Beneficiary Protections -- Uniform PA Implementation for Community Mental Health Centers and MCOs

HB517 Next Business Day Prior Authorization and Peer to Peer Process

- Per HB517, health plans must approve or deny a prior authorization (PA) for medication used to treat serious mental illness that previously was exempted from PA by the close of the next business day.
- If a PA is denied, the Community Mental Health Center (CMHC) prescribing provider may request a Peer to Peer review with a licensed psychiatric specialist with prescribing privileges by close of the next business day. The Peer to Peer may be requested by a stand in, but the actual Peer to Peer must be conducted be the prescribing provider or by a delegate with clinically appropriate authority that has knowledge of the clinical condition of the member.
- For children (under 21 years of age), the Peer to Peer will be with a pediatric specialist.
- Failure of the health plan to provide the Peer to Peer review by close of the next business day deems automatic approval unless the prescriber fails to participate within the time period.
- If the CMHC prescriber fails to participate within the time period, the prescriber may request a standard Peer to Peer from the health plan.

Standard Peer to Peer Requests

- Well Sense Health Plan: the standard Pharmacy Peer to Peer review is usually conducted within 24-48 hours (depending on the availability of the requestor) and is with a licensed pharmacist or a Medical Director.
- NH Healthy Families: the standard Peer to Peer review process is with a licensed pharmacist and is usually conducted within 24 hours of the request for a Peer to Peer. Providers have up to 30 days of the denial determination to request the Peer to Peer.

72 Hour Emergency Supply

- If a member cannot receive a PA before his/her medication is exhausted, the member may need an emergency supply of medication, up to a 72 hour supply for those medications requiring PAs. The pharmacy or CMHC prescriber can request the emergency supply.

Override Request for 96 Hour Supply

- If a member needs an emergency supply of medication exceeding 72 hours (for those medications requiring PAs), then the pharmacy or CMHC prescriber can request a 96 hour emergency supply by:
    - Well Sense Health Plan: calling Well Sense Provider Services (1-877-957-1300, option 3) and asking to be transferred to the PLAN Pharmacy Department. The pharmacy team will verify that the emergency supply request is from a CMHC prescriber and authorize 96 hours of medication. Please note that Plan Pharmacy Staff work Monday-Friday, 8:30-5:00pm.
    - NH Healthy Families: calling Envolve Pharmacy Solutions at 1-866-862-8615 and asking for an emergency supply greater than 72-hours due to extenuating circumstances. Staff is available 24 hours a day, 7 days a week for these requests.
- NOTE: Both Well Sense Health Plan and NH Healthy Families routinely authorize longer than 72 hours for long holiday weekends.

Health Plan Appeals (Standard and Expedited)

- Members, and CMHCs at the request of members, have the right to appeal, within 60 days, an adverse PA decision. There is a Standard and Expedited Appeals Process.

- Providers can file an expedited appeal on behalf of a member without written permission.
- Standard appeals can be initiated by a CMHC with an oral request and followed with the written request and consent form, but the appeal cannot be processed until the consent form is received. Links to the forms are below.
- Standard Appeals are decided within 30 days of the request. Expedited Appeals are decided as expeditiously as the member's health condition requires but no later than 72 hours after the health plan receives the appeal (unless extended).
- Appeals are reviewed by a same or similar clinician but not by the clinician who rendered the denial.
- Appeals usually proceed after the peer to peer process has been completed if one was requested.
- The member must specifically request a continuation of the service or medication they have been receiving pending the outcome of the appeal.
- The appeals process and contact information is provided in the denial letter from the health plan.

State Fair Hearing

- If a member is unhappy with the Standard or Expedited Appeal outcome, a request for a State Fair Hearing may be requested within 120 days of the health plan's written decision.
- A Medicaid beneficiary can continue to receive a service (including a medication) that has been denied and that is being appealed by requesting "aid pending appeal". To ensure that a service or a medication continues pending the State Fair Hearing appeal, a request for continuation of benefits must be submitted within 10 calendar days of the health plan's adverse decision on expedited appeal.
- If a member receives the disputed services while the appeal is pending and the decision is in the member's favor, the health plan will pay for the services or medications provided during the appeal period. If the determination is not in the member's favor, the member may be responsible for the cost of any continued benefits provided during the appeal period.

Contact Numbers

- Well Sense Health Plan:
  - Well Sense Provider Services 1-877-957-1300, option 3
  - Well Sense at pharmacym@bmchp-wellsense.org

- NH Healthy Families:
  - NH Healthy Families Provider Questions: 1-844-761-1064 or NH_Pharmacy@Centene.com
  - Denise Cook (603) 263-7242, DECOOK@CENTENE.COM

- DHHS Medicaid Pharmacy Director:
  - Margaret A. Clifford, Pharmacy Director, 603-271-9098, fax 603-271-8194, margaret.clifford@dhhs.nh.gov

- DHHS Medicaid Care Management:
  - Deb Scheetz, Director Integrated Healthcare Reform, 603-271-9459, Deborah.Scheetz@dhhs.nh.gov

Forms

NH Healthy Families
https://www.nhhealthyfamilies.com/content/dam/centene/NH%20Healthy%20Families/Medicaid/pdfs/NHHF-Auth-Rep-Form.pdf

Well Sense Health Plan
General
https://www.wellsense.org/~/media/14f2cd1c3d084df2bfb10f85f8fa47fa.pdf

Appeal Specific
See Attached Form

WELL SENSE HEALTH PLAN

AUTHORIZED REPRESENTATIVE FORM

Member Name: _____ **Member ID#:**_____
Date of Birth: _____ **Address:** _____
City: _____ **State:** _____ **Zip Code:**_____
Phone #: _____

I hereby authorize the following person to act as my Authorized Representative for the above referenced Appeal. I understand that this person may be given health or payment information related to the above referenced Appeal. Well Sense Health Plan will act on this information until I revoke or amend this authorization. This authorization expires on the Well Sense Health Plan sends out the Appeal decision notice related to this matter.

Authorized Representative Name: _____

Phone #:_____

Member/Legal Representative Signature: _____

Date: _____