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(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. ______

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

Ms. DELBENE (for herself, Mr. KELLY of Pennsylvania, Mr. MARSHALL, and Mr. BERA) introduced the following bill; which was referred to the Committee on ______________________________

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 2019".

1 **SEC. 2. SENSE OF CONGRESS.**

2 It is the sense of Congress that—

3 (1) use of prior authorization should be stream-
4 lined through electronic transmissions for coverage
5 of covered services for individuals enrolled in feder-
6 ally funded programs such as Medicare, Medicaid,
7 and federally contracted managed care plans to im-
8 prove patient access to medically appropriate serv-
9 ices and reduce administrative burden through auto-
10 mation informed by clinical decision support;

11 (2) there should be increased transparency for
12 beneficiaries and providers and increased oversight
13 by the Centers for Medicare & Medicaid Services on
14 the processes used for prior authorization; and

15 (3) prior authorization is a tool that can be
16 used to responsibly prevent unnecessary care and
17 promote safe and evidence-based care.

18 **SEC. 3. ESTABLISHING REQUIREMENTS WITH RESPECT TO**
19 **THE USE OF PRIOR AUTHORIZATION UNDER**
20 **MEDICARE ADVANTAGE PLANS.**

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

24 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

25 “(1) IN GENERAL.—In the case of a Medicare
26 Advantage plan that imposes any prior authorization

1 requirement with respect to any benefit, such plan
2 shall, beginning with the first plan year beginning
3 on or after the date of the enactment of this sub-
4 section—
5 ‘‘(A) comply with the prohibition described
6 in paragraph (2);
7 ‘‘(B) establish the electronic prior author-
8 ization program described in paragraph (3);
9 ‘‘(C) meet the transparency requirements
10 specified in paragraph (4); and
11 ‘‘(D) meet the beneficiary protection stand-
12 ards specified pursuant to paragraph (5).
13 ‘‘(2) PROHIBITION ON PRIOR AUTHORIZATION
14 WITH RESPECT TO CERTAIN ITEMS AND SERVICES.—
15 A Medicare Advantage plan may not impose any ad-
16 ditional prior authorization requirement with respect
17 to any surgical procedure or otherwise invasive pro-
18 cedure (as defined by the Secretary), and any item
19 furnished as part of such surgical or invasive proce-
20 dure, if such procedure (or item) is furnished during
21 the peroperative period of a procedure for which—
22 ‘‘(A) prior authorization was received from
23 such plan before such surgical or otherwise
24 invasive procedure (or item furnished as part of

1 such surgical or otherwise invasive procedure)
2 was furnished; or
3 "(B) prior authorization was not required
4 by such plan.
5 "(3) ELECTRONIC PRIOR AUTHORIZATION PRO-
6 GRAM.—
7 "(A) IN GENERAL.—For purposes of para-
8 graph (1)(B), the electronic prior authorization
9 program described in this paragraph is a prior
10 authorization process implemented by a Medi-
11 care Advantage plan that provides for the se-
12 cure electronic transmission of—
13 "(i) a prior authorization request
14 from a health care professional to such
15 plan with respect to an item or service to
16 be furnished to an individual, including
17 such clinical information as the profes-
18 sional determines appropriate to support
19 the furnishing of such item or service to
20 such individual; and
21 "(ii) a response, in accordance with
22 this paragraph, from such plan to such
23 professional.
24 "(B) ELECTRONIC TRANSMISSION.—

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

8 "(ii) STANDARDS.—

9 "(I) IN GENERAL.—In order to
10 ensure appropriate clinical outcome
11 for individuals, for purposes of this
12 paragraph, an electronic transmission
13 described in subparagraph (A) shall
14 comply with technical standards
15 adopted by the Secretary in consulta-
16 tion with standard-setting organiza-
17 tions determined appropriate by the
18 Secretary, health care professionals,
19 MA organizations, and health infor-
20 mation technology software vendors.
21 In adopting such standards, the Sec-
22 retary shall ensure that such trans-
23 missions support attachments con-
24 taining applicable clinical information
25 and shall prioritize the adoption of

1 standards that encourage integration
2 of the electronic prior authorization
3 program into established electronic
4 health record systems.
5 "(II) TRANSACTION STAND-
6 ARD.—The Secretary shall include in
7 the standards adopted under sub-
8 clause (I) a standard with respect to
9 the transmission of attachments de-
10 scribed in such subclause, and data
11 elements and operating rules for such
12 transmission, consistent with health
13 care industry standards.
14 "(C) REAL-TIME DECISIONS.—
15 "(i) IN GENERAL.—The program de-
16 scribed in subparagraph (A) shall provide
17 for real-time decisions (as defined by the
18 Secretary) with respect to requests identi-
19 fied by the Secretary pursuant to clause
20 (ii) for a plan year if such requests contain
21 all information required by an MA plan to
22 evaluate the criteria described in para-
23 graph (4)(A)(iii)(II).
24 "(ii) IDENTIFICATION OF RE-
25 QUESTS.—For purposes of clause (i) and

