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February 24, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally- Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program [CMS-0057-P]

Dear Administrator Brooks-LaSure,

The American Academy of Neurology (AAN) is the world's largest neurology specialty society representing more than 38,000 neurologists and clinical neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system. These disorders affect one in six people and include conditions such as multiple sclerosis (MS), Alzheimer's disease (AD), Parkinson's disease, stroke, migraine, epilepsy, traumatic brain injury, ALS, and spinal muscular atrophy.

The AAN greatly appreciates the Centers for Medicare and Medicaid Services' (CMS) attention to addressing the growing burden associated with prior authorization (PA) faced by both patients and providers. Burdens associated with PA are often cited as a top concern among AAN members. Physicians in the United States complete an average of 41 PA requests every week, taking an average of 13 hours to process.[1] PA is one of the most time-consuming and expensive administrative requirements preventing physicians from spending more time with patients. Over 90% of clinicians reported that PA requirements have a negative impact on patient clinical outcomes and 82% of clinicians stated that issues associated with PA can lead to patients abandoning a recommended course of treatment.[2]

[1] AMA Prior Authorization (PA) Physician Survey. American Medical Association, 10 Feb. 2022, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[2] Id.

Furthermore, 93% of surveyed physicians indicated that PA leads to care delays and 34% of surveyed clinicians reported that PA has led to a serious adverse event for a patient in their care.[3] In addition to patient harm, delays in care also can lead to increased cost and inconvenience for patients who may otherwise have been able to receive a particular service subject to PA coincident with the initial visit. The AAN supports policies that reduce the burdens associated with PA requirements and address the detrimental impacts that PA has on patients.

The AAN notes that we previously submitted highly supportive comments in favor of CMS-9123-P,[4] which had been proposed in December 2020 and included several policies similar to those contained in this proposed rule. Although many of these critical provisions were finalized, the AAN notes that the final version of this rule was rescinded without being implemented due in part to the regulatory freeze that was put in place during the Biden Administration's 2021 transition. Since the final version of this rule was rescinded without being implemented, PA burden has continued to grow for both patients and providers. Even in the context of system-wide efforts to streamline regulatory and compliance requirements in response to the Covid-19 pandemic, in consecutive years since 2020, approximately 80% of medical groups indicated that PA requirements have increased in the last 12 months.[5][6] The AAN strongly urges CMS to ensure that the much-needed reforms contained in this proposed rule are not subject to further delay and are implemented in an expeditious manner.

Additionally, we laud CMS for heeding the AAN's call to build upon key proposals contained in the December 2020 rule by including Medicare Advantage (MA) plans in this updated proposed rule. Doing so is critical due to recent troubling trends in MA. In recent years, MA plans increasingly have used PA to reduce health care spending, substantially delaying medically necessary patient care and significantly increasing providers' administrative burden, as well as related costs to comply with PA requirements. An August 2022 Issue Brief from the Kaiser Family Foundation found that 99% of Medicare Advantage Enrollees are in plans that require PA for some services.[7] Given the pervasive use of PA in MA, the AAN was deeply disturbed by April 2022 findings from the Office of Inspector General (OIG) for the Department of Health and Human Services relating to inappropriate PA denials. Critically, the OIG report noted that some PA requests were denied by MA plans, even though the requested services met Medicare coverage guidelines.[8] In light of the

[3] Id.
[4] AAN Comments found here: https://www.aan.com/siteassets/home-page/policy-and-guidelines/policy/priority-issues/regulatory-burden/final-medicaid-chip-exchanges-pa-comments.pdf
[5] Virtually All Medical Groups Say Payer Prior Authorization Requirements Aren't Improving, Medical Group Management Association, 2 Mar. 2022, https://www.mgma.com/data/data-stories/virtually-all-medical-groups-say-payer-prior-autho.
[6] "New MGMA Poll Shows Prior Authorization on the Rise despite COVID-19 Pandemic." Medical Group Management Association, 20 May 2021, https://www.mgma.com/advocacy/advocacy-statements-letters/advocacy-statements/may-20,-2021-new-mgma-poll-shows-prior-authorizati.
[7] Freed, Meredith, et al. Medicare Advantage in 2022: Premiums, out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings. Kaiser Family Foundation, 8 Dec. 2022, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.
[8] "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care." Office of the Inspector General, Department of Health and

growing enrollment of Medicare beneficiaries in MA plans, the increasing use of PA by MA plans, and the significant potential for PA to negatively impact patient clinical outcomes, the AAN believes that it is critical for CMS to engage in continual oversight of MA plans' use of PA processes to ensure that Medicare beneficiaries enrolled in MA plans have the same access to covered services as those covered under Medicare Fee-for-Service (FFS).

