Coverage Denied: The Burden of Prior Authorization for Child and Adolescent Psychiatry and the Impacts on Patient Care

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A deafening silence permeated the room. A mother visibly overwhelmed, tears filling her eyes, looked forlorn as she had brought her 14-year-old son to the psychiatric emergency room for evaluation of his behavior. The reasons for prompting the visit were evident on minute one of the encounter. The dysphoric and withdrawn appearing young man adamantly avoided eye contact as he reluctantly revealed numerous superficial and deep lacerations to his forearm. The patient did not engage much and had a prominent apathetic affect, often shrugging his shoulders responding, "who cares" and "whatever" to questions asked. This was a stark contrast from the vibrant straight A high school freshman that had recently joined his school's marching band.

"How could this happen?" questioned the mother as she looked down, sniffling and damply pressing tissues to her eyes. "We were doing so well. He hadn't cut or thought about suicide for over a year."

In fact, the patient had been doing well. He was attending all medication management appointments with his outpatient psychiatrist, had active and engaging participation in individual therapy with his counselor once weekly, and had just started a new job as a cashier at a local pizzeria.

So, What Went Wrong?

COVERAGE was DENIED. The patient's fluoxetine, one of the most commonly prescribed psychotropic medications with well-established US Food and Drug Administration (FDA) indications, was no longer approved by the patient's insurance provider due to formulary changes. An integral part of his stabilization was thus not afforded. What resulted was an unfortunate adverse event in which the patient went days and weeks without his medications as a cumbersome administrative appeal took place via a prior authorization (PA) procedure.

Making changes to medications for pediatric patients is complex. Risks and benefits, contraindications, medication tolerability, patient preferences, and evidence-based practices are all factors that influence the individualized care from child and adolescent psychiatrists (CAPs). Recently however, CAPs and patients are having to familiarize themselves with an onerous PA process that often belabors the decision-making and treatment received. This paper addresses the issue of PAs and identifies how CAPs can best advocate for patients by ultimately improving the quality and trajectory of care with specific principles of reform and advocacy initiatives. The goal is to elevate awareness to change PA procedures through informed intent.

PAs for medications prescribed in clinical practice is commonplace. A recent 2018 American Medical Association (AMA) physician survey indicates 88% of physicians have reported increased PA burden over the last 5 years, completing on average 31 PAs per week.[1] Serving the purpose of ensuring medications are medically necessary, CAPs are often resigned to justify selection, continuation, or dose adjustments of medications in comparison to lesser expensive alternatives. This justification takes time, making it an obstacle to tending directly to patient's needs. This administrative burden reduces meaningful spent time on evaluating patient needs and requires approximately 14.9 business hours of lost clinical time per week.[1] What can result are restrictions and limitations of full range of psychotropic medications utilized, minimizing the evidence-based practices of CAPs and degrading quality of care.

Care-Driven or Cost-Driven?

As stated in *The Principles of Practice of Child and Adolescent Psychiatry*, the primary concern of CAPs is the welfare and optimal development of the child.[2] The informed uses of psychotropic medications, such as the careful selection and uptitration of fluoxetine in the case vignette, becomes elucidated as a fundamental component in improving the lives and outcomes of children and adolescents who suffer from psychiatric illness. Efficacy, safety, and patient satisfaction are always of primary concern in the treatment of pediatric psychiatric issues.[2]

The particular issue of costs has taken center stage in the discussion on the impact of care received by patients. Given that the CAP is often personally completing the required documentation and follow-up for patients, PAs represent an "extra step" health plans require before deciding to pay for certain treatments. On average, the time to complete PAs range from 1 minute to 2 hours, with a mean of 13.4 minutes to complete.[3] The estimated resultant burden of cost for completing PAs, not including psychiatrist involvement and lost patient time, is $7 to $10 per PA request, approximating 10% of the reimbursed costs for public insurance.[3] What results is resources diverted away from patient care, negatively affecting patient health outcomes. A 2018 AMA Prior Authorization Physician Survey indicates that 91% of patients requiring PAs reported care delay, with 26% of patients waiting at least 3-5 days of no treatment received.[1] As was tragically apparent in this case vignette, 75% of patients reported PA can lead to treatment abandonment and nonadherence, resulting in 28% of patient outcomes leading to serious adverse events (eg, death, hospitalizations, disability/permanent bodily damage, or other life-threatening event).[1] CAPS are therefore concerned that PAs do not allow for best practice guidelines, instead preferring lesser expensive options. For example, this can manifest with patients trialing numerous older, less expensive psychotropic agents prior to initiating novel medications with less side effect profiles. It is important to note that adverse patient outcomes should be the center of discussion when advocating for PA reform.

