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S. 4532

To amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans.

IN THE SENATE OF THE UNITED STATES

JUNE 13, 2024

Mr. MARSHALL (for himself, Ms. SINEMA, Mr. THUNE, Mr. BROWN, Mrs. BLACKBURN, Mr. WHITEHOUSE, Mr. CASSIDY, Ms. HASSAN, Mr. TILLIS, Mr. CARPER, Mr. CORNYN, Mr. CASEY, Mr. BOOZMAN, Ms. STABENOW, Mr. MORAN, Ms. KLOBUCHAR, Mr. VANCE, Mrs. GILLIBRAND, Mr. BUDD, Mr. KAINE, Mr. HAWLEY, Mrs. SHAHEEN, Mrs. HYDE-SMITH, Mr. KELLY, Mr. CRAMER, Ms. ROSEN, Mr. BRAUN, Mr. HEINRICH, Mr. SCHMITT, Mr. HICKENLOOPER, Mr. RUBIO, Mr. PETERS, Mr. ROUNDS, Mr. WELCH, Mr. HOEVEN, Mr. PADILLA, Ms. COLLINS, Mr. BLUMENTHAL, Mrs. FISCHER, Mr. WARNOCK, Mr. SCHATZ, Mr. MERKLEY, Mr. FETTERMAN, Ms. WARREN, and Ms. CORTEZ MASTO) introduced the following bill; which was read twice and referred to the Committee on Finance

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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.

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 2024''.

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 plan years beginning
17 on or after January 1, 2027—

18 ''(i) establish the electronic prior au-
19 thorization program described in para-
20 graph (2); and

21 ''(ii) meet the enrollee protection
22 standards specified pursuant to paragraph
23 (4); and

24 ''(B) beginning with plan years beginning
25 on or after January 1, 2026, meet the trans-

1 parency requirements specified in paragraph
2 (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 supporting documentation
18 relating to such 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 applicable technical
6 standards and other requirements to pro-
7 mote the standardization and streamlining
8 of electronic transactions adopted by the
9 Secretary.
10 ''(3) TRANSPARENCY REQUIREMENTS.—
11 ''(A) IN GENERAL.—For purposes of para-
12 graph (1)(B), the transparency requirements
13 specified in this paragraph are, with respect to
14 a Medicare Advantage plan, the following:
15 ''(i) The plan, annually and in a man-
16 ner specified by the Secretary, shall submit
17 to the Secretary the following information:
18 ''(I) A list of all applicable items
19 and services that were subject to a
20 prior authorization requirement under
21 the plan during the previous plan
22 year.
23 ''(II) The percentage and number
24 of specified requests (as defined in
25 subparagraph (F)) approved during

1 the previous plan year by the plan in
2 an initial determination and the per-
3 centage and number of specified re-
4 quests denied during such plan year
5 by such plan in an initial determina-
6 tion (both in the aggregate and cat-
7 egorized by each item and service).

8 "(III) The percentage and num-
9 ber of specified requests that were de-
10 nied during the previous plan year by
11 the plan in an initial determination
12 and that were subsequently appealed.

13 "(IV) The number of appeals of
14 specified requests resolved during the
15 preceding plan year, and the percent-
16 age and number of such resolved ap-
17 peals that resulted in approval of the
18 furnishing of the item or service that
19 was the subject of such request, cat-
20 egorized by each applicable item and
21 service and categorized by each level
22 of appeal (including judicial review).

23 "(V) The percentage and number
24 of specified requests that were denied,
25 and the percentage and number of

1 specified requests that were approved,
2 by the plan during the previous plan
3 year through the utilization of deci-
4 sion support technology, artificial in-
5 telligence technology, machine-learn-
6 ing technology, clinical decision-mak-
7 ing technology, or any other tech-
8 nology specified by the Secretary.

9 ‘‘(VI) The average and the me-
10 dian amount of time (in hours) that
11 elapsed during the previous plan year
12 between the submission of a specified
13 request to the plan and a determina-
14 tion by the plan with respect to such
15 request for each such item and serv-
16 ice, excluding any such requests that
17 were not submitted with the medical
18 or other documentation required to be
19 submitted by the plan.

