

116TH CONGRESS
2D SESSION

S. 5044

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 SENATE OF THE UNITED STATES

DECEMBER 17, 2020

Mr. BROWN (for himself and Mr. THUNE) introduced the following bill; which was read twice and referred to the Committee on Finance

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 2020”.

1 **SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO**
 2 **THE USE OF PRIOR AUTHORIZATION UNDER**
 3 **MEDICARE ADVANTAGE PLANS.**

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

7 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

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

15 “(A) establish the electronic prior author-
 16 ization program described in paragraph (2) and
 17 issue real-time decisions with respect to prior
 18 authorization requests for items and services
 19 identified by the Secretary under subparagraph
 20 (C)(ii) of such paragraph;

21 “(B) meet the transparency requirements
 22 specified in paragraph (3); and

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

25 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
 26 GRAM.—

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

6 “(i) a prior authorization request
7 from a health care professional to a Medi-
8 care Advantage plan with respect to an ap-
9 plicable item or service to be furnished to
10 an individual, including such clinical infor-
11 mation necessary to evidence medical ne-
12 cessity; and

13 “(ii) a response, in accordance with
14 this paragraph, from such plan to such
15 professional.

16 “(B) ELECTRONIC TRANSMISSION.—

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

24 “(ii) STANDARDS.—

1 “(I) IN GENERAL.—In order to
2 ensure appropriate clinical outcome
3 for individuals, for purposes of this
4 paragraph, an electronic transmission
5 described in subparagraph (A) shall
6 comply with technical standards
7 adopted by the Secretary in consulta-
8 tion with standard-setting organiza-
9 tions determined appropriate by the
10 Secretary, health care professionals,
11 Medicare Advantage organizations,
12 and health information technology
13 software vendors. In adopting such
14 standards with respect to which an
15 electronic transmission described in
16 subparagraph (A) shall comply, the
17 Secretary shall ensure that such
18 transmissions support attachments
19 containing applicable clinical informa-
20 tion and shall prioritize the adoption
21 of standards that support integration
22 with interoperable health information
23 technology certified under a program
24 of voluntary certification kept or rec-
25 ognized by the National Coordinator

for Health Information Technology
consistent with section 3001(c)(5) of
the Public Health Service Act.

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

“(C) REAL-TIME DECISIONS.—

“(i) IN GENERAL.—The program de-
scribed in subparagraph (A) shall provide
for real-time decisions (as defined by the
Secretary in accordance with clause (iv))
by a Medicare Advantage plan with respect
to prior authorization requests for applica-
ble items and services identified by the
Secretary pursuant to clause (ii) for a plan
year if such requests contain all docu-
mentation described in paragraph
(3)(A)(ii)(II) required by such plan.

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

14 “(iii) DATA COLLECTION AND CON-
15 SULTATION WITH RELEVANT ELIGIBLE
16 PROFESSIONAL ORGANIZATIONS AND REL-
17 EVANT STAKEHOLDERS.—The Secretary
18 shall use the information described in
19 paragraph (3)(A) (if available) and shall
20 issue a request for information from Medi-
21 care Advantage plans, providers, suppliers,
22 beneficiary advocacy organizations, con-
23 sumer organizations, and other stake-
24 holders for purposes of identifying requests
25 for a period under clause (ii).

“(iv) DEFINITION OF REAL-TIME DECISION.—

“(I) IN GENERAL.—In establishing the definition of a real-time decision for purposes of clause (i), the Secretary shall take into account current medical practice, technology, health care industry standards, and other relevant information and factors to ensure the accurate and timely furnishing of items and services to individuals.

“(II) UPDATE.—The Secretary shall update, not less often than once every 2 years, the definition of a real-time decision for purposes of clause (i), taking into account changes in medical practice, changes in technology, changes in health care industry standards, and other relevant information, such as the information submitted by Medicare Advantage plans under paragraph (3)(A)(i), and factors to ensure the accurate and

1 timely furnishing of items and services
2 to individuals.

3 “(v) IMPLEMENTATION.—The Sec-
4 retary shall use notice and comment rule-
5 making, which may include use of the an-
6 nual call letter process under this part, for
7 each of the following:

8 “(I) Establishing the definition
9 of a ‘real-time decision’ for purposes
10 of clause (i).

11 “(II) Updating such definition
12 pursuant to clause (iv)(II).

13 “(III) Identifying applicable
14 items or services pursuant to clause
15 (ii) for the initial period of 2 plan
16 years as described in such clause.

17 “(IV) Updating the identification
18 of such items and services for each
19 subsequent period of 2 plan years as
20 described in such clause.

21 “(3) TRANSPARENCY REQUIREMENTS.—

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

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

4 “(I) A list of all applicable items
5 and services that are described in sub-
6 section (a)(1)(B) that are subject to a
7 prior authorization requirement under
8 the plan.