A. Patient Access API

The AAN has previously supported the development of Fast Healthcare Interoperability Resources (FHIR) based patient access application program interfaces (APIs) to improve patient access to health data.[9] The AAN believes this will allow patients to be better informed regarding their own care. CMS is proposing to expand on existing Patient Access API requirements by requiring that by January 1, 2026, "via the Patient Access API, impacted payers make information about prior authorization requests and decisions (and related administrative and clinical documentation) for items and services (excluding drugs) available to patients no later than 1 business day after the payer receives the prior authorization request or there is another type of status change for the prior authorization."[10] The AAN is highly supportive of efforts to promote transparency in an otherwise opaque and burdensome system. Utilization management requirements are often difficult to navigate, leaving patients confused regarding the status of requests, approvals, and denials. The AAN is appreciative that Patient Access API requirements will be expanded to include Medicare Advantage plans in addition to Medicaid FFS, Medicaid Managed Care, Children's Health Insurance Program (CHIP) FFS, CHIP Managed Care and Qualified Health Plans (QHP) on the Federally Facilitated Exchanges (FFE).

While the AAN is broadly supportive of these new requirements, we encourage CMS to explore additional strategies to promote access to timely prior authorization-related information for patients who are uncomfortable or unable to use the underlying technology. The AAN strongly supports efforts to educate patients about the availability and utility of the Patient Access API as well as ongoing efforts to close the digital divide.

The AAN opposes CMS' decision to exclude drugs from the items and services subject to the proposed Patient Access API requirements impacting PA. The AAN believes that excluding PA-related information impacting prescription drugs from these requirements will be confusing to patients when they seek clarity regarding the status of coverage decisions impacting medications. The AAN understands that there are both technical and regulatory challenges associated with including PA-related prescription drug information in FHIR-based APIs but urges the agency to work with the Office of the National Coordinator (ONC) and other stakeholders to ensure that patients have expeditious access to this critical information.

Human Services, 27 Apr. 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp?hero=mao-report-04-28-2022.

[9] See AAN comments found here: https://www.aan.com/siteassets/home-page/policy-and-guidelines/advocacy/20190501-aan-response-to-cms-interoperability-proposed-rule.pdf

[10] 87 Fed. Reg. at 76244

B. Provider Access API

CMS is proposing to require payers, beginning January 1, 2026, to implement and maintain a FHIR-based API for the purpose of making "patient data available to providers who have a contractual relationship with the payer and a treatment relationship with the patient."[11] The AAN supports CMS building on the policies initially proposed in December 2020 by including Medicare Advantage plans in addition to Medicaid FFS, Medicaid Managed Care, CHIP FFS, CHIP Managed Care, and QHPs on the FFEs in requirements pertaining to the Provider Access API. The agency is also proposing that for the Provider Access API, "the provider would request and receive access to the patient's information through their EHR, practice management system, or other technology solution for treatment purposes."[12] In principle, the AAN supports integration of this information into the provider's electronic health record (EHR) system and believes doing so will facilitate necessary transfer of information, which could reduce administrative burdens facing clinicians. The AAN notes that there are potentially significant costs associated with the development and integration of these APIs into provider's health IT systems and urges CMS to take steps to ensure that costs borne by EHR vendors are not passed onto providers, and that implementation is done in a manner that minimizes burdens for providers.

The AAN also supports CMS' proposal to establish "a patient opt out (rather than an opt in) policy that would require payers to allow patients to opt out of the Provider Access API."[13] The AAN believes an opt-out approach appropriately balances the need for patient privacy and security against the potential burdens associated with providers needing to have each of their patients opt-in when the provider needs access to patient data through the Provider Access API during the course of treatment. Additionally, the AAN believes that it is appropriate in most cases for patients to indicate whether they want to opt out of sharing information with providers in an "all or none" manner. When a portion of the record is requested to be blocked, it can be very difficult to ensure that specific portion is not copied forward or documented elsewhere in the patient's medical record and then inadvertently shared.

