RRC
Regulatory Relief Coalition
Protecting Patients' Timely Access To Care

# Improving Seniors' Timely Access to Care Act

## Side-by-Side: H.R. 3107 and S. 5044 (House-Senate bill as introduced in the Senate)

OVERVIEW: Champions on the legislation are preparing to introduce legislation to address prior authorization in the 117th Congress in early May 2021. This side-by-side is intended to detail changes made to the legislation between the House-introduced (H.R. 3107) and the House-Senate compromise legislation as introduced by the Senate (S. 5044). Note that the sponsors plan to introduce the language as contained in S. 5044.

| H.R. 3107 as Introduced in 116th | S. 5044 to be introduced 117th | Explanation |
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| **A BILL**<br><br>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.<br><br>*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* | **A BILL**<br><br>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.<br><br>*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* | NO CHANGES |
| **SECTION 1. SHORT TITLE.**<br><br>This Act may be cited as the "Improving Seniors' Timely Access to Care Act of 2019". | **SECTION 1. SHORT TITLE.**<br><br>This Act may be cited as the "Improving Seniors' Timely Access to Care Act of 2021". | Date change |
| **SEC. 2. SENSE OF CONGRESS.**<br><br>It is the sense of Congress that—<br>(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 managedcare plans to improve patient access to medically appropriate services and reduce administrative burden through automationinformed by clinical decision support;<br>(2) there should be increased transparency for beneficiaries and providers and increased oversight by the Centers for Medicare & Medicaid Services on the processesused for prior authorization; and<br>(3) prior authorization is a tool that can be used to responsibly prevent unnecessary care and promote safe andevidence-based care. | ~~**SEC. 2. SENSE OF CONGRESS.**~~<br><br>~~It is the sense of Congress that—~~<br>~~(1) use of prior authorization should be streamlined through electronic transmissions for coverage of covered services for individuals enrolled in federally funded programssuch 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;~~<br>~~(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~~<br>~~(3) prior authorization is a tool that can be used to responsibly prevent unnecessary care and promote safe and evidence-based care.~~ | Legislative Counsel recommended taking out Sense of Congress, does not impact legislation. |

| H.R. 3107 as Introduced in 116th | S. 5044 to be introduced 117th | Explanation |
|---|---|---|
| **SEC. 3. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USEOF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS.**<br><br>(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:<br>"(o) Prior Authorization Requirements.— | **SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USEOF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS.**<br><br>(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:<br>"(o) Prior Authorization Requirements.— | Technical change, section numbering |
| "(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—<br>"(A) comply with the prohibition described in paragraph (2); | "(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 ~~benefit~~ applicable item or service (other than a covered part D drug) during a plan year, such plan shall, ~~beginning with the first planyear beginning on or after the date of the enactment of this subsection—~~<br>~~"(A) comply with the prohibition described in paragraph (2);~~ | Gives CMS time (1 more year) to operationalize change. Clarifies bill applies to items and services, excludes Part D drug plans (HHS TA). |
| "(B) establish the electronic prior authorization program described in paragraph (3); | "(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; | Clarifies goal – to establish not only E-PA, but also to issue real-time decisions. |
| "(C) meet the transparency requirements specified in paragraph (4); and<br>"(D) meet the beneficiary protection standards specifiedpursuant to paragraph (5). | "(B) meet the transparency requirements specified in paragraph (3); and<br>"(C) meet the beneficiary protection standards specified pursuant to paragraph (4). | Technical changes, section numbering |
| "(2) PROHIBITION ON PRIOR AUTHORIZATION WITHRESPECT 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 theSecretary), 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— | ~~"(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 theSecretary), 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—~~<br>~~"(A) prior authorization was received from such plan~~ | Specific surgical exception deleted. Goal is to ensure that there is full transparency of all prior authorization, whether in surgery or other items or services. Bill adds surgical |