9 “(II) The percentage of prior au-
10 thorization requests approved during
11 the previous plan year by the plan in
12 an initial determination with respect
13 to each such item and service.

14 “(III) The percentage of such re-
15 quests that were initially denied and
16 that were subsequently appealed in
17 any manner, and the percentage of
18 such appealed requests that were
19 overturned, with respect to each such
20 item and service, broken down by each
21 stage of appeal (including judicial re-
22 view). The plan may include informa-
23 tion regarding the number of initial
24 denials due to request submissions

1 that did not meet clinical evidence
2 standards.

3 “(IV) The percentage of such re-
4 quests that were denied and the per-
5 centage of the total number of denied
6 requests that were denied as a result
7 of decision support technology or
8 other clinical decision-making tools.

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

19 “(VI) A list that includes a de-
20 scription of each occurrence during
21 the previous plan year in which the
22 plan made a determination to approve
23 or deny an item or service in the case
24 where a provider furnished an addi-
25 tional or differing item or service dur-

1 ing the peroperative period of a sur-
2 gical or otherwise invasive procedure
3 that such provider determined was
4 medically necessary.

5 “(VII) A disclosure and descrip-
6 tion of any software decision-making
7 tools the plan utilizes in making de-
8 terminations with respect to such re-
9 quests.

10 “(VIII) Such other information
11 as the Secretary determines appro-
12 priate.

13 “(ii) The plan shall provide—

14 “(I) to each provider or supplier
15 who seeks to enter into a contract
16 with such plan to furnish applicable
17 items and services under such plan,
18 the list described in clause (i)(I) and
19 any policies or procedures used by the
20 plan for making determinations with
21 respect to prior authorization re-
22 quests;

23 “(II) to each such provider and
24 supplier who does enter into such a
25 contract, access to the criteria used by

the plan for making such determinations, including an itemization of the medical or other documentation required to be submitted by a provider or supplier with respect to such a request, except to the extent that provision of access to such criteria would disclose proprietary information of such plan; and

“(III) to each beneficiary subject to prior authorization under the plan, access to the criteria used by the plan for making such determinations, except to the extent that provision of access to such criteria would disclose proprietary information of such plan.

“(B) REGULATIONS.—The Secretary shall, through notice and comment rulemaking, provide guidance to Medicare Advantage plans regarding—

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

1 “(ii) access to such criteria by bene-
2 ficiaries in accordance with subparagraph
3 (A)(ii)(III).

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

17 “(4) BENEFICIARY PROTECTION STANDARDS.—
18 The Secretary of Health and Human Services shall,
19 through notice and comment rulemaking, specify re-
20 quirements with respect to the use of prior author-
21 ization by Medicare Advantage plans for applicable
22 items and services to ensure—

23 “(A) that such plans adopt transparent
24 prior authorization programs developed in con-
25 sultation with providers and suppliers with con-

1 tracts in effect with such plans for furnishing
2 such items and services under such plans that
3 allow for the modification of prior authorization
4 requirements based on the performance of such
5 providers and suppliers with respect to adher-
6 ence to evidence-based medical guidelines and
7 other quality criteria;

8 “(B) that such plans conduct annual re-
9 views of such items and services for which prior
10 authorization requirements are imposed under
11 such plans through a process that takes into ac-
12 count input from providers and suppliers with
13 such contracts in effect and is based on analysis
14 of past prior authorization requests and current
15 coverage and clinical criteria;

16 “(C) continuity of care for individuals
17 transitioning to, or between, coverage under
18 such plans in order to minimize any disruption
19 to ongoing treatment attributable to prior au-
20 thorization requirements under such plans;

21 “(D) that such plans make timely prior au-
22 thorization determinations, provide rationales
23 for denials, and ensure requests are reviewed by
24 qualified medical personnel; and

1 “(E) that such plans provide information
2 on the appeals process to the beneficiary when
3 denying any request for prior authorization
4 with respect to an item or service.

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

11 “(6) REPORT TO CONGRESS.—Not later than
12 the end of the second plan year beginning on or
13 after the date of the enactment of this subsection,
14 and biennially thereafter through the date that is 10
15 years after such date of enactment, the Secretary
16 shall submit to Congress a report containing an
17 evaluation of the implementation of the requirements
18 of this subsection, an analysis of an issues in imple-
19 menting such requirements faced by Medicare Ad-
20 vantage plans, and a description of the information
21 submitted under paragraph (3)(A)(i) with respect
22 to—

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

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

4 (b) DETERMINATION CLARIFICATION.—Section
5 1852(g)(1)(A) of the Social Security Act (42 U.S.C.
6 1395w-22(g)(1)(A)) is amended by inserting “(including
7 any decision made with respect to a prior authorization
8 request for such service)” after “section”.

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