

117TH CONGRESS
2D SESSION

H. R. 7995

To amend title XVIII of the Social Security Act to exempt qualifying physicians from prior authorization requirements under Medicare Advantage plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 2022

Mr. BURGESS (for himself, Mr. VICENTE GONZALEZ of Texas, and Mr. JACKSON) 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

A BILL

To amend title XVIII of the Social Security Act to exempt qualifying physicians from prior authorization requirements 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 “Getting Over Lengthy
5 Delays in Care As Required by Doctors Act of 2022” or
6 the “GOLD CARD Act of 2022”.

1 **SEC. 2. EXEMPTION FOR QUALIFYING PHYSICIANS FROM**
2 **PRIOR AUTHORIZATION REQUIREMENTS**
3 **UNDER MA 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) EXEMPTION FOR QUALIFYING PHYSICIANS
8 FROM PRIOR AUTHORIZATION REQUIREMENTS.—

9 “(1) IN GENERAL.—

10 “(A) EXEMPTION.—

11 “(i) IN GENERAL.—In the case of an
12 MA organization which utilizes a prior au-
13 thorization process (as defined in subpara-
14 graph (B)) with respect to a plan year (be-
15 ginning with the second plan year begin-
16 ning after the date of the enactment of
17 this subsection), subject to the succeeding
18 provisions of this subsection, a physician
19 shall be exempt from the prior authoriza-
20 tion requirements under such process for
21 the period of such plan year with respect
22 to a specific item, service, or group of simi-
23 lar services, if during the preceding plan
24 year at least 90 percent of prior authoriza-
25 tion requests submitted to such organiza-
26 tion by such physician for such item, serv-

1 ice, or group were approved by such orga-
2 nization (including any approval granted
3 after an appeal). Such exemption shall con-
4 tinue to apply with respect to such physi-
5 cian furnishing such item, service, or group
6 of similar services in subsequent plan years
7 until the earlier of—

8 “(I) the date on which such ex-
9 emption is revoked under paragraph
10 (5); or

11 “(II) the date on which such phy-
12 sician opts out of such exemption
13 under paragraph (3)(C).

14 “(ii) SPECIAL RULES.—For purposes
15 of determining whether a physician quali-
16 fies for an exemption under clause (i) for
17 a plan year for an item, service, or group
18 of services, in calculating whether at least
19 90 percent of prior authorization requests
20 submitted by such physician for such item,
21 services, or group during the preceding
22 plan year were approved, an MA organiza-
23 tion shall—

24 “(I) subject to subclause (II),
25 treat any such claim that was initially

1 denied, subsequently appealed, and
2 that remains pending appeal at the
3 time of such calculation as having
4 been approved if more than 30 days
5 have elapsed since the date such ap-
6 peal was filed; and

7 “(II) in the case that, during
8 such plan year, such organization
9 changed any terms of coverage for
10 such item, service, or group of serv-
11 ices, not take into account any claims
12 for such item, service, or group of
13 services that were submitted during
14 the 90-day period beginning on the
15 date of such change.

16 “(B) PRIOR AUTHORIZATION PROCESS.—
17 For purposes of this subsection, the term ‘prior
18 authorization process’ means, with respect to
19 coverage and payment for items and services
20 (other than a covered part D drug) under an
21 MA plan offered by an MA organization for a
22 plan year, a process under which such organiza-
23 tion (or a contractor of such organization) de-
24 termines the medical necessity or medical ap-
25 propriateness of such items and services prior

1 to the furnishing of such items and services or
2 that otherwise requires an individual enrolled
3 under such plan, or a provider of services or
4 supplier scheduled to furnish items and services
5 to such individual, to notify such plan (or such
6 contractor) prior to such individual receiving
7 such items and services.

8 “(2) FREQUENCY OF DETERMINATION OF ELI-
9 GIBILITY FOR EXEMPTION.—An MA organization
10 may not evaluate a physician for the exemption de-
11 scribed in paragraph (1) more than once during any
12 plan year.

13 “(3) NOTIFICATION REQUIREMENTS.—

14 “(A) QUALIFICATION.—An MA organiza-
15 tion shall, not later than 30 days before the
16 first day of each plan year, notify each physi-
17 cian who qualifies for the exemption described
18 in paragraph (1) of such qualification and the
19 items, services, or group of similar services with
20 respect to which such exemption applies for
21 such physician. Nothing in this subparagraph
22 shall preclude an MA organization from noti-
23 fying a physician of such exemption at addi-
24 tional times throughout a plan year.

1 “(B) REQUESTS UNDER EXEMPTION.—In
2 the case of a physician described in subpara-
3 graph (A) who submits a prior authorization re-
4 quest to an MA organization for an item or
5 service with respect to which an exemption ap-
6 plies under this subsection, such organization
7 shall notify such physician of such exemption as
8 soon as possible (but in no case later than 24
9 hours after receiving such request).

10 “(C) OPT OUT.—Any physician eligible for
11 an exemption under paragraph (1) may volun-
12 tarily waive such exemption by providing writ-
13 ten notice to the applicable MA organization.

14 “(4) REQUIREMENT FOR COVERAGE AND PAY-
15 MENT.—In the case of a physician who qualifies for
16 the exemption described in paragraph (1) with re-
17 spect to an item, service, or group of similar serv-
18 ices, an MA organization may not deny or reduce
19 coverage and payment for such an item, service, or
20 group based on medical necessity or appropriateness
21 of care.

