

116TH CONGRESS  
2D SESSION

**S.** \_\_\_\_\_

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

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IN THE SENATE OF THE UNITED STATES

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

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**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

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

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

13 “(C) REAL-TIME DECISIONS.—

14 “(i) IN GENERAL.—The program de-  
15 scribed in subparagraph (A) shall provide  
16 for real-time decisions (as defined by the  
17 Secretary in accordance with clause (iv))  
18 by a Medicare Advantage plan with respect  
19 to prior authorization requests for applica-  
20 ble items and services identified by the  
21 Secretary pursuant to clause (ii) for a plan  
22 year if such requests contain all docu-  
23 mentation described in paragraph  
24 (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).

1                   “(iv) DEFINITION OF REAL-TIME DE-  
2                   CISION.—

3                   “(I) IN GENERAL.—In estab-  
4                   lishing the definition of a real-time  
5                   decision for purposes of clause (i), the  
6                   Secretary shall take into account cur-  
7                   rent medical practice, technology,  
8                   health care industry standards, and  
9                   other relevant information and factors  
10                  to ensure the accurate and timely fur-  
11                  nishing of items and services to indi-  
12                  viduals.

13                  “(II) UPDATE.—The Secretary  
14                  shall update, not less often than once  
15                  every 2 years, the definition of a real-  
16                  time decision for purposes of clause  
17                  (i), taking into account changes in  
18                  medical practice, changes in tech-  
19                  nology, changes in health care indus-  
20                  try standards, and other relevant in-  
21                  formation, such as the information  
22                  submitted by Medicare Advantage  
23                  plans under paragraph (3)(A)(i), and  
24                  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

1 the plan for making such determina-  
2 tions, including an itemization of the  
3 medical or other documentation re-  
4 quired to be submitted by a provider  
5 or supplier with respect to such a re-  
6 quest, except to the extent that provi-  
7 sion of access to such criteria would  
8 disclose proprietary information of  
9 such plan; and

10 “(III) to each beneficiary subject  
11 to prior authorization under the plan,  
12 access to the criteria used by the plan  
13 for making such determinations, ex-  
14 cept to the extent that provision of ac-  
15 cess to such criteria would disclose  
16 proprietary information of such plan.

17 “(B) REGULATIONS.—The Secretary shall,  
18 through notice and comment rulemaking, pro-  
19 vide guidance to Medicare Advantage plans re-  
20 garding—

21 “(i) the establishment of criteria de-  
22 scribed in subparagraph (A)(ii)(II) and ac-  
23 cess to such criteria by providers and sup-  
24 pliers in accordance with such subpara-  
25 graph; 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”.