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|---|---|---|
| “(A) prior authorization was received from such plan before such surgical or otherwise invasive procedure (or itemfurnished as part of such surgical or otherwise invasive procedure) was furnished; or<br>“(B) prior authorization was not required by such plan. | ~~before such surgical or otherwise invasive procedure (or itemfurnished as part of such surgical or otherwise invasive procedure) was furnished; or~~<br>~~“(B) prior authorization was not required by such plan.~~ | transparency in different section, see below. |
| “(3) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—<br>“(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— | “(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—<br>“(A) IN GENERAL.—For purposes of paragraph (1)(A), the electronic prior authorization program described in this paragraph is a ~~prior authorization process implemented by a Medicare Advantage plan that provides~~ program that providesfor the secure electronic transmission of— | Technical change |
| “(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 thefurnishing of such item or service to such individual; and<br>“(ii) a response, in accordance with this paragraph, from such plan to such professional. | “(i) a prior authorization request from a health care professional to ~~such plan~~ a Medicare Advantage 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 itemor service to such individual~~ necessary to evidence medical necessity; and<br>“(ii) a response, in accordance with this paragraph, from such plan to such professional. | Specifies that health professionals must provide “clinical information necessary to evidence medical necessity.” |
| “(B) ELECTRONIC TRANSMISSION.—<br>“(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 shallnot be treated as an electronic transmission described in subparagraph (A). | “(B) ELECTRONIC TRANSMISSION.—<br>“(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). | NO CHANGES |
| “(ii) STANDARDS.—<br>“(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 ensurethat | “(ii) STANDARDS.—<br>“(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~~ Medicare Advantage organizations, and health information technology software vendors. In adopting such standards | Technical change |

| H.R. 3107 as Introduced in 116th | S. 5044 to be introduced 117th | Explanation |
|---|---|---|
| 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. | 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 ~~encourage~~ support integration ~~of the electronicprior authorization program into established electronic health record systems~~ 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. | Clarifies which transmissions are subject to the provision.<br><br>Clarifies–standards for interoperable health info., adds prioritization of standards to support integration under NCHIT. |
| "(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 suchtransmission, consistent with health care industry standards. | "(II) TRANSACTION STANDARD.—The Secretary shall include inthe 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. | NO CHANGES |
| "(C) REAL-TIME DECISIONS.—<br><br>"(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 allinformation required by an MA plan to evaluate the criteria described in paragraph (4)(A)(iii)(II). | "(C) REAL-TIME DECISIONS.—<br><br>"(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 ~~information~~ documentation ~~required by an MA planto evaluate the criteria~~ described in paragraph (3)(A)(ii)(II) required by such plan. | Adds reference to section (iv) for certain services and substitutes "documentation" for "information". Strikes balance between what providers send and insurers require. |

| H.R. 3107 as Introduced in 116th | S. 5044 to be introduced 117th | Explanation |
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| "(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 forwhich prior authorization requests are routinely approved.<br><br>"(iii) DATA COLLECTION AND CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND RELEVANT STAKEHOLDERS.—In identifying requests for a yearunder 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. | "(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 ~~such~~ 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.<br><br>"(iii) DATA COLLECTION AND CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND RELEVANT STAKEHOLDERS.—~~In identifying requests for a year under clause (ii), the~~ 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, ~~patient~~ beneficiary advocacy organizations, and other stakeholders for purposes of identifying requests for a period under clause (ii). | Technical changes on updates and adds timing (2 years).<br><br>Substitution of "beneficiary" for patient organization for purpose of providing input to data collection process. |
| | "(iv) DEFINITION OF REAL-TIME DECISION.—<br><br>"(I) IN GENERAL.—In establishing the definition of a real-time decision for the purposes of clause (i), the Secretary shalltake into account current medical practice, technology, healthcare industry standards, and other relevant information and factors to ensure the accurate and timely furnishing of items and services to individuals. | Adds definition of real-time decisions, review of current practice, technology, standards, & other info. about items and services. |
| | "(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. | Secretary must provide updates to definition of "real-time decision," review practice, technology, standards, and other info. about items and services. |