Consistent with proposed requirements for the Patient Access API, the Provider Access API would be required to allow providers to initiate access requests "when the provider needs access to a patient's data prior to or during a patient visit."[14] Furthermore, this API "would facilitate the FHIR-based exchange of claims and encounter data, as well as all data classes and data elements included in a content standard adopted at 45 CFR 170.213, such as Immunizations, Procedures, and Assessment and Plan of Treatment, should the payer maintain such information."[15] The AAN supports these proposals and believes it is crucial to support the development and implementation of FHIR-based standards for the exchange of information needed to facilitate patient care.

[11] 87 Fed. Reg. at 76254
[12] 87 Fed. Reg. at 76256
[13] 87 Fed. Reg. at 76254
[14] 87 Fed. Reg. at 76255
[15] Id.

This proposed rule also proposes to "require payers to share information related to prior authorization requests and decisions (including related administrative and clinical documentation) for items and services (excluding drugs)."[16] The AAN supports the specific inclusion of PA-related information and concurs with CMS that these requirements are likely to empower providers to "better manage a patient's total care when they have access to more of that patient's data because the data would provide a more in-depth medical history, enable more informed decision making, and potentially prevent the provision or ordering of duplicative services."[17] While the AAN is aware that the PA processes and standards for drugs are distinct from the processes and standards for other items and services, the AAN strongly urges the agency to promulgate additional rulemaking to ensure that prior authorization information relating to drugs is expeditiously included in the Provider Access API so that providers can more easily access this critical information. AAN members report that drug-related PA is one of the largest sources of overall PA burden. Absent the inclusion of drug-related PA information, the utility of the Provider Access API will be limited. Additionally, the AAN requests clarification regarding whether therapeutic devices are excluded from these requirements. The AAN firmly believes that therapeutic devices should not be excluded.

CMS is not proposing to extend the Provider Access API requirements to require data sharing between covered plans and out-of-network providers. The AAN shares CMS' concern that this policy "could make it more difficult for an out-of-network provider to create a comprehensive care record for a patient."[18] While CMS is encouraging covered "payers to share information via API with out-of-network or unenrolled providers who have a verified treatment relationship with the patient, to the extent permitted by law"[19] the AAN does not believe that a provider should receive less expeditious access to critical patient information that is likely to impact the course of treatment, simply because a particular provider declined to join a particular payer's network. The AAN believes that CMS should allow patients to attest to a treatment relationship and opt-in to information sharing with out-of-network providers and believes that doing so sufficiently balances CMS' concerns related to privacy, security, and program integrity with the need to ensure that patients maintain access to high-quality care, regardless of plan networks.

The AAN supports CMS' proposal to require impacted payers to develop both patient and provider-facing resources regarding the Provider Access API. The AAN supports that these resources must be non-technical and easy to understand and believes that this requirement will aid both patients and providers in understanding how the API can be used to access data and improve care delivery.

C. Payer to Payer Data Exchange on FHIR

CMS is proposing to "require impacted payers (MA organizations, state Medicaid FFS programs, state CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers on the FFEs) to implement and maintain a payer to payer data

[16] Id.
[17] Id.
[18] 87 Fed. Reg. at 76256
[19] Id.

exchange using a FHIR API."[20] CMS is also proposing that "the data exchange take place via a FHIR API at the start of coverage."[21] The AAN supports these proposals and agrees with CMS that "data exchange among payers is a powerful way to help patients accumulate their data over time and to improve information sharing that would allow patients and providers to have more complete access to health information, which can help to promote better patient care."[22]

CMS is also proposing that "impacted payers would be required to make information about prior authorizations available via the Payer-to-Payer API for the duration that the authorization is active and, for at least 1 year after the prior authorization's last status change."[23] Although the AAN believes this transfer of information between payers is necessary, the AAN is disappointed that CMS is "not proposing at this time to require payers to review, consider, or honor the active prior authorization decision of a patient's former payer."[24] The AAN strongly believes when a patient transitions between payers, if the request is from the same provider, efforts should be made to limit the need for resubmission work on the part of the provider through required interoperable elements. To minimize the need for potentially duplicative resubmission of information that the payer would already have access to via the Payer-to-Payer API, the AAN urges CMS to mandate that impacted payers must review the records and notes of the prior payer before making a determination as to whether an additional authorization is necessary.

