATE	CHANGE(S)	REASONS
11/28/2023	Creation	Creation of SOP to comply with CMS-4201-F (Final Rule) and UM Part B Transition Requirement.
12/14/2023	Revised according to regulatory requirements.	Ad hoc revision to comply with UM Requirements of Final Rule CMS4201-F and policy GH-COMP-001.
12/30/2024	Updated template from a Standard Operational Procedure (SOP) to a Policy and Procedure template. Updated references.	Annual review to comply with GH-COMP-001.
12/19/2025	Updated the Organization Determination definition. Included the following definitions: Active Course of Treatment, Course of Treatment, Prior Authorization, Reliable Evidence, Similar Fault, and MR4. Replaced mention of Healthaxis with the PBM platform MR4. Included section 2 – "Effect of prior authorization, pre-service, or concurrent approval" to align with the 2026 Final Rule CMS-4208-F. Updated the references.	Annual review to comply with GH-COMP-001