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| | "(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:<br>"(I) Establishing the definition of a 'real-time decision' for purposes of clause (i).<br>"(II) Updating such definition pursuant to clause (iv)(II).<br>"(III) Identifying applicable items or services pursuant to clause (ii) for the initial period of 2 plan years as described insuch clause.<br>"(IV) Updating the identification of such items andservices for each subsequent period of 2 plan years as described in such clause. | Adds requirement notice and comment rulemaking for updating the definition, identifying the items and services. |
| "(4) TRANSPARENCY REQUIREMENTS.—<br>"(A) IN GENERAL.—For purposes of paragraph (1)(C), the transparency requirements specified in this paragraph are, withrespect to a Medicare Advantage plan, the following: | "(3) TRANSPARENCY REQUIREMENTS.—<br>"(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: | Technical changes – renumbering sections. |
| "(i) The plan, not less frequently than annually and at a time and in a manner specified by the Secretary, shall submit tothe Secretary the following information:<br>"(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. | "(i) The plan, ~~not less frequently than~~ annually and ~~at a time and~~ in a manner specified by the Secretary, shall submitto the Secretary the following information:<br>"(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. | Annual reporting (rather than "no less than annually") for predictability. Technical addition - "applicable." |
| "(II) The percentage of prior authorization requests approved during the previous plan year by the plan with respectto each such item and service. | "(II) The percentage of prior authorization requests approved during the previous plan year by the plan with respect to each such item and service. | NO CHANGES |
| "(III) The percentage of such requests that were initiallydenied and that were subsequently appealed, and the percentage of such appealed requests that were overturned,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 didnot meet clinical evidence standards.<br>"(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 | More broadly construes appeals. Allows plans to share info. on initial denials not meeting clinical evidence standards. Clarifies that disclosure of denials includes denials from |

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| | orother clinical decision-making tools. | decision support technology or other tools. |
| "(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 andservice, excluding any such requests that did not contain all information required to be submitted by the plan. | "(V) The average and the median amount of time (in hours) that elapsed during the previous plan year between thesubmission 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. | Technical change, renumbering. |
| | "(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 itemor service during the peroperative period of a surgical or otherwise invasive procedure that such provider determined was medically necessary. | Replaces the surgical exception with a surgical transparency provision. |
| "(V) Such other information as the Secretary determinesappropriate after consultation with and comment from stakeholders. | "(VII) A disclosure and description of any software decision-making tools the plan utilizes in making determinations with respect to such requests.<br>"(VIII) Such other information as the Secretary determines appropriate ~~after consultation with and commentfrom stakeholders~~. | Adds requirement to disclose the use of decision support tools.<br>Technical change, renumbering. |
| "(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 andshall update such website in a timely manner. | ~~"(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 suchwebsite in any enrollment materials distributed by the plan and shall update such website in a timely manner.~~ | Simplifies plan publication process, limits information to providers under contract or seeking to contract. |

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| “(iii) The plan shall provide—<br><br>“(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 bythe plan for making determinations with respect to prior authorization requests; and<br><br>“(II) to each provider and supplier participating under the plan, access to the criteria used by the plan for making such determinations, including an itemization of the medical or otherdocumentation 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. | “(II) to each such provider and supplier ~~participating under the plan~~ who does enter into such a contract, access tothe 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~~.<br><br>“(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. | Gives more info. to beneficiaries from plans, including criteria used by plans for making determinations.<br><br>The bill excludes information that is proprietary to plans. |
| “(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—<br>“(i) in the case of the first such report, the first plan year beginning on or after such date; and<br>“(ii) in the case of a subsequent report, the 2 full plan years preceding the date of the submission of such report. | ~~“(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—~~<br>~~“(i) in the case of the first such report, the first plan yearbeginning on or after such date; and~~<br>~~“(ii) in the case of a subsequent report, the 2 full plan years preceding the date of the submission of such report.~~ | Moved to another section of the bill. |
| | “(B) REGULATIONS. – The Secretary shall, through noticeand comment rulemaking, provide guidance to Medicare Advantage plans regarding—<br><br>“(i) the establishment of criteria described in subparagraph (A)(ii)(II) and access to such criteria by providersand suppliers in accordance with such subparagraph; and<br>“(ii) access to such criteria by beneficiaries in accordance with subparagraph (A)(ii)(III). | Adds requirement of notice and comment rulemaking giving guidance to plans on criteria, access to criteria, and beneficiary access to the criteria. |