The agency is requesting comment "for possible future rulemaking on whether prior authorizations from a previous payer should be honored by the new payer."[25] The AAN notes that in CMS-4201-P, issued in December 2022, the agency has proposed that MA plans "are required to provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan, switches from traditional Medicare to the approved course of an MA plan, or is new to Medicare."[26] In addition to requiring impacted payers to review the records and notes of the previous payer, to promote continuity of care, the AAN believes that, at a minimum, a similar 90-day transition period would be appropriate for all payers subject to the Payer-to-Payer API requirements.

D. Improving Prior Authorization Processes

Proposed Requirement for Payers: Implement an API for Prior Authorization Requirements, Documentation, and Decision (PARDD API)

CMS is proposing that impacted payers beginning January 1, 2026 "implement and maintain a FHIR Prior Authorization Requirements, Documentation, and Decision (PARDD) API to be used by providers to facilitate the prior authorization process."[27] This API would "allow a provider to query the payer's system to determine whether a prior authorization was required

[20] 87 Fed. Reg. at 76268
[21] Id.
[22] 87 Fed. Reg. at 76269
[23] 87 Fed. Reg. at 76270
[24] Id.
[25] 87 Fed. Reg. at 76271
[26] 87 Fed. Reg. at 79454
[27] 87 Fed. Reg. at 76289

for certain items and services and identify documentation requirements. The API would also automate the compilation of necessary data for populating the HIPAA-compliant prior authorization transaction and enable payers to provide the status of the prior authorization request, including whether the request has been approved or denied."[28] The AAN strongly supports the development of the proposed PARDD API. In addition to the proposed capabilities, the AAN urges CMS to work with ONC to consider the need for capabilities to support electronic appeal and peer-to-peer review.

While the AAN is highly supportive of this proposed API, we note that AAN members have expressed frustration with existing electronic prior authorization systems relating to inaccurate or inadequate population of information from the EHR to the relevant form and payer. The AAN believes if data can be accurately and comprehensively pulled electronically rather than requiring manual entry, it will likely alleviate burden on providers and staff. Alternatively, inadequate systems and standards may lead to an increase in administrative burdens as additional data entry responsibilities would be placed on the provider and support staff. The AAN is concerned with the potential for faulty or inadequate design of the API resulting in similar or additional labor both for physician and non-physician staff to review and correct information that is not correctly transmitted.

Additionally, the AAN believes that the standards for the PARDD API should be aligned with the HIPAA minimum necessary standard to ensure that payers are making reasonable efforts to ensure that all data that is automatically collected is necessary to complete a particular transaction. The AAN is concerned that payers may use the PARDD API to automatically fill as many fields as possible and submit more than the strictly necessary and relevant information. In doing so, the AAN is concerned that extraneous data may be used by an impacted payer to inappropriately justify a denial or prolong the approval process.

CMS is considering the appropriateness of a phased-in approach to allow impacted payers additional time to program all existing PA rules and requirements into the PARDD API. The AAN does not support a phased-in approach and instead supports the proposal that payers would be required "to implement the PARDD API for all prior authorization rules and requirements for items and services, excluding drugs, by January 1, 2026 (for Medicaid managed care plans and CHIP managed care entities, by the rating period beginning on or after January 1, 2026, and for QHP issuers on the FFEs, for plan years beginning on or after January 1, 2026)."[29] The AAN strongly believes it is critical to address mounting PA burden as expeditiously as possible and allowing for a phased-in approach is likely to contribute to provider confusion as impacted payers inconsistently phase-in requirements across various items and services that are subject to PA. The AAN also concurs with CMS that "a phased approach could delay the availability of electronic prior authorization for certain items and services, which may in turn reduce the overall adoption of the PARDD API by providers who do not see their specialties and services represented in the initial rollout of the available PARDD API for items and services."[30]

[28] Id.
[29] Id.
[30] 87 Fed. Reg. at 76290

The AAN is concerned with CMS' decision to exclude drugs from these proposed requirements. The AAN supports efforts that allow physicians to check PA requirements and drug formulary status at the point of prescribing in EHRs and support informed conversations with patients about therapy costs. As we have noted earlier, the AAN understands that there are both technical and regulatory challenges associated with including PA-related prescription drug information in FHIR-based APIs but urges the agency to work with ONC and other stakeholders to ensure that providers can access to this critical information at the point of care. The AAN also requests clarification to ensure that therapeutic devices are not excluded from the proposed requirements.

