The Improving Seniors' Timely Access to Care Act of 2021 (H.R. 3173)

Introduced by Rep. Suzan DelBene (D-WA) Rep. Mike Kelly (R-PA), Rep. Ami Bera (D-CA), and Rep. Larry Buchson (R-IN). It has 202 co-sponsors, evenly split between Democrats and Republicans.

The legislation is supported by the American Academy of Neurology, the American Academy of Ophthalmology, the American Academy of Neurological Surgeons, the American Academy of Orthopedic Surgeons, the American College of Rheumatology, the American Gastroenterological Association, the American Society of Clinical Oncology, the American Urological Association, the Congress of Neurological Surgeons, and the National Association of Spine Specialists

The bill reforms the prior authorization process within Medicare Advantage by:

- Establishing an electronic prior authorization process;
- Minimizing the use of prior authorization for routinely approved services;
- Ensuring prior authorization requests are reviewed by qualified medical personnel;
- Requiring regular reports from Medicare Advantage plans on their use of prior authorization and rates of delay and denial; and
- Prohibiting the use of prior authorization for medically necessary services performed during pre-approved surgeries or other invasive procedures.

RRC
Regulatory Relief Coalition
Protecting Patients' Timely Access To Care

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Leading Medical Specialty Coalition Welcomes Reintroduction of Prior Authorization Relief Bill

Coalition Continues Fighting for Seniors' Timely Access to Care

WASHINGTON, DC, May 13, 2021— Leading coalition applauds Reps. **Suzan DelBene** (D-Wash.), **Mike Kelly** (R-Pa.), **Ami Bera**, MD, (D-Calif.) and **Larry Bucshon**, MD, (R-Ind.) for the reintroduction of the *Improving Seniors' Timely Access to Care Act of 2021*. The legislation provides much-needed oversight and transparency of health insurance for America's seniors.

The legislation is the culmination of months of bipartisan, bicameral discussions that included full engagement with all involved stakeholders, resulting in balanced, common-sense legislation that would help protect patients from unnecessary delays in care by streamlining and standardizing prior authorization in the Medicare Advantage (MA) program.

Similar legislation (H.R. 3107) introduced in 2019 garnered 280 co-sponsors, making it one of the most evenly bipartisan and widely supported health care bills in the 116th Congress. Changes to the legislation, summarized HERE, are modest, responsible and should pave the way to committee and floor action in the 117th Congress.

The regulatory burdens of prior authorization have amplified the risks for patients and burdens for practices during the COVID-19 crisis. Even in areas where the health care system is beginning to recover sufficiently to treat non-emergent cases, providers are faced with the challenge of delivering long-delayed, medically necessary services to patients whose health care needs were postponed during the crisis. Prior authorization burdens will only further delay this care.

"Prior Authorization burdens are more than burdens. They can be dangerous barriers to necessary patient care," said **John K. Ratliff**, MD, a practicing neurosurgeon at Stanford University. "The COVID-19 crisis has exacerbated the need to reform prior authorizations as our patients are facing new obstacles to getting the care they need." He added, "Some of my patients have already waited months for necessary surgeries because of the COVID crisis." Ratliff concluded, "The legislation's common-sense oversight and transparency of prior authorization should now be a national imperative."

"Imagine waiting for an insurance company to approve a service that can save your vision," said George A. Williams, MD, Senior Secretary for Advocacy of the **American Academy of Ophthalmology**. "This situation is very real for many of our patients. We strongly believe help is on the way. The Improving Seniors' Timely Access to Care Act reimagines prior authorization, taking bold steps to improve patient access to care." He noted, "we are especially pleased that the bill would establish — for the first time ever — an electronic prior authorization system,

avenues for real-time decisions, full transparency, and real patient protections for America's seniors."

The Improving Seniors' Timely Access to Care Act of 2021 would:

- Establish an electronic prior authorization (ePA) program and require MA plans to adopt ePA capabilities;
- Require the Secretary of Health and Human Services to establish a list of items and services eligible for real-time decisions under an MA ePA program;
- Standardize and streamline the prior authorization process for routinely approved items and services;
- Ensure prior authorization requests are reviewed by qualified medical personnel;
- Increase transparency around MA prior authorization requirements and their use; and
- Protect beneficiaries from any disruptions in care due to prior authorization requirements as they transition between MA plans.

The Regulatory Relief Coalition is a group of fourteen national physician specialty organizations advocating for a reduction in Medicare program regulatory burdens to protect patients' timely access to care and allow physicians to spend more time with their patients.

American Academy of Family Physicians, the American Academy of Neurology, American Academy of Ophthalmology, American Academy of Orthopedic Surgeons, American Association of Neurological Surgeons, College of Cardiology, American College of Rheumatology, American College of Surgeons, American Gastroenterological Association, American Osteopathic Association, Association for Clinical Oncology, Congress of Neurological Surgeons, National Association of Spine Specialists, American Society for Cardiovascular Angiography and Interventions.

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(Original Signature of Member)

117TH 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

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IN THE HOUSE OF REPRESENTATIVES

Ms. DELBENE 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

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 2021''.

