

117<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 3173

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## AN ACT

To amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Improving Seniors’  
3 Timely Access to Care Act of 2022”.

4 **SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO**  
5 **THE USE OF PRIOR AUTHORIZATION UNDER**  
6 **MEDICARE ADVANTAGE PLANS.**

7 (a) IN GENERAL.—Section 1852 of the Social Secu-  
8 rity Act (42 U.S.C. 1395w–22) is amended by adding at  
9 the end the following new subsection:

10 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

11 “(1) IN GENERAL.—In the case of a Medicare  
12 Advantage plan that imposes any prior authorization  
13 requirement with respect to any applicable item or  
14 service (as defined in paragraph (5)) during a plan  
15 year, such plan shall—

16 “(A) beginning with the third plan year be-  
17 ginning after the date of the enactment of this  
18 subsection—

19 “(i) establish the electronic prior au-  
20 thorization program described in para-  
21 graph (2); and

22 “(ii) meet the enrollee protection  
23 standards specified pursuant to paragraph  
24 (4); and

25 “(B) beginning with the fourth plan year  
26 beginning after the date of the enactment of

1           this subsection, meet the transparency require-  
2           ments specified in paragraph (3).

3           “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-  
4           GRAM.—

5                   “(A) IN GENERAL.—For purposes of para-  
6                   graph (1)(A), the electronic prior authorization  
7                   program described in this paragraph is a pro-  
8                   gram that provides for the secure electronic  
9                   transmission of—

10                           “(i) a prior authorization request  
11                           from a provider of services or supplier to  
12                           a Medicare Advantage plan with respect to  
13                           an applicable item or service to be fur-  
14                           nished to an individual and a response, in  
15                           accordance with this paragraph, from such  
16                           plan to such provider or supplier; and

17                           “(ii) any attachment relating to such  
18                           request or response.

19                   “(B) ELECTRONIC TRANSMISSION.—

20                           “(i) EXCLUSIONS.—For purposes of  
21                           this paragraph, a facsimile, a proprietary  
22                           payer portal that does not meet standards  
23                           specified by the Secretary, or an electronic  
24                           form shall not be treated as an electronic

1 transmission described in subparagraph  
2 (A).

3 “(ii) STANDARDS.—An electronic  
4 transmission described in subparagraph  
5 (A) shall comply with—

6 “(I) applicable technical stand-  
7 ards adopted by the Secretary pursu-  
8 ant to section 1173; and

9 “(II) other requirements to pro-  
10 mote the standardization and stream-  
11 lining of electronic transactions under  
12 this part specified by the Secretary.

13 “(iii) DEADLINE FOR SPECIFICATION  
14 OF ADDITIONAL REQUIREMENTS.—Not  
15 later than July 1, 2023, the Secretary  
16 shall finalize requirements described in  
17 clause (ii)(II).

18 “(C) REAL-TIME DECISIONS.—

19 “(i) IN GENERAL.—Subject to clause  
20 (iv), the program described in subpara-  
21 graph (A) shall provide for real-time deci-  
22 sions (as defined by the Secretary in ac-  
23 cordance with clause (v)) by a Medicare  
24 Advantage plan with respect to prior au-  
25 thorization requests for applicable items

1 and services identified by the Secretary  
2 pursuant to clause (ii) if such requests are  
3 submitted with all medical or other docu-  
4 mentation required by such plan.

5 “(ii) IDENTIFICATION OF ITEMS AND  
6 SERVICES.—

7 “(I) IN GENERAL.—For purposes  
8 of clause (i), the Secretary shall iden-  
9 tify, not later than the date on which  
10 the initial announcement described in  
11 section 1853(b)(1)(B)(i) for the third  
12 plan year beginning after the date of  
13 the enactment of this subsection is re-  
14 quired to be announced, applicable  
15 items and services for which prior au-  
16 thorization requests are routinely ap-  
17 proved.

18 “(II) UPDATES.—The Secretary  
19 shall consider updating the applicable  
20 items and services identified under  
21 subclause (I) based on the information  
22 described in paragraph (3)(A)(i) (if  
23 available and determined practicable  
24 to utilize by the Secretary) and any  
25 other information determined appro-

1           prorate by the Secretary not less fre-  
2           quently than biennially. The Secretary  
3           shall announce any such update that  
4           is to apply with respect to a plan year  
5           not later than the date on which the  
6           initial announcement described in sec-  
7           tion 1853(b)(1)(B)(i) for such plan  
8           year is required to be announced.

9           “(iii) REQUEST FOR INFORMATION.—

10          The Secretary shall issue a request for in-  
11          formation for purposes of initially identi-  
12          fying applicable items and services under  
13          clause (ii)(I).