Requirement for Payers To Provide Status of Prior Authorization and Reason for Denial of Prior Authorizations

CMS is proposing that beginning January 1, 2026, "impacted payers would be required to provide a specific reason for denied prior authorization decisions, excluding prior authorization decisions for drugs, regardless of the method used to send the prior authorization request."[31] CMS is also proposing that "responses about a prior authorization decision sent through the PARDD API from the payer to the provider would have to include information regarding whether the payer approves (and for how long) or denies the prior authorization request, or requests more information from the provider to support the request."[32] Payers impacted by these proposals include "MA organizations, state Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers on the FFEs."[33] The AAN strongly supports these proposals. The AAN believes that providing information related to length of approval and requiring a clear and specific reason for a denial will facilitate better communication and understanding between the provider and payer, which has the potential to reduce PA burdens over the long term. Additional clarity in instances in which the payer needs more information when processing a request will improve a system that is often confusing and lacking in transparency.

The AAN urges CMS to develop robust requirements defining the term "specific reason" in relation to a PA denial. The AAN strongly believes that payers should be required to specifically identify the issue for the rejection in as precise terms as possible, with actionable information. The AAN is concerned that payers may interpret the proposed requirements as permitting a vague reason such as "incomplete claim" or "overlapping claim" rather than requiring disclosure of specific actionable information. If the denial reason is allowed to be vague, the AAN is concerned that considerable administrative burden will be placed on providers to clarify the actual reason for the denial and what action is needed. The AAN believes that clear requirements relating to the "specific reason" for a PA denial will promote transparency, while reducing the need for appeals and peer-to-peer reviews. Below are several illustrative examples of actionable information:

- Instead of citing "incomplete claim" as the reason for denial, the payer should be required to specifically cite the documentation of a particular test or treatment that is missing.

[31] 87 Fed. Reg. at 76292
[32] Id.
[33] Id.

- Instead of citing "patient obligation" as the reason for denial, the payer should be required to specifically indicate that a deductible hasn't been met or that a referral is needed.
- Instead of citing "overlapping claim" as the reason for denial, the payer should be required to specifically identify which submissions are overlapping.

Requirements for Prior Authorization Decision Timeframes and Communications

The AAN strongly supports efforts to ensure PA requests are processed quickly and believes it is necessary to hold plans accountable for making timely PA determinations. As noted earlier in these comments, the available data clearly indicates that PA delays care and leads to patient harm. In addition to the survey data from the American Medical Association cited earlier in this letter, there is a substantial body of literature that spans across specialties demonstrating the detrimental impact of PA-related care delays on patient outcomes.[34][35][36] The AAN firmly believes that delays in decision-making can have significant real-world consequences for patients and that CMS ought to prioritize policies that adequately account for the need for timely decision-making.

To address the need for timely PA determinations, CMS is proposing "beginning January 1, 2026, MA organizations and applicable integrated plans, Medicaid FFS programs, and CHIP FFS programs must provide notice of prior authorization decisions as expeditiously as a patient's health condition requires, but no later than 7 calendar days for standard requests. We also propose that Medicaid FFS and CHIP FFS programs must provide notice of prior authorization decisions as expeditiously as a patient's health condition requires, but no later than 72 hours for expedited requests unless a shorter minimum time frame is established under state law."[37] CMS' proposals "would not change the 72-hour deadline required by current Federal regulations, or the authority for an extension of that deadline, for expedited decisions made by MA organizations, applicable integrated plans, Medicaid managed care plans, and CHIP managed care entities."[38] Given the urgent need for clarity to avoid adverse health outcomes, when an expedited PA is requested, the AAN urges the agency to consider the feasibility of requiring a 24-hour deadline for PA responses across all impacted payers in urgent situations. The AAN concurs with stakeholders that "it is possible, given advances in technology, that responses to certain types of prior authorization requests could be made within 24 hours."[39]

[34] Wirrell, Elaine C, et al. "Impact of Prior Authorization of Antiepileptic Drugs in Children with Epilepsy." Pediatric Neurology, Elsevier, 3 Apr. 2018, https://www.sciencedirect.com/science/article/abs/pii/S0887899418301516.
[35] Constant, Brad D, et al. "Delays Related to Prior Authorization in Inflammatory Bowel Disease." Pediatrics, U.S. National Library of Medicine, 1 Mar. 2022, https://pubmed.ncbi.nlm.nih.gov/35190811/.
[36] Bodurtha Smith, Anna Jo, et al. "Prior Authorization in Gynecologic Oncology: An Analysis of Clinical Impact." Gynecologic Oncology, U.S. National Library of Medicine, Dec. 2022, https://pubmed.ncbi.nlm.nih.gov/36244827/.
[37] 87 Fed. Reg. at 76296
[38] 87 Fed. Reg. at 76297
[39] Id.

