Improving Seniors Timely Access to Care Act
2023 Ways and Means passed version with redline edits for 2024 reintroduction.

HR 3173 EH
117th CONGRESS
2d Session
H. R. 3173

AN ACT
Title: 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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.
This Act may be cited as the “Improving Seniors’ Timely Access to Care Act of 2022”.

SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USE OF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS.
(a) In General.—Section 1832 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

“(o) Prior Authorization Requirements.—
“(1) IN GENERAL.—In the case of a Medicare Advantage plan that imposes any prior authorization requirement with respect to any applicable item or service (as defined in paragraph (3)) during a plan year, such plan shall—
“(A) beginning with the third plan year beginning after the date of the enactment of this subsection—plan years beginning on or after January 1, 2027—
“(i) establish the electronic prior authorization program described in paragraph (2); and
“(ii) meet the enrollee protection standards specified pursuant to paragraph (4); and
“(B) beginning with the fourth plan year beginning after the date of the enactment of this subsection—plan years beginning on or after January 1, 2026, meet the transparency requirements specified in paragraph (3).
“(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—
“(A) IN GENERAL.—For purposes of paragraph (1)(A), the electronic prior authorization program described in this paragraph is a program that provides for the secure electronic transmission of—
“(i) a prior authorization request from a provider of services or supplier to a

Technical change: 117th Congress to 118th Congress.

Technical change: Date.

Technical change: Changed from plan year date to actual date – January 1, 2027.

Technical change: Changed from plan year date to actual date – January 1, 2027.
Medicare Advantage plan with respect to an applicable item or service to be furnished to an individual and a response, in accordance with this paragraph, from such plan to such provider or supplier; and

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

“(B) ELECTRONIC TRANSMISSION.—

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

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

“(I) applicable technical standards adopted by the Secretary pursuant to section 1173; and

“(II) other requirements to promote the standardization and streamlining of electronic transactions under this part specified by the Secretary.

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

“(C) Real-time decisions.—

“(i) In general.—Subject to clause (iv), the program described in subparagraph (A) shall provide for real-time decisions (as defined by the Secretary in accordance with clause (c)) by a Medicare Advantage plan with respect to prior authorization requests for applicable items and services identified by the Secretary pursuant to clause (ii) if such requests are submitted with all medical or other documentation required by such plan.

“(ii) Identification of items and services.—

“(I) In general.—For purposes of clause (i), the Secretary shall identify, not later than the date on which the initial announcement described in section 1833(b)(1)(B)(1) for the third plan year beginning after the date of the enactment of this subsection is required to be announced, applicable items and services for which prior authorization requests are routinely approved.

“(II) Updates.—The Secretary shall consider updating the applicable items and services identified under clause (I) based on the information described in paragraph (3)(A)(ii)(I) (if available and determined practicable to utilize by the Secretary) and any other information determined appropriate by the Secretary not less frequently than biennially. The Secretary shall announce any such update that is to apply with respect to a plan year not later than the date on which the initial announcement described in section 1833(b)(1)(B)(1) for such plan year is required to be announced.

“(III) Request for information.—The Secretary shall issue a request for information for purposes of initially identifying applicable items and services under clause (ii)(I).

“(IV) Exception for extenuating circumstances.—In the case of a prior authorization
Continuation of refinement on page 2 of real-time decisions for routinely approved services; see page 7.

Deleted additional timeline requirements for prior authorization requests for extenuating circumstances. This represented the remaining 20 percent of the $4 billion CBO score.
Technical change: Renumbered.

that were approved (categorized by each item and service).

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The percentage and number of specified requests that were denied during the previous plan year by the plan in an initial determination and that were subsequently appealed.

The number of appeals of specified requests resolved during the preceding plan year, and the percentage and number of such resolved appeals that resulted in approval of the furnishing of the item or service that was the subject of such request, categorized by each applicable item and service and categorized by each level of appeal (including judicial review).

The percentage and number of specified requests that were denied, and the percentage and number of specified requests that were approved, by the plan during the previous plan year through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

The average and the median amount of time (in hours) that elapsed during the previous plan year between the submission of a specified request to the plan and a determination by the plan with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan.

The percentage and number of specified requests that were excluded from the calculation described in subclause (VII) based on the plan’s determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

Information on each occurrence during the previous plan year in which, during a surgical or medical procedure involving the furnishing of an applicable item or service with respect to which such plan had approved a prior authorization request, the provider of services or supplier furnishing such item or service determined that a different or additional item or service was medically necessary, including a specification of whether such plan subsequently approved the furnishing of such different or additional item or service.

A disclosure and description of any technology described in subclause (VII) that the plan utilized during the previous plan year in making determinations with respect to specified requests.

The number of grievances (as described in subsection (f)) received by such plan during the previous plan year that were related to a prior authorization requirement.

Such other information as the Secretary determines appropriate.

“(ii) The plan shall provide—
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“(I) to each provider or supplier who seeks to enter into a contract with
such plan to furnish applicable items and services under such plan, the list
described in clause (i)(I) and any policies or procedures used by the plan for
making determinations with respect to prior authorization requests;

“(II) to each such provider and supplier that enters into such a contract,
access to the criteria used by the plan for making such determinations and an
itemization of the medical or other documentation required to be submitted
by a provider or supplier with respect to such a request; and

“(III) to an enrollee of the plan, upon request, access to the criteria used by
the plan for making determinations with respect to prior authorization
requests for an item or service.

