

117TH CONGRESS
1ST SESSION

H. R. 3173

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.

IN THE HOUSE OF REPRESENTATIVES

MAY 13, 2021

Ms. DELBENE (for herself, Mr. KELLY of Pennsylvania, Mr. BERA, Mr. BUCSHON, Mr. RUSH, Mr. WENSTRUP, Mr. EVANS, Mr. BURGESS, Mr. MICHAEL F. DOYLE of Pennsylvania, Mr. SMUCKER, Mr. SUOZZI, Mr. DUNN, Ms. SCHRIER, Mr. ARRINGTON, Mr. PASCRELL, Mr. JOYCE of Pennsylvania, Ms. DEGETTE, Mr. FERGUSON, Mr. BRENDAN F. BOYLE of Pennsylvania, Mr. LONG, Mr. O'HALLERAN, Mr. LAHOOD, Mr. KILDEE, Mr. PENCE, Mr. SCHRADER, Mr. SMITH of Missouri, Ms. SEWELL, Mr. ARMSTRONG, Ms. KELLY of Illinois, Mr. RICE of South Carolina, Mr. HIGGINS of New York, Mr. HARRIS, Ms. BARRAGÁN, Mrs. MILLER of West Virginia, Ms. MOORE of Wisconsin, Mr. MURPHY of North Carolina, Mr. WELCH, Mr. SCHWEIKERT, Mr. THOMPSON of California, Mr. KELLER, Mr. BUTTERFIELD, Mrs. WALORSKI, Mr. LARSON of Connecticut, Mr. THOMPSON of Pennsylvania, Mr. SARBANES, Mr. KELLY of Mississippi, Mr. CARTWRIGHT, Mr. MEUSER, Ms. SCANLON, Mr. VAN DREW, Ms. WILD, Mr. FITZPATRICK, Mr. CICILLINE, Mr. GROTHMAN, Mr. LIEU, Mr. RESCHENTHALER, Mr. CONNOLLY, Ms. SALAZAR, Mr. MOULTON, Mr. FLEISCHMANN, Mrs. MCBATH, Mr. ALLEN, Mr. NADLER, Mr. BURCHETT, Mr. ALLRED, Mr. RUTHERFORD, Mr. RASKIN, Mr. POSEY, Mr. CLEAVER, Mr. JOHNSON of South Dakota, Mrs. AXNE, Mr. AUSTIN SCOTT of Georgia, Ms. LOIS FRANKEL of Florida, Mr. LAMBORN, Mr. LANGEVIN, Mr. NORMAN, Mr. KIM of New Jersey, Mr. MEIJER, Ms. PINGREE, Mr. LYNCH, Mr. PAPPAS, Ms. ROSS, Mr. SMITH of Washington, Ms. STRICKLAND, Ms. TENNEY, Ms. DEAN, Ms. HOULAHAN, Ms. MCCOLLUM, Mr. GIBBS, Ms. HERRERA BEUTLER, Mr. LAMB, and Mr. BUCHANAN) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Improving Seniors’
 5 Timely Access to Care Act of 2021”.

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

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

12 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

13 “(1) IN GENERAL.—Beginning with the second
 14 plan year beginning after the date of the enactment
 15 of this subsection, in the case of a Medicare Advan-
 16 tage plan that imposes any prior authorization re-
 17 quirement with respect to any applicable item or
 18 service (other than a covered part D drug) during a
 19 plan year, such plan shall—

20 “(A) establish the electronic prior author-
 21 ization program described in paragraph (2) and

1 issue real-time decisions with respect to prior
2 authorization requests for items and services
3 identified by the Secretary under subparagraph
4 (C)(ii) of such paragraph;

5 “(B) meet the transparency requirements
6 specified in paragraph (3); and

7 “(C) meet the beneficiary protection stand-
8 ards specified pursuant to paragraph (4).

9 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
10 GRAM.—

11 “(A) IN GENERAL.—For purposes of para-
12 graph (1)(A), the electronic prior authorization
13 program described in this paragraph is a pro-
14 gram that provides for the secure electronic
15 transmission of—

16 “(i) a prior authorization request
17 from a health care professional to a Medi-
18 care Advantage plan with respect to an ap-
19 plicable item or service to be furnished to
20 an individual, including such clinical infor-
21 mation necessary to evidence medical ne-
22 cessity; and

23 “(ii) a response, in accordance with
24 this paragraph, from such plan to such
25 professional.

1 “(B) ELECTRONIC TRANSMISSION.—

2 “(i) EXCLUSIONS.—For purposes of
3 this paragraph, a facsimile, a proprietary
4 payer portal that does not meet standards
5 specified by the Secretary, or an electronic
6 form shall not be treated as an electronic
7 transmission described in subparagraph
8 (A).

