

PrimeTime Health Plan's Medicare Part D 2019 Transition Supply Policy

Regulation/Requirement:	42 CFR §423.120(b)(3) 42 CFR § 423.154(a)(1)(i); 42 CFR § 423.578(b); Prescription Drug Manual, Chapter 6, Section 30.4; Part D Transition Letter 2019 Final Rule
Purpose:	This document defines PrimeTime Health Plan's prescription drug transition policy which ensures compliance with Medicare Part D transition supply requirements.
Scope:	This Policy is applicable to the PrimeTime Health Plan's Prescription Drug Plan and its enrollees covered under CMS Contract(s) H3664.
Policy:	Where applicable and as required by CMS, PrimeTime Health Plan 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. 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.

II. Definitions

Centers for Medicare & Medicaid Services (CMS)	The United States federal agency which administers several federally-funded health care programs including, but not limited to, Medicare, Medicaid, and Children's Health Insurance Programs.
Current Enrollee	A beneficiary who remains enrolled in a Part D Plan across a contract year without any gaps in coverage.

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Exception	An exception request is a type of coverage determination. An enrollee, an enrollee's prescriber, or an enrollee's representative may request a tiering exception or a formulary exception. Exceptions requests are granted when a Plan sponsor determines that a requested drug is medically necessary for an enrollee.
Express Scripts, Inc. (ESI)	The pharmacy benefit management organization who is delegated the role of providing services to clients that operated as a Plan Sponsor.
GCN	Generic Code Number - One of First Data Bank's Smart Keys that is specific to a particular drug.
HICL	Hierarchical Ingredient Code List- One of First Data Bank's Smart Keys that identifies the chemical ingredient of a drug.
LTC	Long Term Care – A facility that provides long-term care including the dispensing of eligible drugs.
MDD	Maximum Daily Dose – The maximum amount of a drug per dosing event as defined by the manufacturer and included on approved drug labeling.
New Enrollee	Beneficiaries who enroll for the first time into a Part D Plan.
Part D Eligible Drugs	Medications determined by Medicare to count toward the true out of pocket costs for a Medicare Part D beneficiary.
Pharmacy and Therapeutics Committee (P&T)	A committee, comp rising of enrollees from various clinical specialties that makes decisions affecting formulary content including exceptions, tier value, prior authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect drug access.
Prior Authorization (PA)	A process through which the physician or other health care provider is required to obtain advance approval from the Plan that payment will be made for a service or item furnished to an enrollee.
RT	Route of Administration – One of First Data Bank's Smart Keys that identifies how a drug is administered (e.g., oral, injectable).
RTS	Refill Too Soon – An edit that exists indicating that a drug claim has been presented too early for the pharmacy to dispense to an enrollee.
SCF	Short Cycle Fill – Guidance and related edits pertaining to enrollees receiving certain drugs in a LTC setting. Drugs subject to short-cycle fill edits were defined by CMS and must be dispensed to patients in limited quantities as per the CMS guidance.

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III. Policy

Task 1:	Transition Requirements – CMS Attestation #1
	<p>The Plan offers this transition policy as a written description of the appropriate transition processes consistent with 42 CFR §423.120(b)(3) for our enrollees whose current drug therapies may not be included in their new Plan formulary. The Plan will maintain this policy and effectuate a meaningful transition as delegated for:</p> <ol style="list-style-type: none"> 1. New enrollees into its 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; 6. In some cases, enrollees who change treatment settings due to a change in level of care. <p>Enrollees who are undergoing a change in care are eligible for a temporary fill to ensure the continuity of needed medications across care settings. If the enrollee is not in their transition period during their care change, or is in the transition period but have already received their transition fill days supply maximum, the system will reject the claim and appropriate reject codes are returned to the pharmacy. The network pharmacy receives additional secondary messaging (IF LEVEL OF CARE) and training to inform the pharmacy of the appropriate procedure. In the circumstance where a beneficiary is changing care setting and may not have access to current prescriptions, the network pharmacy may contact the ESI help desk for an override to dispense a temporary transition fill. Appropriate CMS model transition notifications are generated to the enrollee and the prescriber in the required timetable. As these enrollees are vulnerable to disruption in care, ESI also provides daily rejected claims data to the plans for oversight of these enrollees experiencing a change in their care to assure the transition has been effectuated.</p>
Task 2:	Transition Policy Submission CMS Attestation #2
	<p>The Plan will submit a copy of its transition policy to CMS and ensure 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>
Task 3:	Transition Scope CMS Attestation #3