14          “(iv) EXCEPTION FOR EXTENUATING  
15          CIRCUMSTANCES.—In the case of a prior  
16          authorization request submitted to a Medi-  
17          care Advantage plan for an individual en-  
18          rolled in such plan during a plan year with  
19          respect to an item or service identified by  
20          the Secretary pursuant to clause (ii) for  
21          such plan year, such plan may, in lieu of  
22          providing a real-time decision with respect  
23          to such request in accordance with clause  
24          (i), delay such decision under extenuating  
25          circumstances (as specified by the Sec-

1           retary), provided that such decision is pro-  
2           vided no later than 72 hours after receipt  
3           of such request (or, in the case that the  
4           provider of services or supplier submitting  
5           such request has indicated that such delay  
6           may seriously jeopardize such individual's  
7           life, health, or ability to regain maximum  
8           function, no later than 24 hours after re-  
9           ceipt of such request).

10           “(v) DEFINITION OF REAL-TIME DECI-  
11           SION.—In establishing the definition of a  
12           real-time decision for purposes of clause  
13           (i), the Secretary shall take into account  
14           current medical practice, technology,  
15           health care industry standards, and other  
16           relevant information relating to how quick-  
17           ly a Medicare Advantage plan may provide  
18           responses with respect to prior authoriza-  
19           tion requests.

20           “(vi) IMPLEMENTATION.—The Sec-  
21           retary shall use notice and comment rule-  
22           making for each of the following:

23                   “(I) Establishing the definition  
24                   of a ‘real-time decision’ for purposes  
25                   of clause (i).

1 “(II) Updating such definition.

2 “(III) Initially identifying appli-  
3 cable items or services pursuant to  
4 clause (ii)(I).

5 “(IV) Updating applicable items  
6 and services so identified as described  
7 in clause (ii)(II).

8 “(3) TRANSPARENCY REQUIREMENTS.—

9 “(A) IN GENERAL.—For purposes of para-  
10 graph (1)(B), the transparency requirements  
11 specified in this paragraph are, with respect to  
12 a Medicare Advantage plan, the following:

13 “(i) The plan, annually and in a man-  
14 ner specified by the Secretary, shall submit  
15 to the Secretary the following information:

16 “(I) A list of all applicable items  
17 and services that were subject to a  
18 prior authorization requirement under  
19 the plan during the previous plan  
20 year.

21 “(II) The percentage and number  
22 of specified requests (as defined in  
23 subparagraph (F)) approved during  
24 the previous plan year by the plan in  
25 an initial determination and the per-



1           centage and number of specified re-  
2           quests denied during such plan year  
3           by such plan in an initial determina-  
4           tion (both in the aggregate and cat-  
5           egorized by each item and service).

6           “(III) The percentage and num-  
7           ber of specified requests submitted  
8           during the previous plan year that  
9           were made with respect to an item or  
10          service identified by the Secretary  
11          pursuant to paragraph (2)(C)(ii) for  
12          such plan year, and the percentage  
13          and number of such requests that  
14          were subject to an exception under  
15          paragraph (2)(C)(iv) (categorized by  
16          each item and service).

17          “(IV) The percentage and num-  
18          ber of specified requests submitted  
19          during the previous plan year that  
20          were made with respect to an item or  
21          service identified by the Secretary  
22          pursuant to paragraph (2)(C)(ii) for  
23          such plan year that were approved  
24          (categorized by each item and serv-  
25          ice).

1           “(V) The percentage and number  
2 of specified requests that were denied  
3 during the previous plan year by the  
4 plan in an initial determination and  
5 that were subsequently appealed.

6           “(VI) The number of appeals of  
7 specified requests resolved during the  
8 preceding plan year, and the percent-  
9 age and number of such resolved ap-  
10 peals that resulted in approval of the  
11 furnishing of the item or service that  
12 was the subject of such request, cat-  
13 egorized by each applicable item and  
14 service and categorized by each level  
15 of appeal (including judicial review).

16           “(VII) The percentage and num-  
17 ber of specified requests that were de-  
18 nied, and the percentage and number  
19 of specified requests that were ap-  
20 proved, by the plan during the pre-  
21 vious plan year through the utilization  
22 of decision support technology, artifi-  
23 cial intelligence technology, machine-  
24 learning technology, clinical decision-

1 making technology, or any other tech-  
2 nology specified by the Secretary.

3 “(VIII) The average and the me-  
4 dian amount of time (in hours) that  
5 elapsed during the previous plan year  
6 between the submission of a specified  
7 request to the plan and a determina-  
8 tion by the plan with respect to such  
9 request for each such item and serv-  
10 ice, excluding any such requests that  
11 were not submitted with the medical  
12 or other documentation required to be  
13 submitted by the plan.