9 “(ii) STANDARDS.—

10 “(I) IN GENERAL.—In order to
11 ensure appropriate clinical outcome
12 for individuals, for purposes of this
13 paragraph, an electronic transmission
14 described in subparagraph (A) shall
15 comply with technical standards
16 adopted by the Secretary in consulta-
17 tion with standard-setting organiza-
18 tions determined appropriate by the
19 Secretary, health care professionals,
20 Medicare Advantage organizations,
21 and health information technology
22 software vendors. In adopting such
23 standards with respect to which an
24 electronic transmission described in
25 subparagraph (A) shall comply, the

1 Secretary shall ensure that such
2 transmissions support attachments
3 containing applicable clinical informa-
4 tion and shall prioritize the adoption
5 of standards that support integration
6 with interoperable health information
7 technology certified under a program
8 of voluntary certification kept or rec-
9 ognized by the National Coordinator
10 for Health Information Technology
11 consistent with section 3001(c)(5) of
12 the Public Health Service Act.

13 “(II) TRANSACTION STAND-
14 ARD.—The Secretary shall include in
15 the standards adopted under sub-
16 clause (I) a standard with respect to
17 the transmission of attachments de-
18 scribed in such subclause, and data
19 elements and operating rules for such
20 transmission, consistent with health
21 care industry standards.

22 “(C) REAL-TIME DECISIONS.—

23 “(i) IN GENERAL.—The program de-
24 scribed in subparagraph (A) shall provide
25 for real-time decisions (as defined by the

1 Secretary in accordance with clause (iv))
2 by a Medicare Advantage plan with respect
3 to prior authorization requests for applica-
4 ble items and services identified by the
5 Secretary pursuant to clause (ii) for a plan
6 year if such requests contain all docu-
7 mentation described in paragraph
8 (3)(A)(ii)(II) required by such plan.

9 “(ii) IDENTIFICATION OF RE-
10 QUESTS.—For purposes of clause (i) and
11 with respect to a period of 2 plan years,
12 the Secretary shall identify, not later than
13 the date on which the initial announcement
14 described in section 1853(b)(1)(B)(i) for
15 the first plan year of such period is re-
16 quired to be announced, applicable items
17 and services for which prior authorization
18 requests are routinely approved, and shall
19 update the identification of such items and
20 services for each subsequent period of 2
21 plan years.

22 “(iii) DATA COLLECTION AND CON-
23 SULTATION WITH RELEVANT ELIGIBLE
24 PROFESSIONAL ORGANIZATIONS AND REL-
25 EVANT STAKEHOLDERS.—The Secretary

1 shall use the information described in
2 paragraph (3)(A) (if available) and shall
3 issue a request for information from Medi-
4 care Advantage plans, providers, suppliers,
5 beneficiary advocacy organizations, con-
6 sumer organizations, and other stake-
7 holders for purposes of identifying requests
8 for a period under clause (ii).

9 “(iv) DEFINITION OF REAL-TIME DE-
10 CISION.—

11 “(I) IN GENERAL.—In estab-
12 lishing the definition of a real-time
13 decision for purposes of clause (i), the
14 Secretary shall take into account cur-
15 rent medical practice, technology,
16 health care industry standards, and
17 other relevant information and factors
18 to ensure the accurate and timely fur-
19 nishing of items and services to indi-
20 viduals.

21 “(II) UPDATE.—The Secretary
22 shall update, not less often than once
23 every 2 years, the definition of a real-
24 time decision for purposes of clause
25 (i), taking into account changes in

1 medical practice, changes in tech-
2 nology, changes in health care indus-
3 try standards, and other relevant in-
4 formation, such as the information
5 submitted by Medicare Advantage
6 plans under paragraph (3)(A)(i), and
7 factors to ensure the accurate and
8 timely furnishing of items and services
9 to individuals.

10 “(v) IMPLEMENTATION.—The Sec-
11 retary shall use notice and comment rule-
12 making, which may include use of the an-
13 nual call letter process under this part, for
14 each of the following:

15 “(I) Establishing the definition
16 of a ‘real-time decision’ for purposes
17 of clause (i).

18 “(II) Updating such definition
19 pursuant to clause (iv)(II).

20 “(III) Identifying applicable
21 items or services pursuant to clause
22 (ii) for the initial period of 2 plan
23 years as described in such clause.

24 “(IV) Updating the identification
25 of such items and services for each

1 subsequent period of 2 plan years as
2 described in such clause.

3 “(3) TRANSPARENCY REQUIREMENTS.—

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

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

11 “(I) A list of all applicable items
12 and services that are described in sub-
13 section (a)(1)(B) that are subject to a
14 prior authorization requirement under
15 the plan.

16 “(II) The percentage of prior au-
17 thorization requests approved during
18 the previous plan year by the plan in
19 an initial determination with respect
20 to each such item and service.

21 “(III) The percentage of such re-
22 quests that were initially denied and
23 that were subsequently appealed in
24 any manner, and the percentage of
25 such appealed requests that were

1 overturned, with respect to each such
2 item and service, broken down by each
3 stage of appeal (including judicial re-
4 view). The plan may include informa-
5 tion regarding the number of initial
6 denials due to request submissions
7 that did not meet clinical evidence
8 standards.