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	<p>The transition process is applicable to non-formulary drugs, meaning:</p> <ol style="list-style-type: none"> 1. Part D Drugs that are not on a plan's formulary; 2. Part D Drugs that are on a plan's formulary but require prior authorization or step therapy, or that have an approved QL lower than the beneficiary's current dose under a plan's utilization management rules. <p>The Plan will ensure that its policy addresses procedures for medical review of non-formulary drug requests, and, when appropriate, a process for switching new Part D plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination. The Plan's coverage review and care coordination process addresses this requirement.</p>
Task 4:	System Capabilities - CMS Attestation #4
	<p>The Plan has systems capabilities that allow the plan 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. Transition system capabilities are outlined in detail in* Attachment A.</p>
Task 5:	Transition Timeframes and Temporary Fills – CMS Attestation #5
	<p>The plan ensures that, in the retail setting, the transition policy provides for at least 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 of medication, in which case the plan will allow multiple fills to provide up to a total of one 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. In some instances, greater than a month's supply will be dispensed in order to avoid having an enrollee that encounters a hard reject leave the pharmacy without their prescribed drug.</p>
Task 6:	Cost-Sharing Considerations CMS Attestation #6
	<p>The Plan 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, the plan will 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.</p>

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Task 7:	LTC Day Supply CMS Attestation #7	
	7.1	<p>The plan will ensure that in the LTC setting:</p> <ol style="list-style-type: none"> 1. The transition policy provides for a one month 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) while an exception or prior authorization is requested; and 3. For enrollees being admitted to or discharged from a LTC facility, early refill edits can be overridden at point of sale to allow the enrollee access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge.
	7.2	<p>Emergency Supply for LTC Enrollees Outside of their Transition Period An automated process is in place so that an enrollee residing in an LTC will be allowed an additional transition supply of an eligible drug once they are outside of their transition period. These automated emergency transition supply claims provide at least a 31 day supply (or in appropriate increments in the case of SCF or prepack drugs), unless the prescription is written for less than 31 days, while an exception or prior authorization request is in process. Appropriate CMS model transition notifications will be generated for both enrollee and prescriber.</p>
Task 8:	Edits for Transition fills CMS Attestation #8	

	<p>The plan's transition process will automatically effectuate a transition supply where appropriate for enrollees except where the following edits apply to the claim at the point of sale:</p> <ol style="list-style-type: none"> 1. Edits to determine Part A or B versus Part D coverage; 2. Edits to prevent coverage of non-Part D drugs; 3. Edits to promote safe utilization of a Part D drug. <p>Secondary messaging is sent to the pharmacy to further inform the pharmacy on the reason for the edit and 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. The plan will conduct oversight to assure prescriber's response to coverage review requests for enrollee access to needed medications.</p> <p>Step Therapy and Prior Authorization edits will be resolved at POS through system logic.</p>
<p>Task 9:</p>	<p>Quantity Limits CMS Attestation #9</p>
	<p>The plan 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. The enrollee will be allowed refills up to the days supply allowed in the benefit.</p>
<p>Task 10:</p>	<p>New Prescriptions Versus Ongoing Drug Therapy CMS Attestation #10</p>
	<p>ESI, as delegated, will apply transition processes to a brand-new prescription for all non-formulary drugs at the point of sale if the pharmacy cannot make the distinction whether the prescription is brand-new or an ongoing prescription for a non-formulary drug. 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 fill if the enrollee has not received their full transition supply. The process will allow for refills of a transition eligible drug at the point of sale to ensure enrollees receive at least a one month supply of a transition eligible drug.</p> <p>The system will allow for refills of a transition eligible drug at the point of sale to ensure enrollees receive at least a one month supply of a transition eligible drug. In some cases, more than a one month supply will be extended when the drug is prepackaged and cannot be dispensed at a lower day supply.</p>