SEC. 2. 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.—Beginning with the second plan year beginning after the date of the enactment of this subsection, in the case of a Medicare Advantage plan that imposes any prior authorization requirement with respect to any applicable item or service (other than a covered part D drug) during a plan year, such plan shall—

''(A) establish the electronic prior authorization program described in paragraph (2) and issue real-time decisions with respect to prior authorization requests for items and services identified by the Secretary under subparagraph (C)(ii) of such paragraph;

''(B) meet the transparency requirements specified in paragraph (3); and

''(C) meet the beneficiary protection standards specified pursuant to paragraph (4).

''(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—

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

''(i) a prior authorization request from a health care professional to a Medicare Advantage plan with respect to an applicable item or service to be furnished to an individual, including such clinical information necessary to evidence medical necessity; 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, Medicare Advantage organizations, and health information technology software vendors. In adopting such standards with respect to which an electronic transmission described in subparagraph (A) shall comply, the Secretary shall ensure that such transmissions support attachments containing applicable clinical information and shall prioritize the adoption of standards that support integration with interoperable health information technology certified under a program of voluntary certification kept or recognized by the National Coordinator

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

''(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 in accordance with clause (iv)) by a Medicare Advantage plan with respect to prior authorization requests for applicable items and services identified by the Secretary pursuant to clause (ii) for a plan year if such requests contain all documentation described in paragraph (3)(A)(ii)(II) required by such plan.

"(ii) IDENTIFICATION OF REQUESTS.—For purposes of clause (i) and with respect to a period of 2 plan years, the Secretary shall identify, not later than the date on which the initial announcement described in section 1853(b)(1)(B)(i) for the first plan year of such period is required to be announced, applicable items and services for which prior authorization requests are routinely approved, and shall update the identification of such items and services for each subsequent period of 2 plan years.

"(iii) DATA COLLECTION AND CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND RELEVANT STAKEHOLDERS.—The Secretary shall use the information described in paragraph (3)(A) (if available) and shall issue a request for information from Medicare Advantage plans, providers, suppliers, beneficiary advocacy organizations, consumer organizations, and other stakeholders for purposes of identifying requests 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

timely furnishing of items and services to individuals.

''(v) IMPLEMENTATION.—The Secretary shall use notice and comment rulemaking, which may include use of the annual call letter process under this part, for each of the following:

''(I) Establishing the definition of a 'real-time decision' for purposes of clause (i).

''(II) Updating such definition pursuant to clause (iv)(II).

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

''(IV) Updating the identification of such items and services for each subsequent period of 2 plan years as described in such clause.

''(3) TRANSPARENCY REQUIREMENTS.—

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

''(i) The plan, annually and in a manner specified by the Secretary, shall submit to the Secretary the following information:

''(I) A list of all applicable 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 in an initial determination with respect to each such item and service.

''(III) The percentage of such requests that were initially denied and that were subsequently appealed in any manner, and the percentage of such appealed requests that were overturned, with respect to each such item and service, broken down by each stage of appeal (including judicial review). The plan may include information regarding the number of initial denials due to request submissions

that did not meet clinical evidence standards.

''(IV) The percentage of such requests that were denied and the percentage of the total number of denied requests that were denied as a result of decision support technology or other clinical decision-making tools.

''(V) 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.

''(VI) A list that includes a description of each occurrence during the previous plan year in which the plan made a determination to approve or deny an item or service in the case where a provider furnished an additional or differing item or service dur-

ing the peroperative period of a surgical or otherwise invasive procedure that such provider determined was medically necessary.

''(VII) A disclosure and description of any software decision-making tools the plan utilizes in making determinations with respect to such requests.

''(VIII) Such other information as the Secretary determines appropriate.

''(ii) The plan shall provide—

''(I) to each provider or supplier who seeks to enter into a contract with such plan to furnish applicable items and services under such 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;

''(II) to each such provider and supplier who does enter into such a 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

''(ii) access to such criteria by beneficiaries in accordance with subparagraph (A)(ii)(III).

''(C) MEDPAC REPORT.—Not later than 3 years after the date information is first submitted under subparagraph (A)(i), the Medicare Payment Advisory Commission shall submit to Congress a report on such information that includes a descriptive analysis of the use of prior authorization. As appropriate, the Commission should report on statistics including the frequency 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.

''(4) BENEFICIARY PROTECTION STANDARDS.—The Secretary of Health and Human Services shall, through notice and comment rulemaking, specify requirements with respect to the use of prior authorization by Medicare Advantage plans for applicable items and services to ensure—

''(A) that such plans adopt transparent prior authorization programs developed in consultation with providers and suppliers with con-

tracts in effect with such plans for furnishing such items and services under such plans that allow for the modification of prior authorization 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 such items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input from providers and suppliers with such contracts in effect and is based on analysis of past prior authorization requests and current coverage and 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 such plans provide information on the appeals process to the beneficiary when denying any request for prior authorization with respect to an item or service.

''(5) APPLICABLE ITEM OR SERVICE.—For purposes of this subsection, the term 'applicable item or service' means, with respect to a Medicare Advantage plan, any item or service for which benefits are available under such plan, other than a covered part D drug.

''(6) 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 through the date that is 10 years after such date of enactment, the Secretary shall submit to Congress a report containing an evaluation of the implementation of the requirements of this subsection, an analysis of an issues in implementing such requirements faced by Medicare Advantage plans, and a description of the information submitted under paragraph (3)(A)(i) with respect to—

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

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

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