20 ‘‘(VII) The percentage and num-
21 ber of specified requests that were ex-
22 cluded from the calculation described
23 in subclause (VIII) based on the
24 plan’s determination that such re-
25 quests were not submitted with the

1 medical or other documentation re-
2 quired to be submitted by the plan.
3 “(VIII) Information on each oc-
4 currence during the previous plan
5 year in which, during a surgical or
6 medical procedure involving the fur-
7 nishing of an applicable item or serv-
8 ice with respect to which such plan
9 had approved a prior authorization re-
10 quest, the provider of services or sup-
11 plier furnishing such item or service
12 determined that a different or addi-
13 tional item or service was medically
14 necessary, including a specification of
15 whether such plan subsequently ap-
16 proved the furnishing of such dif-
17 ferent or additional item or service.
18 “(IX) A disclosure and descrip-
19 tion of any technology described in
20 subclause (V) that the plan utilized
21 during the previous plan year in mak-
22 ing determinations with respect to
23 specified requests.
24 “(X) The number of grievances
25 (as described in subsection (f)) re-

1 ceived by such plan during the pre-
2 vious plan year that were related to a
3 prior authorization requirement.

4 ‘‘(XI) Such other information as
5 the Secretary determines appropriate.

6 ‘‘(ii) The plan shall provide—

7 ‘‘(I) to each provider or supplier
8 who seeks to enter into a contract
9 with such plan to furnish applicable
10 items and services under such plan,
11 the list described in clause (i)(I) and
12 any policies or procedures used by the
13 plan for making determinations with
14 respect to prior authorization re-
15 quests;

16 ‘‘(II) to each such provider and
17 supplier that enters into such a con-
18 tract, access to the criteria used by
19 the plan for making such determina-
20 tions and an itemization of the med-
21 ical or other documentation required
22 to be submitted by a provider or sup-
23 plier with respect to such a request;
24 and

1 "(III) to an enrollee of the plan,
2 upon request, access to the criteria
3 used by the plan for making deter-
4 minations with respect to prior au-
5 thorization requests for an item or
6 service.

7 "(B) OPTION FOR PLAN TO PROVIDE CER-
8 TAIN ADDITIONAL INFORMATION.—As part of
9 the information described in subparagraph
10 (A)(i) provided to the Secretary during a plan
11 year, a Medicare Advantage plan may elect to
12 include information regarding the percentage
13 and number of specified requests made with re-
14 spect to an individual and an item or service
15 that were denied by the plan during the pre-
16 ceding plan year in an initial determination
17 based on such requests failing to demonstrate
18 that such individuals met the clinical criteria
19 established by such plan to receive such items
20 or services.

21 "(C) REGULATIONS.—The Secretary shall,
22 through notice and comment rulemaking, estab-
23 lish requirements for Medicare Advantage plans
24 regarding the provision of—

1 "(i) access to criteria described in
2 subparagraph (A)(ii)(II) to providers of
3 services and suppliers in accordance with
4 such subparagraph; and
5 "(ii) access to such criteria to enroll-
6 ees in accordance with subparagraph
7 (A)(ii)(III).
8 "(D) PUBLICATION OF INFORMATION.—
9 The Secretary shall publish information de-
10 scribed in subparagraph (A)(i) and subpara-
11 graph (B) on a public website of the Centers
12 for Medicare & Medicaid Services. Such infor-
13 mation shall be so published on an individual
14 plan level and may in addition be aggregated in
15 such manner as determined appropriate by the
16 Secretary.
17 "(E) MEDPAC REPORT.—Not later than 3
18 years after the date information is first sub-
19 mitted under subparagraph (A)(i), the Medicare
20 Payment Advisory Commission shall submit to
21 Congress a report on such information that in-
22 cludes a descriptive analysis of the use of prior
23 authorization. As appropriate, the Commission
24 should report on statistics including the fre-
25 quency 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), 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) the 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 for the waiver or modification of prior authorization requirements based on the performance of such providers and suppliers in demonstrating compliance with such

