National Association
for Behavioral Healthcare

Access. Care. Recovery.

Access to Care Resolution

Adopted by the NABH Board of Trustees on Monday, March 18, 2019

The National Association for Behavioral Healthcare's (NABH) provider systems are committed to ensuring patient access to behavioral healthcare treatment across the entire behavioral healthcare continuum. This continuum includes inpatient, residential, partial hospitalization, intensive outpatient, outpatient, and recovery and support services.

Competent clinical management of access to care must be based on a clear understanding of the purpose behind behavioral healthcare services. Generally accepted standards of professional practice, articulated in robust clinical research and clinical specialty organization consensus statements, recognize that behavioral healthcare treatment is intended to:

(1) Prevent, diagnose, and/or treat behavioral health conditions;
(2) Promote age-appropriate growth and development;
(3) Minimize the progression of disability;
(4) Facilitate, maintain, and/or restore functional capacity; and
(5) Support long-term recovery.

Fair and appropriate coverage for behavioral healthcare services must ensure, not solely offer, access to the entire behavioral healthcare continuum. In the present environment, managed care organizations (MCOs) in all markets nationwide use a variety of rationing practices that too often restrict patient access to medically necessary care. Consequently, these practices compromise patient safety and recovery; worsen disease prognosis; and increase total healthcare costs.

MCOs frequently limit coverage to crisis stabilization or short-term, acute-care services for all levels of care because they often use internally developed, and/or proprietary and non-transparent, medical-necessity criteria that do not reflect generally accepted standards of behavioral healthcare professional practices. These denials are issued regularly without regard for comorbidities, chronicity, or pervasiveness, which result in the briefest of interventions that do not support long-term, meaningful recovery.

In their effort to deny medically necessary care, MCOs rely heavily on non-evidence-based, utilization-management practices, such as frequent concurrent reviews — which are intrusive for patients and inefficient for providers.

Moreover, MCOs often fail to develop networks that provide access to the entire continuum of behavioral healthcare services. The lack of genuine networks impedes, and sometimes altogether precludes, access to the critical continuity of care, such as step-down service levels.

Simply stated: MCOs have erected barriers to medically necessary care.

NABH Guiding Principles: Access to Behavioral Healthcare Services

NABH has developed the following guiding principles to ensure that patients receiving behavioral healthcare services have genuine access to the entire behavioral healthcare continuum. NABH recommends incorporating these principles in all network contracts with MCOs.

1. **Medical Necessity**

   MCOs over-manage behavioral healthcare and dismiss the judgement of experienced clinicians. In addition, MCOs often apply unduly restrictive medical-necessity criteria developed internally or by external organizations, rather than by clinical specialty associations.

   Patients are entitled to access the full continuum of behavioral healthcare services that follow generally accepted standards of professional practice. Therefore:

   a. Medical-necessity criteria should be transparent, publicly accessible, and developed by clinical specialty organizations that do not service MCOs as primary clients.
   b. MCOs should apply level-of-care/intensity selection criteria developed by clinical specialty associations such as *The American Society of Addiction Medicine (ASAM) Criteria* (for substance use disorders); the Level of Care Utilization System, or LOCUS, for adults and CA-LOCUS for children and adolescents; the *American Psychiatric Association (APA) Practice Guideline for Treatment of Patients with Eating Disorders*; or comparable criteria that behavioral healthcare providers recognize and accept as standards of professional practice.

2. **Utilization Management**

   MCOs generally conduct concurrent and peer reviews with individuals who have never met with the patients involved.

   Patients are entitled to have their behavioral healthcare claims processed through a fair, evidence-based, mutually efficient, and *transparent* utilization-management system. Therefore:

   a. Utilization management for behavioral healthcare services must be comparable to and no more restrictive than utilization-management practices used for medical/surgical services. This means:
      i. Pre-authorizations: should not be limited to “day of admission” if medical/surgical pre-authorizations do not require the same;
      ii. Concurrent reviews: should not occur more frequently or with greater stringency for behavioral healthcare services than for medical/surgical services;
      iii. Retrospective reviews: should not be required — except in cases of fraud — when preauthorization (upon admission or concurrent review) has been obtained, unless otherwise required by law;
      iv. Transparency: meaningful data regarding MCOs’ compliance with the *Mental Health Parity and Addiction Equity Act (MHPAEA)* of 2008 should be given to patients, authorized representatives, and providers upon request.

b. Health information should flow both ways between providers and MCOs. MCOs should ensure ***timely*** production of internal policies and procedures as well as utilization-management data when requested by patients, authorized representatives, and providers.
c. MCOs — including their outsourced, third-party contractors — must process claims and appeals (for preauthorization and concurrent care) on a timely, expedited basis when designated as "urgent" by providers.
d. MCOs should develop behavioral healthcare service networks that meet suitability, timeliness, and geographic access standards set by law or state contract. If MCOs are unable to meet these standards, MCOs must authorize out-of-network services at no additional patient cost beyond in-network cost sharing. MCOs should not deny, interrupt, or delay ongoing care if they cannot locate suitable, timely, and geographically accessible behavioral healthcare services for transition from a current intensity/level of care.

3. Network Adequacy

MCOs often fail to cover services along the full behavioral healthcare continuum, particularly early intervention, intermediate services such as intensive outpatient treatment, partial hospitalization, and residential treatment. Consequently, they deny patients access to appropriate levels of care and undermine treatment's primary goal: recovery.

Patients are entitled to suitable, timely, and geographically accessible care, and MCOs have an obligation to facilitate such care. Therefore:

a. MCOs should recognize and cover all services in the behavioral healthcare continuum.
b. In the case of coverage exclusions, MCOs should ensure that benefits are in compliance with the *MHPAEA* of 2008.
c. MCOs should ensure reimbursement is consistent with fair-market rates that promote interest in network participation.
d. MCOs should expedite the credentialing process for licensed providers (including all facilities in good standing) to participate in networks.

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