22 “(5) PROTECTIONS PERTAINING TO REVOCA-
23 TION OF GOLD CARD.—

24 “(A) IN GENERAL.—An MA organization
25 may revoke an exemption described in para-

1 graph (1) granted with respect to a physician
2 for an item, service, or group of similar services
3 for a plan year only if—

4 “(i) the MA organization—

5 “(I) determines that—

6 “(aa) less than 90 percent
7 of claims submitted by such phy-
8 sician for such item, service, or
9 group during the 90-day period
10 ending on the date of such rev-
11 ocation would have been ap-
12 proved under the prior authoriza-
13 tion process employed by such
14 plan had such process applied
15 with respect to such claims; or

16 “(bb) in the case that fewer
17 than 10 claims were submitted
18 by such physician for such item,
19 service, or group during the 90-
20 day period ending on the date of
21 such revocation, less than 90 per-
22 cent of the last 10 claims sub-
23 mitted by such physician for such
24 item, service, or group as of the

1 date of such revocation would
2 have been so approved;

3 “(II) furnishes such physician
4 with a notice of such revocation con-
5 taining the claim information (includ-
6 ing identification of specific items and
7 services and the individual to whom
8 such items and services were fur-
9 nished) on which the determination
10 under subclause (I) was made; and

11 “(III) includes in such notice a
12 plain-language description of how
13 such physician may appeal such deter-
14 mination in accordance with the rules
15 promulgated under subparagraph (B);
16 and

17 “(ii) the individual conducting the de-
18 termination under clause (ii)(I)—

19 “(I) is a physician;

20 “(II) possesses a current and
21 nonrestricted license to practice medi-
22 cine in the State in which the items,
23 services, or group of services to which
24 such exemption applies were fur-
25 nished;

1 “(III) is actively engaged in the
2 practice of medicine in the same or
3 similar specialty as a physician that
4 would typically furnish such item,
5 service, or group of services; and

6 “(IV) is knowledgeable about the
7 furnishing of, and has experience fur-
8 nishing, such item, service, or group
9 of services.

10 “(B) APPEAL OF EXEMPTION.—The Sec-
11 retary shall, through notice and comment rule-
12 making, establish a process under which a phy-
13 sician may appeal a revocation under subpara-
14 graph (A). Such process shall ensure that any
15 such appeal is resolved within 30 days of such
16 appeal being submitted under such process.

17 “(C) TREATMENT OF UNRESOLVED
18 CLAIMS.—The provisions of paragraph
19 (1)(A)(ii) shall apply with respect to the treat-
20 ment of claims for a determination made under
21 subparagraph (A) in the same manner as such
22 provisions apply with respect to the treatment
23 of claims for a determination made under para-
24 graph (1)(A).”.

1 (b) RULEMAKING.—The Secretary of Health and
2 Human Services shall, through rulemaking, specify re-
3 quirements with respect to the use of prior authorization
4 by Medicare Advantage plans for items and services de-
5 scribed in subsection (o)(1) of section 1852 of the Social
6 Security Act (42 U.S.C. 1395w–22), as added by sub-
7 section (a), to ensure continuity of care for individuals
8 transitioning to, or between, coverage under such plans
9 in order to minimize any disruption to ongoing treatment
10 attributable to prior authorization requirements under
11 such plans.

12 (c) REPORT.—Not later than 2 years after the date
13 of the enactment of this Act, the Secretary of Health and
14 Human Services shall submit to Congress a report on the
15 potential impacts of the amendment made by this section
16 on communities at high risk for health disparities.

17 **SEC. 3. OPPORTUNITY FOR PROVIDERS TO PRESENT CASES**
18 **FOR COVERAGE AND PAYMENT DURING THE**
19 **PRIOR AUTHORIZATION PROCESS UNDER MA**
20 **PLANS.**

21 Section 1852 of the Social Security Act (42 U.S.C.
22 1395w–22), as amended by section 2, is further amended
23 by adding at the end the following new subsection:

1 “(p) OPPORTUNITY FOR PROVIDERS TO PRESENT
2 CASES FOR COVERAGE AND PAYMENT DURING THE
3 PRIOR AUTHORIZATION PROCESS.—

4 “(1) IN GENERAL.—For plan years beginning
5 with the second plan year beginning after the date
6 of the enactment of this subsection, any prior au-
7 thorization process (as defined in subsection
8 (o)(1)(B)) with respect to the coverage and payment
9 for items and services (other than a covered part D
10 drug) under an MA plan offered by an MA organiza-
11 tion shall provide, prior to any coverage or payment
12 determination with respect to an item or service sub-
13 ject to such process, for an opportunity for a pro-
14 vider of services or supplier seeking prior authoriza-
15 tion to furnish such item or service to discuss with
16 a qualifying physician (as defined in paragraph
17 (2))—

18 “(A) the treatment plan for the individual
19 who would be furnished such item or service;
20 and

21 “(B) the clinical basis on which the organi-
22 zation will determine coverage or payment for
23 such item or service.

24 “(2) QUALIFYING PHYSICIAN DEFINED.—For
25 purposes of paragraph (1), the term ‘qualifying phy-

1 sician’ means, with respect to an item or service sub-
2 ject to a process described in such paragraph that
3 a provider of services or supplier is seeking to fur-
4 nish to an individual, a physician that—

5 “(A) possesses a current and nonrestricted
6 license to practice medicine in the State in
7 which such item or service is to be furnished;

8 “(B) is actively engaged in the practice of
9 medicine in the same or similar specialty as a
10 provider of services or supplier that would typi-
11 cally furnish such item or service; and

12 “(C) is knowledgeable about the furnishing
13 of, and has experience furnishing, such item or
14 service.”.

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