“(B) OPTION FOR PLAN TO PROVIDE CERTAIN ADDITIONAL INFORMATION.—As part of
the information described in subparagraph (A)(i) provided to the Secretary during a
plan year, a Medicare Advantage plan may elect to include information regarding the
percentage and number of specified requests made with respect to an individual and an
item or service that were denied by the plan during the preceding plan year in an initial
determination based on such requests failing to demonstrate that such individuals met
the clinical criteria established by such plan to receive such items or services.

“(C) REGULATIONS.—The Secretary shall, through notice and comment rulemaking,
establish requirements for Medicare Advantage plans regarding the provision of—

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

“(ii) access to such criteria to enrollees in accordance with subparagraph
(A)(ii)(III).

“(D) PUBLICATION OF INFORMATION.—The Secretary shall publish information
described in subparagraph (A)(i) and subparagraph (B) on a public website of the
Centers for Medicare & Medicaid Services. Such information shall be so published on
an individual plan level and may in addition be aggregated in such manner as
determined appropriate by the Secretary.

“(E) MEDPAC REPORT.—Not later than 3 years after the date information is first
submitted under subparagraph (A)(i), the Medicare Payment Advisory Commission
shall submit to Congress a report on such information that includes a descriptive
analysis of the use of prior authorization. As appropriate, the Commission should
report on statistics including the frequency of appeals and overturned decisions. The
Commission shall provide recommendations, as appropriate, on any improvement that
should be made to the electronic prior authorization programs of Medicare Advantage
plans.

“(F) SPECIFIED REQUEST DEFINED.—For purposes of this paragraph, the term
‘specified request’ means a prior authorization request made with respect to an
applicable item or service.

“(4) ENROLLEE PROTECTION STANDARDS.—For purposes of paragraph (1)(A)(ii), the
Secretary shall, through notice and comment rulemaking, specify the following enrollee

Protection standards with respect to the use of prior authorization by Medicare Advantage plans for applicable items and services, the enrollee protection standards specified in this paragraph are—

“(A) Adoption of transparent prior authorization programs developed in consultation with enrollees and with providers and suppliers with contracts in effect with such plans for furnishing such items and services under such plans;

“(B) Allowing the waiver or modification of prior authorization requirements based on the performance of such providers and suppliers in demonstrating compliance with such requirements, such as adherence to evidence-based medical guidelines and other quality criteria; and

“(C) Conducting annual reviews of such items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input from enrollees and from providers and suppliers with such contracts in effect and is based on consideration of prior authorization data from previous plan years and analyses of current coverage criteria.

“(5) APPLICABLE ITEM OR SERVICE—FOR SERVICE DEFINED.—For purposes of this subsection, the term ‘applicable item or service’ means, with respect to a Medicare Advantage plan, any item or service for which benefits are available under such plan, other than a covered Part D drug.

“(6) REPORTS TO CONGRESS.—

“(A) GAO.—Not later than the end of the fourth plan year beginning on or after the date of the enactment of this subsection January 1, 2028, the Comptroller General of the United States shall submit to Congress a report containing an evaluation of the implementation of the requirements of this subsection and an analysis of issues in implementing such requirements faced by Medicare Advantage plans.

“(B) HHS.—Not HHS.

“(i) THE SECRETARY.—Not later than the end of the fifth plan year beginning after the date of the enactment of this subsection, and biennially thereafter through the date that is 10 years after such date of enactment, the Secretary shall submit to Congress a report containing a description of the information submitted under paragraph (3)(A)(i) during—

“(ii) in the case of the first such report, the fourth plan year beginning after the date of the enactment of this subsection; and

“(ii) in the case of a subsequent report, the 2 plan years preceding the year of the submission of such report—report.

“(2) Ensuring CMS.—Not later than January 1, 2027, the Centers for Medicare & Medicaid Services and the Office of National Coordinator for Health Information Technology shall submit to Congress and publish on the Internet website of the Centers for Medicare & Medicaid Services a report that—

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
Outlined parameters in the new report:

- Define real-time and establish a process for updating real-time determinations for items and services.
- Leverage data to detail a process for real-time decisions for routinely approved services.
- Require an analysis of the following:
  - Identifying routinely approved items and services,
  - Determining which items and services that could be eligible for real-time,
  - How establishing such a process could...
    - Improve access to care
    - Produce operational efficiencies
      for MA,
    - Reduce health disparities
      for rural and low-income communities
  - How automated decisions and AI by MA impact patient access to such items and services including access for rural and low-income communities.

Clarified the Secretary has regulatory authority to enforce this section and set additional timelines for response to PA requests. Included a suggestion that the Secretary may adopt a 24-hour timeframe for MA plans to notify providers and enrollees of determinations.

The final rule included expedited determinations for extenuating circumstances. CBO assessed a 24-hour timeframe to impact the baseline when compared to the final rule's 72-hour determination.
Continuation from page 7 of changes to determination timeframes.

Removed funding transfer of $25 million for CMS to use and remain available until expended to carry out the Act. This funding measure is no longer necessary as CMS has already carried out majority of provisions outlined in the Act. Moreover, this is aligned with the Sponsors’ intention to ensure the updated bill score is negligible, likely asterisks over a budget window.

Technical rule of construction to ensure that the bill does not conflict with the delay in issuing the last remaining rule, Health Care Attachments Transactions and Electronic Signatures and Modification to Referral Certification and Authorization Transaction.

Technical change.