Public Reporting of Prior Authorization Metrics

CMS is proposing to require "impacted payers to publicly report certain aggregated metrics about prior authorization by posting them directly on the payer's website or via a publicly accessible hyperlink(s)."[40] The AAN believes that this proposal will improve transparency and help to ensure that PA is not being used as a means to dissuade the provision of covered items and services. The AAN believes that it is critical that PA data be disclosed on both an individual service basis and on an aggregate basis across the plan. Disclosure solely on an aggregate basis is likely to be confusing for both providers and patients who would seek to understand how a particular plan's use of PA would impact the patient's specific course of treatment. Disclosure on a service specific basis will also aid in identifying services for which there is a high rate of approval and for which PA requirements may no longer be necessary. Additionally, the AAN believes in order to facilitate access to this data during the open enrollment period, the proposed PA-related data should be accessible, along with other plan data, on CMS' website. Since health plans already have the capability to provide this data, the AAN does not believe that transparency of PA decision making should be delayed until 2026, and instead urges the agency to implement these requirements as rapidly as possible.

''Gold-Carding'' Programs for Prior Authorization

The AAN is grateful for the opportunity to provide comments on how CMS can improve utilization and efficiency of "gold-carding" through future rulemaking. The AAN believes that, at present, gold-card programs have not lived up to their potential as tools for burden reduction and expanding access to care.

An AHIP survey conducted online from February to April 2022 completed by 26 commercial health plans representing 122 million covered lives has provided preliminary data on the utilization of gold-carding programs. Gold-carding popularity is increasing in 2022 vs 2019, almost doubling its use for medical services (58 percent vs 32 percent) but is far less used for prescription drugs (21 percent vs 9 percent). Gold-carding was more frequently used for imaging services (44 percent) while 19 percent of plans used it for orthopedic, elective inpatient, and cardiology services. Common criteria for accepting providers in a gold-carding program include: a low PA denial rate in the last year, submission by the provider of a minimum number of PA requests, and provider participation in a risk-based contract with the payer. Approximately two thirds of plans review performance criteria annually or bi-annually, and 50% report reduced administrative burden and higher provider satisfaction with gold-carding. Conversely one third of payer respondents reported that gold-carding is administratively difficult to implement, leading to abandonment of the program.[41]

The AAN believes that gold-carding programs should be utilized to improve the lives of patients with chronic neurological disease. Imaging studies are universally ordered for patients with chronic neurological disease, for both establishing a new diagnosis and

[40] 87 Fed. Reg. at 76304

[41] "AHIP 2022 Survey on Prior Authorization Practices and Gold Carding..." AHIP, 14 Nov. 2022, https://www.ahip.org/resources/ahip-2022-survey-on-prior-authorization-practices-and-gold-carding-experiences.

monitoring disease progression. Gold-carding programs that eliminate prior authorizations for imaging studies would greatly reduce the time required for a new patient diagnosis, potentially preventing further disease progression by lifting additional requirements for ongoing monitoring, while reducing provider prior authorization burden. Currently 44 percent of health plans already offer gold-carding programs for imaging procedures. The AAN recommends extending this program across payers by requiring that a gold-carding program be included in their prior authorization policies.

The following is the AAN's recommended structure for a pilot program wherein a payer could stipulate that a neurologist will be enrolled in a gold-card program that exempts them from requesting prior authorization for MRIs:

- If the neurologist has achieved a $\geq$ 90% approval rate for all neurology specific imaging studies (MRI requests) in the last 12 months.
- If the neurologist is treating a patient that requires an MRI for ongoing monitoring while being treated with a high-risk drug/biologicial such as Tysabri or Leqembi
- If either of the above criteria are met, eligible providers will be exempt from any prior authorization for similar requests for a 12-month period following confirmation of eligibility.

Structural and Performance Metric Considerations:

- Provider eligibility will be determined by the payer, including a retrospective look back period that will be communicated to each provider within 60 days of launching the gold-card program.
- Monthly summaries of provider performance will be sent to individual providers by the payer to incentivize continued performance.
- Pilot program can be initially launched with 1-2 neurology subspecialties such as multiple sclerosis and headache.
- Performance metrics can potentially include the number of MRIs ordered for new patients that resulted in a new diagnosis for neurological disease.

