

117TH CONGRESS
2^D SESSION

H. R. 3173

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.

117TH CONGRESS
2^D SESSION

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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.