PAs can also represent a unique barrier to equity of care by lowering resource levels at CAP practices who service patients from underserved and minority populations. Persistent racial and ethnic disparities have been found in access to pediatric mental health care and use of psychotropic drug use.[4] PA procedures only further perpetuate treatment disparities,[5] and policy reform should aim to focus on reducing barriers to access of non-white, black and Hispanic patients. Ensuring the strength of CAP workforce by addressing principles of PA reform is essential in optimizing patient care and targeting bias mitigation for marginalized patients.

Increased Collaboration With Insurers?

The issue of costs and care are not dichotomous amongst CAPs and insurers. Both share concomitant goals of delivering patients with psychiatric illness access to quality care. Despite perceptions of being a workplace hinderance, the US Government Accountability Office in 2012 addressed how PAs have reduced systems costs by $1.9 billion over 5 years of implementation.[6] Similarly, states implementing PA have found utility in addressing prescribing patterns, with evidence pertaining to CAPs. For instance, many state Medicaid programs have seen prescribing reductions of antipsychotics in children ages 6 to 12 years old.[7] These policies have better educated patients and families of long-term cardiometabolic profile changes associated with antipsychotic use, in addition to inform CAPs on best evidence-based practices negotiating risks and benefits.

PAs are here to stay, are standard operating practice in the United States, and have a powerful lobbying force behind them. Given the potential daily impact of PAs, CAPs are having to adjust accordingly by working with, not against payers, to mitigate the structural impediments of PAs. Many CAPs are staying informed and continuously familiarizing themselves with requirements for PAs by reading bulletins and newsletters offered by insurance and pharmaceutical companies.[8] CAPs are learning to better engage with insurers by avoiding PA submissions with unmet requirements or little chance of approval, which can explain a recent June 2020 quality

assurance study with a scope of psychopharmacologic prescribing practices at Massachusetts General Hospital revealing 84% of PAs were approved, with only 16% denied requiring appeal or change to another medication.[3]

The AMA, AACAP, and a host of other medical organizations have also partnered to identify similar opportunities in improving the PA process with the collective goals of promoting safe, timely, and affordable access to evidence-based care for patients.[9] Costs alone are never the sole arbiter of psychiatric decision making, and it has been well established that untreated and undertreated psychiatric disorders in children increase medical costs for children and their parents.[10] The specific reform principles developed by the AMA to improve the PA process and patient outcomes can be found on AMA's website, at **https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf** and **https://www.aacap.org/AACAP/Policy_Statements/2019/Prior_Authorization_for_Psychopharmacology.aspx**.

An Advocacy Call to Action

PA reform must be included among the advocacy priorities selected to improve access to care for the children we serve. Improvements must include reduction of the overall volume of PA requests; streamlined, standardized and automated procedures; increased transparency; and timely responses from payers. CAPs have specific knowledge and clinical experience that will help to advance advocacy efforts and support the unique mental health needs of children and adolescents.

The following steps provide a framework to engage in grassroots advocacy.