14 “(IX) The percentage and num-  
15 ber of specified requests that were ex-  
16 cluded from the calculation described  
17 in subclause (VIII) based on the  
18 plan’s determination that such re-  
19 quests were not submitted with the  
20 medical or other documentation re-  
21 quired to be submitted by the plan.

22 “(X) Information on each occur-  
23 rence during the previous plan year in  
24 which, during a surgical or medical  
25 procedure involving the furnishing of

1 an applicable item or service with re-  
2 spect to which such plan had ap-  
3 proved a prior authorization request,  
4 the provider of services or supplier  
5 furnishing such item or service deter-  
6 mined that a different or additional  
7 item or service was medically nec-  
8 essary, including a specification of  
9 whether such plan subsequently ap-  
10 proved the furnishing of such dif-  
11 ferent or additional item or service.

12 “(XI) A disclosure and descrip-  
13 tion of any technology described in  
14 subclause (VII) that the plan utilized  
15 during the previous plan year in mak-  
16 ing determinations with respect to  
17 specified requests.

18 “(XII) The number of grievances  
19 (as described in subsection (f)) re-  
20 ceived by such plan during the pre-  
21 vious plan year that were related to a  
22 prior authorization requirement.

23 “(XIII) Such other information  
24 as the Secretary determines appro-  
25 priate.

1 “(ii) The plan shall provide—

2 “(I) to each provider or supplier  
3 who seeks to enter into a contract  
4 with such plan to furnish applicable  
5 items and services under such plan,  
6 the list described in clause (i)(I) and  
7 any policies or procedures used by the  
8 plan for making determinations with  
9 respect to prior authorization re-  
10 quests;

11 “(II) to each such provider and  
12 supplier that enters into such a con-  
13 tract, access to the criteria used by  
14 the plan for making such determina-  
15 tions and an itemization of the med-  
16 ical or other documentation required  
17 to be submitted by a provider or sup-  
18 plier with respect to such a request;  
19 and

20 “(III) to an enrollee of the plan,  
21 upon request, access to the criteria  
22 used by the plan for making deter-  
23 minations with respect to prior au-  
24 thorization requests for an item or  
25 service.

1           “(B) OPTION FOR PLAN TO PROVIDE CER-  
2           TAIN ADDITIONAL INFORMATION.—As part of  
3           the information described in subparagraph  
4           (A)(i) provided to the Secretary during a plan  
5           year, a Medicare Advantage plan may elect to  
6           include information regarding the percentage  
7           and number of specified requests made with re-  
8           spect to an individual and an item or service  
9           that were denied by the plan during the pre-  
10          ceding plan year in an initial determination  
11          based on such requests failing to demonstrate  
12          that such individuals met the clinical criteria  
13          established by such plan to receive such items  
14          or services.

15          “(C) REGULATIONS.—The Secretary shall,  
16          through notice and comment rulemaking, estab-  
17          lish requirements for Medicare Advantage plans  
18          regarding the provision of—

19                 “(i) access to criteria described in  
20                 subparagraph (A)(ii)(II) to providers of  
21                 services and suppliers in accordance with  
22                 such subparagraph; and

23                 “(ii) access to such criteria to enroll-  
24                 ees in accordance with subparagraph  
25                 (A)(ii)(III).

1           “(D) PUBLICATION OF INFORMATION.—  
2           The Secretary shall publish information de-  
3           scribed in subparagraph (A)(i) and subpara-  
4           graph (B) on a public website of the Centers  
5           for Medicare & Medicaid Services. Such infor-  
6           mation shall be so published on an individual  
7           plan level and may in addition be aggregated in  
8           such manner as determined appropriate by the  
9           Secretary.

10           “(E) MEDPAC REPORT.—Not later than 3  
11           years after the date information is first sub-  
12           mitted under subparagraph (A)(i), the Medicare  
13           Payment Advisory Commission shall submit to  
14           Congress a report on such information that in-  
15           cludes a descriptive analysis of the use of prior  
16           authorization. As appropriate, the Commission  
17           should report on statistics including the fre-  
18           quency of appeals and overturned decisions.  
19           The Commission shall provide recommenda-  
20           tions, as appropriate, on any improvement that  
21           should be made to the electronic prior author-  
22           ization programs of Medicare Advantage plans.

23           “(F) SPECIFIED REQUEST DEFINED.—For  
24           purposes of this paragraph, the term ‘specified  
25           request’ means a prior authorization request

1           made with respect to an applicable item or serv-  
2           ice.