1 with respect to a plan year, the Secretary
2 shall identify, not later than the date on
3 which the initial announcement described
4 in section 1853(b)(1)(B)(i) for such plan
5 year is required to be announced, items
6 and services for which prior authorization
7 requests are routinely approved.
8 "(iii) DATA COLLECTION AND CON-
9 SULTATION WITH RELEVANT ELIGIBLE
10 PROFESSIONAL ORGANIZATIONS AND REL-
11 EVANT STAKEHOLDERS.—In identifying re-
12 quests for a year under clause (ii), the Sec-
13 retary shall use the information described
14 in paragraph (4)(A) (if available) and shall
15 issue a request for information from pro-
16 viders, suppliers, patient advocacy organi-
17 zations, and other stakeholders.
18 "(4) TRANSPARENCY REQUIREMENTS.—
19 "(A) IN GENERAL.—For purposes of para-
20 graph (1)(C), the transparency requirements
21 specified in this paragraph are, with respect to
22 a Medicare Advantage plan, the following:
23 "(i) The plan, not less frequently than
24 annually and at a time and in a manner

1 specified by the Secretary, shall submit to
2 the Secretary the following information:
3 ‘‘(I) A list of all items and serv-
4 ices that are described in subsection
5 (a)(1)(B) that are subject to a prior
6 authorization requirement under the
7 plan.
8 ‘‘(II) The percentage of prior au-
9 thorization requests approved during
10 the previous plan year by the plan
11 with respect to each such item and
12 service.
13 ‘‘(III) The percentage of such re-
14 quests that were initially denied and
15 that were subsequently appealed, and
16 the percentage of such appealed re-
17 quests that were overturned, with re-
18 spect to each such item and service.
19 ‘‘(IV) The average and the me-
20 dian amount of time (in hours) that
21 elapsed during the previous plan year
22 between the submission of such a re-
23 quest to the plan and a determination
24 by the plan with respect to such re-
25 quest for each such item and service,

1 excluding any such requests that did
2 not contain all information required to
3 be submitted by the plan.
4 "(V) Such other information as
5 the Secretary determines appropriate
6 after consultation with and comment
7 from stakeholders.
8 "(ii) The plan shall publish the infor-
9 mation described in clause (i) annually be-
10 fore open enrollment on a publicly available
11 website. Such plan shall provide the ad-
12 dress of such website in any enrollment
13 materials distributed by the plan and shall
14 update such website in a timely manner.
15 "(iii) The plan shall provide—
16 "(I) along with contract mate-
17 rials for any provider or supplier who
18 seeks to participate under the plan,
19 the list described in clause (i)(I) and
20 any policies or procedures used by the
21 plan for making determinations with
22 respect to prior authorization requests
23 ; and
24 "(II) to each provider and sup-
25 plier participating under the plan, ac-

1 cess to the criteria used by the plan
2 for making such determinations, in-
3 cluding an itemization of the medical
4 or other documentation required to be
5 submitted by a provider or supplier
6 with respect to such a request, except
7 to the extent that provision of access
8 to such criteria would disclose propri-
9 etary information of such plan, as de-
10 termined by the Secretary.

11 ''(B) REPORT TO CONGRESS.—Not later
12 than the end of the second plan year beginning
13 on or after the date of the enactment of this
14 subsection, and biennially thereafter, the Sec-
15 retary shall submit to Congress a report de-
16 scribing the information submitted under sub-
17 paragraph (A)(i) with respect to—

18 ''(i) in the case of the first such re-
19 port, the first plan year beginning on or
20 after such date; and

21 ''(ii) in the case of a subsequent re-
22 port, the 2 full plan years preceding the
23 date of the submission of such report.

24 ''(5) BENEFICIARY PROTECTION STANDARDS.—
25 The Secretary of Health and Human Services shall,

1 through notice and comment rulemaking, specify
2 standards with respect to the use of prior authoriza-
3 tion by MA plans to ensure—
4 ‘‘(A) that such plans adopt transparent
5 programs developed in consultation with pro-
6 viders and suppliers participating under the
7 plans that promote the modification of such re-
8 quirements based on the performance of such
9 providers and suppliers with respect to adher-
10 ence to evidence-based medical guidelines and
11 other quality criteria;
12 ‘‘(B) that such plans conduct annual re-
13 views of items and services for which prior au-
14 thorization requirements are imposed under
15 such plans through a process that takes into ac-
16 count input from participating providers and
17 suppliers and is based on analysis of past prior
18 authorization requests and current clinical cri-
19 teria;
20 ‘‘(C) continuity of care for individuals
21 transitioning to, or between, coverage under
22 such plans in order to minimize any disruption
23 to ongoing treatment attributable to prior au-
24 thorization requirements under such plans;

1 "(D) that such plans make timely prior au-
2 thorization determinations, provide rationales
3 for denials, and ensure requests are reviewed by
4 qualified medical personnel; and
5 "(E) that plans assist providers and sup-
6 pliers in submitting the information necessary
7 to enable the plan to make a prior authorization
8 determination in a timely manner.".
9 (b) DETERMINATION CLARIFICATION.—Section
10 1852(g)(1)(A) of the Social Security Act (42 U.S.C.
11 1392w–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".