1. Understand the PA laws in your **state**.
2. Review resources that will inform recommendations and solutions, including the following documents: **AACAP Policy Statement on Prior Authorization**, **AMA Prior Authorization and Utilization Management Reform Principles**, and the **AMA Consensus Statement on Improving the Prior Authorization Process**.
3. Collect examples of PA policies, practices or regulations that conform to or do not conform to the principles as outlined in the above resources. Incorporate these examples in your elevator speech to illustrate the impact of PA policies on patient care, clinical outcomes and health care costs.
4. Contact **AACAP's Department of Government Affairs** and the AACAP Advocacy Liaison representing your regional organization to learn about PA advocacy initiatives.
5. Join grassroots campaigns.
   a. Your AMA state medical society may be organizing advocacy efforts and likely in need of physician advocates.
   b. Share your PA experiences at **FixPriorAuth.org**.
   c. Identify and meet with other allies and coalition partners.
6. Meet with payers, elected officials and other decision makers who have jurisdiction over utilization management policies and regulations.

Simply put, PAs are somewhat of a necessary and inevitable evil. Therefore, an informed understanding of the cost savings, safety and patient outcomes of PA will surely benefit early-career CAPs and the patients we serve. Similarly, any further research efforts should address patient outcomes that guide advocacy efforts, as PAs have been known to affect patient satisfaction, distrust of medical professionals, and poor psychiatric service utilization.[7]

The need for PA reform is critical and the time for action is now. With knowledge and an empowered voice to stand up for patients' rights, CAPs can have a transformative impact on the landscape of utilization management principles and health care coverage.

Take Home Summary

PA remains an integral and inevitable component in practice. It serves CAPs to have a firm understanding of PA including the benefits, drawbacks, and impact on quality patient care. AACAP encourages advocacy efforts by all members to reform the PA process through the listed means.

References

1. 2019 AMA Prior Authorization Physician Survey. The American Medical Association. Published June 2020. https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf. Accessed May 18, 2020.
2. Principles of Practice of CAP, Code of Ethics. The American Academy of Child and Adolescent Psychiatry. Published 1982. https://www.aacap.org/AACAP/About_Us/Principles_of_Practice_of_CAP.aspx. Accessed May 18, 2020.
3. Wilens T, Wilens K, Woodworth KY, Chippari V, Firmin ES. (2020). Prior Authorizations: A Necessary Evil? *J Am Acad Child Adolesc Psychiatry*. 2020; 59(9): 1005-1007. doi:10.1016/j.jaac.2020.06.003
4. Lu, CY, Adams S, Ross-Degnan D, Zhang F, Zhang Y, Salzman C, Soumerai SB. Association between prior authorization for medications and health service use by Medicaid patients with bipolar disorder. *Psychiatr Ser.* 2011;62(2):186-193. https://doi.org/10.1176/ps.62.2.pss6202_0186
5. Cook BL, Barry CL, Busch SH. Racial/Ethnic Disparity Trends in Children's Mental Health Care Access and Expenditures from 2002 to 2007. *Health Serv Res*. 2012;48(1):129-149. https://doi.org/10.1111/j.1475-6773.2012.01439.x.
6. MEDICARE: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending. US Government Accountability Office. Published April 20, 2018. http:www.gao.gov/products/GAO-18-341. Accessed May 18, 2020.
7. Stein BD, Leckman-Westin E, Okele E, *et al.* The effects of prior authorization policies on Medicaid-enrolled children's use of antipsychotic medications: evidence from two mid-Atlantic states. *J Child Adolesc Psychopharmacol.* 2014;24:374-381. https://doi.org/10.1089/cap.2014.0008.
8. Lapointe J. 3 Strategies to Minimize the Burden of Prior Authorizations. Practice Management News. Published October 8, 2018. http://revcycleintelligence.com/news/86-of-providers-saw-prior-authorization-requirements-increase. Accessed May 18, 2020.
9. Prior Authorization and Utilization Management Reform Principles. Prior Authorization Reform Initiatives. The American Medical Association. Published December 2019. https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf. Accessed May 15, 2020.
10. Prior Authorization for Psychopharmacology. AACAP Policy Statement. The American Academy of Child and Adolescent Psychiatry. Published May 2019. https://www.aacap.org/AACAP/Policy_Statements/2019/Prior_Authorization_for_Psychopharmacology.aspx. Accessed May 22, 2020.
11. Consensus Statement on Improving the Prior Authorization Process. Prior Authorization Reform Initiatives. The American Medical Association. Published December 2019. http://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf. Accessed April 14, 2020.

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