Task 11:	Transition Notices CMS Attestation #11	
	11.1	<p>The plan will send written notice consistent with CMS transition requirements. A written CMS approved notice is sent via USPS First Class Mail to the plan's enrollee within three business days of adjudication of a temporary transition fill. The notice includes:</p> <ol style="list-style-type: none"> 1. An explanation of the temporary nature of the transition supply that the enrollee has received; 2. Instructions for working with the plan and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on the plan's formulary; 3. An explanation of the enrollee's right to request a formulary exception; 4. A description of the procedures for requesting a formulary exception, which includes expected timeframes to decision the request, and information on the right to appeal. <p>For long term care residents dispensed multiple supplies of a Part D 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.</p>
	11.2	<p>The Plan will also ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice. Where delegated, ESI will send prescriber notifications with a fax notification, followed by mailing a written notification if faxing is not successful; typically the letter is sent within five business days of the adjudication date of a transition supply dispensed to their patient. The prescriber notification utilizes a separate letter for the prescribing physician notifying them of the transition supply obtained by the enrollee.</p>
	11.3	<p>There are circumstances in which notifications cannot be mailed to either an enrollee or a prescriber, or faxed to a prescriber. Those circumstances include enrollees for whom the Plan or ESI does not have an approved USPS mailing address on file, or valid prescriber information despite ESI accessing multiple national prescriber databases. In these situations, ESI produces both member and prescriber drop files each business day to facilitate plan action and outreach. 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 letter being sent. Monitoring of daily reject reports and letter reports support the enrollee experience for this potential circumstance.</p>

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Task 12:	Exception Request Forms CMS Attestation #12
	Enrollees and prescribers may call Customer Service lines and request prior authorization or exceptions request forms upon request via a variety of mechanisms including mail, fax, or email. They may also download the forms from the plan's website.
Task 13:	Transition Across Contract Years CMS Attestation #13
	The plan will extend its transition policy across contract years should a beneficiary 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 minimum 90 day transition window under this across plan year transition process.
Task 14:	Public Notice of Transition Process CMS Attestation #14
	The plan will make their transition policy available to enrollees via link from Medicare Prescription Drug Plan Finder to the plan's web site and included in pre-and post-enrollment marketing materials as directed by CMS.
Task 15:	Transition Extension CMS Attestation #15
	The Plan will continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, where delegated, to the extent that 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 (either through a switch to an appropriate formulary drug or a decision on an exception request.)
Task 16:	Current Enrollees CMS Attestation #16

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	<p>16.1 For current enrollees whose drugs will be affected by negative formulary changes in the upcoming year, the plan will effectuate a meaningful transition by either:</p> <ol style="list-style-type: none"> 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. <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 will be provided with a transition supply of an eligible drug unless the drug was previously filled as a transition supply.</p> <p>The system queries current enrollee's previous utilization through a look-back window that begins on the last day of the previous plan year and extends back 180 days. If the enrollee had previous utilization, they are 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 their cross-plan year window, as that enrollee is not transition eligible.</p> <p>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 for the same HICL and RT code.</p>
<p>Task 17:</p>	<p>Transition Process Oversight and Monitoring</p>
	<p>ESI oversees and monitors the Transition Supply process to ensure that enrollees have access to necessary drugs as required by CMS guidance.</p> <ul style="list-style-type: none"> • ESI reporting is made available to demonstrate to plans the appropriate paid, rejected, and transition-related claims. • Oversight reports are provided to plans to monitor required enrollee notifications and prescriber notifications, if delegated. • ESI's system monitors rejected claims three times a day. • If action is not taken by a pharmacy to clear a reject and successfully adjudicate the transition eligible claim, ESI outreach is made by automated outbound messaging to advise the pharmacy of the concern for action on the steps to have the claim pay.

Attachment A

**ESI
Transition Supply – Plan Implementation Statement**

This document provides the following information:

1. A detailed explanation of the ESI system processes in support of transition supply requests within our adjudication system;
2. How a network pharmacy is notified when a transition supply of medication is processed at the point of sale; and
3. A description of the edits and an explanation of the process network pharmacies must follow to resolve those edits at the point of sale during the adjudication of a transition supply.

The ESI adjudication process that supports transition supply requirements operates as follows:

1. A pharmacy receives a prescription request from:
 - An enrollee who is new to a plan and within their first 90 days of enrollment or;
 - An existing enrollee at the beginning of a plan year who is established on a drug that has become transition eligible or;
 - An enrollee who has experienced a Level of Care change or;
 - An LTC resident enrollee in need of an emergency supply
2. The pharmacy submits the prescription request and the transition process continues if the drug is identified as non-formulary or, on the formulary but with utilization management edits applied based on the plan's approved formulary submission.
3. ESI system verifies enrollment in the plan based on the eligibility set up requirements and file sent by the plan; or the ESI system verifies that the enrollee is within the transition period by reviewing the enrollee's available plan eligibility history.
4. ESI system verifies that the drug submitted qualifies for a transition supply based on the reject messaging triggered. The rejects indicate one of the four transition eligible categories:
 - 1.Non-Formulary;
 - 2.Prior Authorization Required;
 - 3.Step Therapy rules;
 - 4.Quantity rules.
5. ESI system determines the allowable days supply for a transition fill based on the plan's benefit set up requirements
6. ESI 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.
7. ESI system is set-up to automatically pay emergency supply claims. 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 31 days will be paid