3           “(4) ENROLLEE PROTECTION STANDARDS.—  
4           For purposes of paragraph (1)(A)(ii), the Secretary  
5           shall, through notice and comment rulemaking,  
6           specify the following enrollee protection standards  
7           with respect to the use of prior authorization by  
8           Medicare Advantage plans for applicable items and  
9           services:

10                   “(A) Adoption of transparent prior author-  
11                   ization programs developed in consultation with  
12                   enrollees and with providers and suppliers with  
13                   contracts in effect with such plans for fur-  
14                   nishing such items and services under such  
15                   plans;

16                   “(B) Allowing for the waiver or modifica-  
17                   tion of prior authorization requirements based  
18                   on the performance of such providers and sup-  
19                   pliers in demonstrating compliance with such  
20                   requirements, such as adherence to evidence-  
21                   based medical guidelines and other quality cri-  
22                   teria; and

23                   “(C) Conducting annual reviews of such  
24                   items and services for which prior authorization  
25                   requirements are imposed under such plans



1 through a process that takes into account input  
2 from enrollees and from providers and suppliers  
3 with such contracts in effect and is based on  
4 consideration of prior authorization data from  
5 previous plan years and analyses of current cov-  
6 erage criteria.

7 “(5) APPLICABLE ITEM OR SERVICE.—For pur-  
8 poses of this subsection, the term ‘applicable item or  
9 service’ means, with respect to a Medicare Advan-  
10 tage plan, any item or service for which benefits are  
11 available under such plan, other than a covered part  
12 D drug.

13 “(6) REPORTS TO CONGRESS.—

14 “(A) GAO.—Not later than the end of the  
15 fourth plan year beginning on or after the date  
16 of the enactment of this subsection, the Comp-  
17 troller General of the United States shall sub-  
18 mit to Congress a report containing an evalua-  
19 tion of the implementation of the requirements  
20 of this subsection and an analysis of issues in  
21 implementing such requirements faced by Medi-  
22 care Advantage plans.

23 “(B) HHS.—Not later than the end of the  
24 fifth plan year beginning after the date of the  
25 enactment of this subsection, and biennially

1           thereafter through the date that is 10 years  
2           after such date of enactment, the Secretary  
3           shall submit to Congress a report containing a  
4           description of the information submitted under  
5           paragraph (3)(A)(i) during—

6                     “(i) in the case of the first such re-  
7                     port, the fourth plan year beginning after  
8                     the date of the enactment of this sub-  
9                     section; and

10                    “(ii) in the case of a subsequent re-  
11                    port, the 2 plan years preceding the year  
12                    of the submission of such report.”.

13           (b) ENSURING TIMELY RESPONSES FOR ALL PRIOR  
14           AUTHORIZATION REQUESTS SUBMITTED UNDER PART  
15           C.—Section 1852(g) of the Social Security Act (42 U.S.C.  
16           1395w–22(g)) is amended—

17                    (1) in paragraph (1)(A), by inserting “and in  
18                    accordance with paragraph (6)” after “paragraph  
19                    (3)”;

20                    (2) in paragraph (3)(B)(iii), by inserting “(or,  
21                    subject to subsection (o), with respect to prior au-  
22                    thorization requests submitted on or after the first  
23                    day of the third plan year beginning after the date  
24                    of the enactment of the Improving Seniors’ Timely

1 Access to Care Act of 2022, not later than 24  
2 hours)” after “72 hours”.

3 (3) by adding at the end the following new  
4 paragraph:

5 “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-  
6 THORIZATION REQUESTS.—Subject to paragraph (3)  
7 and subsection (o), in the case of an organization  
8 determination made with respect to a prior author-  
9 ization request for an item or service to be furnished  
10 to an individual submitted on or after the first day  
11 of the third plan year beginning after the date of the  
12 enactment of this paragraph, the organization shall  
13 notify the enrollee (and the physician involved, as  
14 appropriate) of such determination no later than 7  
15 days (or such shorter timeframe as the Secretary  
16 may specify through notice and comment rule-  
17 making, taking into account enrollee and stakeholder  
18 feedback) after receipt of such request.”.

19 **SEC. 3. FUNDING.**

20 The Secretary of Health and Human Services shall  
21 provide for the transfer, from the Federal Hospital Insur-  
22 ance Trust Fund established under section 1817 of the  
23 Social Security Act (42 U.S.C. 1395i) and the Federal  
24 Supplementary Medical Insurance Trust Fund established  
25 under section 1841 of such Act (42 U.S.C. 1395t) (in such

1 proportion as determined appropriate by the Secretary) to  
2 the Centers for Medicare & Medicaid Services Program  
3 Management Account, of \$25,000,000 for fiscal year  
4 2022, to remain available until expended, for purposes of  
5 carrying out the amendments made by this Act.

Passed the House of Representatives September 14,  
2022.

Attest:

*Clerk.*



117<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

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To amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans, and for other purposes.