E. Electronic Prior Authorization for the Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

CMS is proposing to establish a new measure under the MIPS Promoting Interoperability performance category "to address stakeholder concerns regarding possible low provider utilization of APIs established by payers for electronic prior authorization."[42] CMS is "proposing to require MIPS eligible clinicians to report this measure beginning with the CY 2026 performance period/CY 2028 MIPS payment year."[43] This proposed measure will be titled "Electronic Prior Authorization" and it will be included in the Health Information Exchange objective.

[42] 87 Fed. Reg. at 76312
[43] 87 Fed. Reg. at 76313

Measure Description	For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the prior authorization is requested electronically from a PARDD API using data from Certified EHR Technology (CEHRT). The MIPS eligible clinician would be required to report a numerator and denominator for the measure or (if applicable) report an exclusion:
Numerator	The number of unique prior authorizations in the denominator that are requested electronically from a PARDD API using data from CEHRT.
Denominator	The number of unique prior authorizations requested for medical items and services (excluding drugs) ordered by the MIPS eligible clinician during the performance period, excluding prior authorizations that cannot be requested using the PARDD API because the payer does not offer an API that meets the PARDD API requirements outlined in section II.D.3.a of this proposed rule.
Exclusions	Any MIPS eligible clinician who: (1) Does not order any medical items or services (excluding drugs) requiring prior authorization during the applicable performance period; or (2) Only orders medical items or services (excluding drugs) requiring prior authorization from a payer that does not offer an API that meets the PARDD API requirements outlined in section II.D.3.a of this proposed rule during the applicable performance period.

Additionally, CMS is proposing for CY 2026 "that the Electronic Prior Authorization measure would not be scored and would not affect the total score for the MIPS Promoting Interoperability performance Category."[44] As such, "a MIPS eligible clinician, eligible hospital, or CAH would be required to report a numerator of at least one for the measure or claim an exclusion, but the measure would not be scored."[45] While the AAN understands CMS' interest in ensuring that providers utilize APIs for the purposes of electronic prior authorization, the AAN does not believe that this measure is necessary. Neurology providers are eager to reduce the enormous burden of PA faced by their practices and their patients. The AAN firmly believes that if capabilities are implemented to allow for seamless completion of electronic PA processes, that these new capabilities would be widely and rapidly adopted by providers. Providers want to spend more time on patient care and less time managing PA-related requirements.

If CMS insists on moving forward with developing and including this measure in a future iteration of MIPS, the AAN believes it should remain unscored indefinitely. The AAN strongly believes CMS should consider how this measure can be implemented in a manner that does not increase reporting burden on providers. The AAN urges CMS to consider making this measure an attestation-based measure indicating that the provider has successfully requested prior authorization from a PARDD API using data from CEHRT. This attestation should suffice in accounting for CMS' interest ensuring that providers utilize PARDD APIs as they are developed and implemented. The AAN believes that requiring providers to collect and report the information included in the numerator and denominator of this measure specification unfairly place the burden of ensuring that impacted payers develop workable PARDD APIs onto the provider. The AAN also questions the utility of this

[44] Id.
[45] Id.

generalized data, as the numerator and denominator data will not be payer specific and could vary greatly depending on a particular provider's payer mix.

Instead of developing this measure, the AAN believes that CMS should engage in stringent oversight to ensure that impacted payers are not only developing and implementing workable PARDD APIs, but are also implementing all of the provisions of this rulemaking, and specifically those aimed at improving prior authorization processes. The AAN urges CMS to release additional information concerning how the agency intends to enforce the proposed requirements contained in this proposed rule and ensure compliance from impacted payers.

Conclusion

The AAN appreciates CMS' attention to addressing the burdens associated with prior authorization faced by both patients and providers. The AAN is highly supportive of efforts to improve electronic prior authorization processes and to promote standards across payers. The AAN believes that reducing PA-related burdens will reduce costs and improve patient outcomes by allowing providers to focus more of their time on patient care rather than administrative tasks. Furthermore, the AAN believes PA reform is necessary to promote health equity and ensure timely access to care. Please contact Matt Kerschner, the AAN's Director, Regulatory Affairs at mkerschner@aan.com or Max Linder, the AAN's Government Relations Manager at mlinder@aan.com with any questions or requests for additional information.

Sincerely,

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President, American Academy of Neurology