1 requirements, such as adherence to evidence-
2 based medical guidelines and other quality cri-
3 teria; and
4 "(C) conducting annual reviews of such
5 items and services for which prior authorization
6 requirements are imposed under such plans
7 through a process that takes into account input
8 from enrollees and from providers and suppliers
9 with such contracts in effect and is based on
10 consideration of prior authorization data from
11 previous plan years and analyses of current cov-
12 erage criteria.
13 "(5) APPLICABLE ITEM OR SERVICE DE-
14 FINED.—For purposes of this subsection, the term
15 'applicable item or service' means, with respect to a
16 Medicare Advantage plan, any item or service for
17 which benefits are available under such plan, other
18 than a covered part D drug.
19 "(6) REPORTS TO CONGRESS.—
20 "(A) GAO.—Not later than January 1,
21 2032, the Comptroller General of the United
22 States shall submit to Congress a report con-
23 taining an evaluation of the implementation of
24 the requirements of this subsection and an

1 analysis of issues in implementing such require-
2 ments faced by Medicare Advantage plans.
3 "(B) HHS.—
4 "(i) THE SECRETARY.—Not later than
5 the end of the fifth plan year beginning
6 after the date of the enactment of this sub-
7 section, and biennially thereafter through
8 the date that is 10 years after such date
9 of enactment, the Secretary shall submit to
10 Congress a report containing a description
11 of the information submitted under para-
12 graph (3)(A)(i) during—
13 "(I) in the case of the first such
14 report, the fourth plan year beginning
15 after the date of the enactment of this
16 subsection; and
17 "(II) in the case of a subsequent
18 report, the 2 plan years preceding the
19 year of the submission of such report.
20 "(ii) CMS.—Not later than January
21 1, 2027, the Centers for Medicare & Med-
22 icaid Services and the Office of National
23 Coordinator for Health Information Tech-
24 nology shall submit to Congress and pub-
25 lish on the Internet website of the Centers

1 for Medicare & Medicaid Services a report
2 that—
3 ''(I) defines the term 'real-time
4 decision' and details how the defini-
5 tion for such term may be updated
6 based on any technological advances;
7 ''(II) using the data submitted to
8 the Secretary under paragraph
9 (3)(A)(i), details a process for real-
10 time decisions for items and services
11 for routinely approved services for
12 purposes of the electronic prior au-
13 thorization program described in
14 paragraph (2); and
15 ''(III) includes an analysis of—
16 ''(aa) items and services
17 that are routinely approved;
18 ''(bb) items and services
19 identified in item (aa) that could
20 be eligible for real-time decisions;
21 ''(cc) how establishing real-
22 time decisions for such items and
23 services could—

1 "(AA) improve enrollee
2 access to benefits under this
3 part;
4 "(BB) produce oper-
5 ational efficiencies for pro-
6 viders of services and sup-
7 pliers and Medicare Advan-
8 tage plans; and
9 "(CC) reduce health
10 disparities for Medicare Ad-
11 vantage enrollees in rural
12 and low-income commu-
13 nities; and
14 "(dd) how the use of auto-
15 mated decision-making and artifi-
16 cial intelligence by Medicare Ad-
17 vantage plans impact patient ac-
18 cess, including disparities in ac-
19 cess for rural and low-income
20 beneficiaries, to routinely ap-
21 proved items and services.".
22 (b) PROVIDING THE SECRETARY AUTHORITY TO EN-
23 FORCE TIMELY RESPONSES FOR ALL PRIOR AUTHORIZA-
24 TION REQUESTS SUBMITTED UNDER PART C.—Section

1852(g) of the Social Security Act (42 U.S.C. 1395w–22(g)) is amended—

(1) in paragraph (1)(A), by inserting ''and in accordance with any timeframe established by the Secretary under paragraph (6)'' after ''paragraph (3)'';

(2) in paragraph (3)(B)(iii), by inserting ''(or, subject to subsection (o), with respect to prior authorization requests submitted on or after the first day of the third plan year beginning after the date of the enactment of the Improving Seniors' Timely Access to Care Act of 2024, any timeframe established by the Secretary under paragraph (6))'' after ''72 hours''; and

(3) by adding at the end the following new paragraph:

''(6) TIMEFRAME FOR RESPONSE TO PRIOR AUTHORIZATION REQUESTS.—Subject to paragraph (3) and subsection (o), the Secretary may establish, for purposes of an organization determination made with respect to a prior authorization request for an item or service to be furnished to an individual, timeframes, such as 24 hours, for the organization to notify the enrollee (and the physician involved, as appropriate) of such determination for—

1 "(A) a request for expedited determination
2 described in paragraph (3)(A);
3 "(B) a real time decision for routinely ap-
4 proved items and services; and
5 "(C) any other prior authorization re-
6 quest.".

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