9 “(IV) The percentage of such re-
10 quests that were denied and the per-
11 centage of the total number of denied
12 requests that were denied as a result
13 of decision support technology or
14 other clinical decision-making tools.

15 “(V) The average and the median
16 amount of time (in hours) that
17 elapsed during the previous plan year
18 between the submission of such a re-
19 quest to the plan and a determination
20 by the plan with respect to such re-
21 quest for each such item and service,
22 excluding any such requests that did
23 not contain all information required to
24 be submitted by the plan.

1 “(VI) A list that includes a de-
2 scription of each occurrence during
3 the previous plan year in which the
4 plan made a determination to approve
5 or deny an item or service in the case
6 where a provider furnished an addi-
7 tional or differing item or service dur-
8 ing the peroperative period of a sur-
9 gical or otherwise invasive procedure
10 that such provider determined was
11 medically necessary.

12 “(VII) A disclosure and descrip-
13 tion of any software decision-making
14 tools the plan utilizes in making de-
15 terminations with respect to such re-
16 quests.

17 “(VIII) Such other information
18 as the Secretary determines appro-
19 priate.

20 “(ii) The plan shall provide—

21 “(I) to each provider or supplier
22 who seeks to enter into a contract
23 with such plan to furnish applicable
24 items and services under such plan,
25 the list described in clause (i)(I) and

1 any policies or procedures used by the
2 plan for making determinations with
3 respect to prior authorization re-
4 quests;

5 “(II) to each such provider and
6 supplier who does enter into such a
7 contract, access to the criteria used by
8 the plan for making such determina-
9 tions, including an itemization of the
10 medical or other documentation re-
11 quired to be submitted by a provider
12 or supplier with respect to such a re-
13 quest, except to the extent that provi-
14 sion of access to such criteria would
15 disclose proprietary information of
16 such plan; and

17 “(III) to each beneficiary subject
18 to prior authorization under the plan,
19 access to the criteria used by the plan
20 for making such determinations, ex-
21 cept to the extent that provision of ac-
22 cess to such criteria would disclose
23 proprietary information of such plan.

24 “(B) REGULATIONS.—The Secretary shall,
25 through notice and comment rulemaking, pro-

1 vide guidance to Medicare Advantage plans re-
2 garding—

3 “(i) the establishment of criteria de-
4 scribed in subparagraph (A)(ii)(II) and ac-
5 cess to such criteria by providers and sup-
6 pliers in accordance with such subpara-
7 graph; and

8 “(ii) access to such criteria by bene-
9 ficiaries in accordance with subparagraph
10 (A)(ii)(III).

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

24 “(4) BENEFICIARY PROTECTION STANDARDS.—

25 The Secretary of Health and Human Services shall,

1 through notice and comment rulemaking, specify re-
2 quirements with respect to the use of prior author-
3 ization by Medicare Advantage plans for applicable
4 items and services to ensure—

5 “(A) that such plans adopt transparent
6 prior authorization programs developed in con-
7 sultation with providers and suppliers with con-
8 tracts in effect with such plans for furnishing
9 such items and services under such plans that
10 allow for the modification of prior authorization
11 requirements based on the performance of such
12 providers and suppliers with respect to adher-
13 ence to evidence-based medical guidelines and
14 other quality criteria;

15 “(B) that such plans conduct annual re-
16 views of such items and services for which prior
17 authorization requirements are imposed under
18 such plans through a process that takes into ac-
19 count input from providers and suppliers with
20 such contracts in effect and is based on analysis
21 of past prior authorization requests and current
22 coverage and clinical criteria;

23 “(C) continuity of care for individuals
24 transitioning to, or between, coverage under
25 such plans in order to minimize any disruption

1 to ongoing treatment attributable to prior au-
2 thorization requirements under such plans;

3 “(D) that such plans make timely prior au-
4 thorization determinations, provide rationales
5 for denials, and ensure requests are reviewed by
6 qualified medical personnel; and

7 “(E) that such plans provide information
8 on the appeals process to the beneficiary when
9 denying any request for prior authorization
10 with respect to an item or service.

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

17 “(6) REPORT TO CONGRESS.—Not later than
18 the end of the second plan year beginning on or
19 after the date of the enactment of this subsection,
20 and biennially thereafter through the date that is 10
21 years after such date of enactment, the Secretary
22 shall submit to Congress a report containing an
23 evaluation of the implementation of the requirements
24 of this subsection, an analysis of an issues in imple-
25 menting such requirements faced by Medicare Ad-

1 vantage plans, and a description of the information
2 submitted under paragraph (3)(A)(i) with respect
3 to—

4 “(A) in the case of the first such report,
5 such second plan year; and

6 “(B) in the case of a subsequent report,
7 the 2 full plan years preceding the date of the
8 submission of such report.”.

9 (b) DETERMINATION CLARIFICATION.—Section
10 1852(g)(1)(A) of the Social Security Act (42 U.S.C.
11 1395w–22(g)(1)(A)) is amended by inserting “(including
12 any decision made with respect to a prior authorization
13 request for such service)” after “section”.

○