Introduction
Prior authorization of medical procedures, services, and medications have been a standard requirement for health care providers for decades. Rising health care costs, specifically the escalating cost of cancer drug therapies, have led to a renewed focus by payers, providers, and policy makers on prior authorization. Similarly, the challenges and frustrations of the prior authorization process have become an increasing concern to providers. Recently, leading cancer groups and a national specialty care management company which utilizes prior authorization as one of its management tools hosted an in-depth discussion on the topic. The purpose of this paper is to review the status of prior authorization and offer policy suggestions that provide clinical oversight in a way which promotes, rather than hinders, patient access to high-value cancer care.

Rising Costs and Complaints
Increasingly, prior authorization imposes burdens and inefficiencies upon oncology practices. The Council for Affordable Health Care reports that the cost for providers to manually generate a prior authorization increased from $6.61 in 2018 to $10.92 in 2019, while the payer cost for the same transaction decreased from $3.50 in 2018 to $3.32 in 2019.¹ A 2020 study published by the American Medical Association reported that physicians and their staff spend two full business days per week completing prior authorizations, with 40 percent of physicians having staff who work exclusively on prior authorizations.² Given the volume of high-cost cancer drugs, it is likely that even more time is spent by oncology practices. Providers raise legitimate concerns of delays in care with 28 percent of physicians saying prior authorizations have led to serious adverse events.³

Payers counter by arguing that prior authorization plays a role ensuring quality of care. In the experience of one specialty management company, five to 10 percent of requests do not align with the National Comprehensive Cancer Network compendia (Category 1 or 2A), with prior authorization routinely yielding a significant return on investment. Some providers appreciate the degree of protection prior authorization provides so that their claims for expensive cancer drugs will be covered. The consensus of the focus group was not so much objection to a process which monitors quality, creates value, and provides some assurance of payment to the provider, but rather objection to a process which has become onerous and intrusive, leading to practice inefficiencies.

Prior Authorizations: Where Are We and Where Can We Go?
Observations from a working group of leaders in the oncology and payer space

The Current Private and Public Landscapes
In the current prior authorization landscape, administrators for Medicare Part C (Medicare Advantage Plans) and Medicare Part D follow strict guidelines for prior authorization.\(^4\) Compliance is mandatory, and failure to comply potentially jeopardizes a plan’s Medicare Star rating. Third party administrators who administer prior authorizations are often accredited by the National Committee for Quality Assurance and/or URAC. Accreditation by either organization assures the clinical and operational soundness of the utilization management process by evaluating it against a stringent set of nationally recognized, evidence-based criteria.

Medicare guidelines for prior authorization in Part C and D establish:

- Multiple routes for submitting a prior authorization request, including phone, fax, or website
- A requirement to accept requests 24 hours a day, seven days a week
- Strict timelines for decisions
- Processes for expedited determinations
- The requirement that a partial or fully adverse determination must be completed by a physician or other health care professional who has “sufficient and other expertise” and a “knowledge of Medicare coverage criteria” as well as a current and unrestricted license to practice within the scope of his or her profession
- A right to a reconsideration or redetermination of an adverse determination (appeals process)

Similar guidelines are not available for commercial insurance companies, though many payers follow the Medicare guidelines.

Despite the existence of these guidelines, our team of cancer center administrators outlined several specific challenges to obtaining a prior authorization, including:

- The prior authorization request must come through the primary care provider
- Differing prior authorization processes for medical and pharmacy benefits
- The requirement to use specific biosimilar drugs that are not in the cancer care team’s formulary or are not preferred
- Failure to authorize an entire treatment plan with the initial request
- Difficulty locating prior authorization criteria for a specific payer
- Peer-to-peer conversations conducted with a non-oncology trained physician
- Portals with numerous questions (10-30) for each drug/item requested

Creating a Fairer, More Equitable Prior Authorization System

In charting a path forward, there are several steps both payers and providers can take which meet the common goal of assuring high-quality, high-value cancer care to members/patients while minimizing disruption of provider workflow.

For payers (insurance companies, HMOs, and MSOs):

- Make a commitment to follow Medicare Advantage Plan prior authorization guidelines for all commercial plans.
- Solicit feedback from providers on current prior authorization policies.
- Exempt biosimilars that meet medical necessity requirements from preferred drug list requirements (perhaps by offering to pay the price of the “least costly alternative product” as specified by average sales price for the reference product and all its biosimilars).
- Provide oncologists for all peer-to-peer conversations.
- Design all prior authorization processes for maximum efficiency with minimal clicks and minimal requirements for document uploads.
- Coordinate prior authorization between medical and pharmacy benefits.
- Proactively announce all changes to prior authorization procedures to care teams in advance of their implementation and grandfather all patients that are impacted by that change.
- Utilize mutually agreed upon clinical pathways for prior authorization with consideration of exempting providers from prior authorization when specified compliance levels are met.

For providers:

- Cancer care teams should have working knowledge of Medicare Advantage guidelines on prior authorization.
- File a complaint with the payer when the above guidelines are not being followed. Payers should publish complaints related to systems or processes - rather than complaints related to specific patient cases - with a path to escalate any concerns or trends.
- Be accurate and complete when providing details needed for approval.
- Use expedited requests when there is a need for care to be initiated in less than 72 hours.
- Make the appropriate team member available when a peer-to-peer clinical discussion is needed with the prior authorization entity. This will ensure that timely cancer care is provided.
- Negotiate with the payer when and how prior authorizations should apply to a patient population.
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Working together, payers and providers can make the care and comfort of their patients the highest priority. In any process, guidelines should leave room for individualized decision making when circumstances warrant. In this way, the high quality of care desired can be provided to all plan members with cancer.

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If you have questions, know of pressing issues that are starting to impact your practice and/or patients, or have suggestions to share, please don't hesitate to contact COA at (202) 729-8147 or send us an email at info@coacancer.org.