I

116TH CONGRESS
1ST SESSION

H. R. 3107

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

JUNE 5, 2019

Ms. DELBENE (for herself, Mr. KELLY of Pennsylvania, Mr. MARSHALL, and Mr. BERA) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Seniors' Timely Access to Care Act of 2019''.

SEC. 2. SENSE OF CONGRESS.

It is the sense of Congress that—

(1) use of prior authorization should be streamlined through electronic transmissions for coverage of covered services for individuals enrolled in federally funded programs such as Medicare, Medicaid, and federally contracted managed care plans to improve patient access to medically appropriate services and reduce administrative burden through automation informed by clinical decision support;

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

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

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

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

''(o) PRIOR AUTHORIZATION REQUIREMENTS.—

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

requirement with respect to any benefit, such plan shall, beginning with the first plan year beginning on or after the date of the enactment of this subsection—

"(A) comply with the prohibition described in paragraph (2);

"(B) establish the electronic prior authorization program described in paragraph (3);

"(C) meet the transparency requirements specified in paragraph (4); and

"(D) meet the beneficiary protection standards specified pursuant to paragraph (5).

"(2) PROHIBITION ON PRIOR AUTHORIZATION WITH RESPECT TO CERTAIN ITEMS AND SERVICES.—A Medicare Advantage plan may not impose any additional prior authorization requirement with respect to any surgical procedure or otherwise invasive procedure (as defined by the Secretary), and any item furnished as part of such surgical or invasive procedure, if such procedure (or item) is furnished during the peroperative period of a procedure for which—

"(A) prior authorization was received from such plan before such surgical or otherwise invasive procedure (or item furnished as part of

such surgical or otherwise invasive procedure) was furnished; or

''(B) prior authorization was not required by such plan.

''(3) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the electronic prior authorization program described in this paragraph is a prior authorization process implemented by a Medicare Advantage plan that provides for the secure electronic transmission of—

''(i) a prior authorization request from a health care professional to such plan with respect to an item or service to be furnished to an individual, including such clinical information as the professional determines appropriate to support the furnishing of such item or service to such individual; and

''(ii) a response, in accordance with this paragraph, from such plan to such professional.

''(B) ELECTRONIC TRANSMISSION.—

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

''(ii) STANDARDS.—

''(I) IN GENERAL.—In order to ensure appropriate clinical outcome for individuals, for purposes of this paragraph, an electronic transmission described in subparagraph (A) shall comply with technical standards adopted by the Secretary in consultation with standard-setting organizations determined appropriate by the Secretary, health care professionals, MA organizations, and health information technology software vendors. In adopting such standards, the Secretary shall ensure that such transmissions support attachments containing applicable clinical information and shall prioritize the adoption of

standards that encourage integration of the electronic prior authorization program into established electronic health record systems.

"(II) TRANSACTION STANDARD.—The Secretary shall include in the standards adopted under subclause (I) a standard with respect to the transmission of attachments described 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 described in subparagraph (A) shall provide for real-time decisions (as defined by the Secretary) with respect to requests identified by the Secretary pursuant to clause (ii) for a plan year if such requests contain all information required by an MA plan to evaluate the criteria described in paragraph (4)(A)(iii)(II).

"(ii) IDENTIFICATION OF REQUESTS.—For purposes of clause (i) and

with respect to a plan year, the Secretary shall identify, not later than the date on which the initial announcement described in section 1853(b)(1)(B)(i) for such plan year is required to be announced, items and services for which prior authorization requests are routinely approved.

''(iii) DATA COLLECTION AND CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND RELEVANT STAKEHOLDERS.—In identifying requests for a year under clause (ii), the Secretary shall use the information described in paragraph (4)(A) (if available) and shall issue a request for information from providers, suppliers, patient advocacy organizations, and other stakeholders.

''(4) TRANSPARENCY REQUIREMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(C), the transparency requirements specified in this paragraph are, with respect to a Medicare Advantage plan, the following:

''(i) The plan, not less frequently than annually and at a time and in a manner

specified by the Secretary, shall submit to the Secretary the following information:

''(I) A list of all items and services that are described in subsection (a)(1)(B) that are subject to a prior authorization requirement under the plan.

''(II) The percentage of prior authorization requests approved during the previous plan year by the plan with respect to each such item and service.

''(III) The percentage of such requests that were initially denied and that were subsequently appealed, and the percentage of such appealed requests that were overturned, with respect to each such item and service.

''(IV) The average and the median amount of time (in hours) that elapsed during the previous plan year between the submission of such a request to the plan and a determination by the plan with respect to such request for each such item and service,

excluding any such requests that did not contain all information required to be submitted by the plan.

''(V) Such other information as the Secretary determines appropriate after consultation with and comment from stakeholders.

''(ii) The plan shall publish the information described in clause (i) annually before open enrollment on a publicly available website. Such plan shall provide the address of such website in any enrollment materials distributed by the plan and shall update such website in a timely manner.

''(iii) The plan shall provide—

''(I) along with contract materials for any provider or supplier who seeks to participate under the plan, the list described in clause (i)(I) and any policies or procedures used by the plan for making determinations with respect to prior authorization requests; and

''(II) to each provider and supplier participating under the plan, ac-

cess 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, as determined by the Secretary.

''(B) REPORT TO CONGRESS.—Not later than the end of the second plan year beginning on or after the date of the enactment of this subsection, and biennially thereafter, the Secretary shall submit to Congress a report describing the information submitted under subparagraph (A)(i) with respect to—

''(i) in the case of the first such report, the first plan year beginning on or after such date; and

''(ii) in the case of a subsequent report, the 2 full plan years preceding the date of the submission of such report.

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

through notice and comment rulemaking, specify standards with respect to the use of prior authorization by MA plans to ensure—

"(A) that such plans adopt transparent programs developed in consultation with providers and suppliers participating under the plans that promote the modification of such requirements based on the performance of such providers and suppliers with respect to adherence to evidence-based medical guidelines and other quality criteria;

"(B) that such plans conduct annual reviews of items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input from participating providers and suppliers and is based on analysis of past prior authorization requests and current clinical criteria;

"(C) continuity of care for individuals transitioning to, or between, coverage under such plans in order to minimize any disruption to ongoing treatment attributable to prior authorization requirements under such plans;

''(D) that such plans make timely prior authorization determinations, provide rationales for denials, and ensure requests are reviewed by qualified medical personnel; and

''(E) that plans assist providers and suppliers in submitting the information necessary to enable the plan to make a prior authorization determination in a timely manner.''.

(b) DETERMINATION CLARIFICATION.—Section 1852(g)(1)(A) of the Social Security Act (42 U.S.C. 1392w–22(g)(1)(A)) is amended by inserting ''(including any decision made with respect to a prior authorization request for such service)'' after ''section''.

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