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8. ESI system determines if an current enrollee is eligible for transition across Plan years when a paid claim is found within 180 days of the previous Plan year for the same drug by HICL/RT where the history claim did not pay under transition logic.
9. Using the submitted days supply from the claim, the ESI system will verify that the claim is within the transition days supply limit or has remaining transition day supply to be dispensed.
 - Transition claims will be 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.
 - When greater than the overarching Plan limits, the claim will hard reject and a message will be returned to the pharmacy noting the allowable day supply/quantity for a transition fill. The pharmacy is then notified to resubmit the claim within the limits presented in the message.
10. Oversight of the Transition Process includes daily outreach via telephone. AOM is made to any retail network pharmacy that is not able to resolve hard rejects for a transition eligible claim on their own. The outreach is intended to ensure a timely transition supply of needed medication for an eligible enrollee.
11. If a previous transition supply of the same drug was already dispensed within the same transition period, ESI system will verify whether a refill is allowable based on the previous days supply already dispensed.
12. If a required full transition supply was found to have already been provided to the enrollee while in their transition period, the system will hard reject the claim and return an IF LEVEL OF CARE CHANGE message to the pharmacy with instruction to contact the pharmacy help desk to determine if the enrollee is eligible for a level of care fill.
13. ESI system will calculate cost-sharing for the transition supply based on the plans benefit requirements. For plan benefits where all enrollees are low income subsidy eligible, the copay is tiered to Brand or Generic LICs levels or, if specified, the Part D drugs are tiered to \$0 dollar cost sharing in line with the CMS LICs waiver for Plan.
14. The process will successfully adjudicate the claim and send 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.
15. The required enrollee notifications are mailed within 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.
16. The required prescriber notifications are mailed or faxed within 5 business days after the first fill of a transition supply if we are able to locate valid prescriber contact information in one of the national prescriber databases ESI utilizes (mail notifications for refills of a transition supply are not generated, unless the transition criteria for the drug changes between fills).

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17. ESI's adjudication process described above is configured to automatically pay a claim for an eligible medication when an enrollee is in their transition period, or as a result of the enrollee needing an LTC emergency fill. If a beneficiary is changing care setting and may not have access to current prescriptions, the network pharmacy may contact the ESI help desk for an override to dispense a temporary transition fill. ESI provides additional secondary messaging (IF LEVEL OF CARE) and training to inform the network pharmacy of the appropriate procedure to allow a level of care override.
18. If an enrollee is in need of an extension to the transition fill they can reach out to their plan in advance or at POS to request an extension. ESI network pharmacies are aware of the potential need for an extension while the enrollees prescriber or plan are resolving the exception or prior authorization needed for their medication. The network pharmacy may call the help desk to get an override for an additional transition supply in this circumstance. This final manual step enables transition eligible non-formulary, step therapy and PA edits to be resolved at POS.
19. 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 their account teams on any additional care coordination or action to ensure the transition process is effectuated for their enrollees.

Other Edits:

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. 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. The steps required by the pharmacy are included in the associated messaging returned at point of sale. Training and documentation on these processes is included in the ESI Network Manual to support timely determinations. In addition to limited safety editing, the hard reject messaging conditions that may be triggered during adjudication of a transition supply eligible claim are:

1. 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 will pay and be marked as a transition supply. One message text example is: "ALLOW QT nnnn."
2. 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.

3. Refill Too Soon (RTS)

To limit inappropriate or unnecessary access to Part D drugs, an early refill edit will trigger a hard reject for a transition eligible drug during an enrollee's transition period. The Plans RTS logic considers both mail and retail paid claims, 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 the plan limits the override for each of the following reasons within 180 days:

- Therapy change = unlimited overrides;
- Lost or spilled medication = one override on a case by case basis;
- Vacation supply = two overrides.

The Plan's RTS allowance requires that an enrollee has consumed 70% of their drug on-hand of an ophthalmic agent as well as at least 80% of any other medication at retail and 75% at mail order with the exception of opioids at 85%. The consumption requirement for enrollees in an LTC facility is 80%.

4. Med B/D Determination Required

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 ESI Network Manual to support timely determinations.

5. Med D/non D Determination Required

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"

6. Short Cycle Fill (SCF)

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.

7. Opioid Medication Quantity Limits

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. Beneficiary-level opioid point-of-sale claim edits (and cumulative opioid MME edits), are applied during transition.