| H.R. 3107 as Introduced in 116th | S. 5044 to be introduced 117th | Explanation |
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| | "(C) MEDPAC REPORT.—Not later than 3 years after thedate 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 theelectronic prior authorization programs of Medicare Advantage plans. | Adds MedPAC report and recommendations to Congress within 3 years on use of prior authorization and e-prior authorization program. |
| "(5) BENEFICIARY PROTECTION STANDARDS.—The Secretary of Health and Human Services shall, through notice and comment rulemaking, specify standards with respect to theuse of prior authorization by MA plans to ensure— | "(4) BENEFICIARY PROTECTION STANDARDS.—The Secretary of Health and Human Services shall, through notice and comment rulemaking, specify ~~standards~~ requirements with respect to the use of prior authorization by ~~MA~~ MedicareAdvantage plans for applicable items and services to ensure— | Technical changes – renumbering, rewording and clarifies application to applicable items and services. |
| "(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 providersand suppliers with respect to adherence to evidence-based medical guidelines and other quality criteria; | "(A) that such plans adopt transparent prior authorization programs developed in consultation with providers and suppliers ~~participating under the~~ with contracts in effect with such plans that ~~promote~~ allow for the modification of ~~such~~ 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; | Clarifies transparency on P.A., allows for performance-based changes on use of evidence-based guidelines, quality. |
| "(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 isbased on analysis of past prior authorization requests and current clinical criteria; | "(B) that such plans conduct annual reviews of such itemsand services for which prior authorization requirements are imposed under such plans through a process that takes into account input from ~~participating~~ providers and suppliers with such contracts in effect and is based on analysis of past prior authorization requests and current coverage and clinical criteria; | Technical changes reflecting contracts with plans to reflect analysis of use of clinical criteria and coverage. |
| "(C) continuity of care for individuals transitioning to, orbetween, coverage under such plans in order to minimize anydisruption to ongoing treatment attributable to prior authorization requirements under such plans; | "(C) continuity of care for individuals transitioning to, or between, coverage under such plans in order to minimize anydisruption to ongoing treatment attributable to prior authorization requirements under such plans; | NO CHANGES |

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| "(D) that such plans make timely prior authorization determinations, provide rationales for denials, and ensure requests are reviewed by qualified medical personnel; and | "(D) that such plans make timely prior authorization determinations, provide rationales for denials, and ensure requests are reviewed by qualified medical personnel; and | NO CHANGES |
| "(E) that plans assist providers and suppliers in submitting the information necessary to enable the plan to make a priorauthorization determination in a timely manner.". | "(E) that such plans ~~assist providers and suppliers in submitting the information necessary to enable the plan to make a prior authorization determination in a timely manner~~ provide information on the appeals process to the beneficiary when denying any request for prior authorization with respect to an item or service. | Provides bene. rights. Requires plan to assist bene's by providing info. on appeals process on denial. |
| | "(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.<br>"(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 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—<br>"(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.". | Creates definition of "applicable item or service" for MA plans, excludes covered part D drugs (HHS TA).<br>Moved from another portion of the bill, specifies reporting timeframe to start at the end of the second plan year, is reported every two years, and shall continue as such ten years after enactment. |
| (b) Determination Clarification.—Section 1852(g)(1)(A) ofthe 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". | (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". | NO CHANGES |