

The Improving Seniors’ Timely Access to Care Act

Section-by-Section Summary

SECTION 1: SHORT TITLE

The Act is cited as the “Improving Seniors’ Timely Access to Care Act of 2024”.

SECTION 2: ESTABLISHING REQUIREMENTS TO THE USE OF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS

Electronic Prior Authorization Program

For plan years beginning on or after January 1, 2027, this provision would require MA plans that impose any PA requirements to establish an electronic PA program that provides for the secure electronic transmission of both PA requests from health care providers and suppliers to the MA plan, as well as the corresponding response from the plan to the provider or supplier.

Transmission would be required to be capable of including any supporting documentation related to the request or response.

The provision would not allow facsimiles, proprietary payer portals that do not meet standards specified by the HHS Secretary, nor electronic forms to qualify as secure electronic transmissions.

The MA plans’ electronic PA program would be required to comply with technical standards adopted by the HHS Secretary and other requirements to promote the standardization and streamlining of electronic transactions.

Transparency Requirements

This provision would establish reporting requirements for plan years beginning on or after January 1, 2026. MA plans would be required to submit the following information to the HHS Secretary annually:

1. A list of all applicable items and services subject to a PA requirement the previous plan year.
2. The percentage and number of specified requests (i.e., prior authorization requests for applicable items and services) approved during the previous plan year in an initial determination and the percent and number of specified requests denied during the previous plan year in an initial determination (both in the aggregate and categorized by each item and service).
3. The percentage and number of specified requests that were denied during the previous year in an initial determination and that were subsequently appealed.
4. The number of appeals of specified requests resolved during the preceding plan year and the percentage and number of resolved appeals that resulted in the approval of the applicable item and service and categorized by each level of appeal (including judicial review).
5. The percentage and number of specified requests that were denied, and the percentage and number of specified requests that were approved, by the plan during the previous plan year using decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

6. The average and median amount of time (in hours) that elapsed during the previous plan year between the submission of a specified request to the plan and the determination by the plan, by item and service, but excluding any request that did not contain all the medical or other documentation the plan required.
7. The percentage and number of specified requests that were excluded from the calculation described in number 8 below based on the plan's determination that the requests were not submitted with the required medical and other documentation.
8. Descriptions of each occurrence during the previous plan year in which, initially, the plan made a determination to approve an applicable item or service as part of a surgical or medical procedure, and subsequently, the provider or supplier determined that a different or additional item or service was medically necessary. The description would be required to include whether the plan approved the different or additional item or service.
9. A disclosure and description of any software decision-making tools the plan uses with respect to specified requests mentioned in number 5 above.
10. The number of grievances received by a plan during the previous year that were related to a prior authorization requirement.
11. Such other information as the HHS Secretary determines appropriate.

This provision also allows the MA plan to elect to include the percentage and number of specified requests made during the preceding plan year that were denied during an initial determination based on failing to demonstrate that the individual met clinical criteria established by the plan to receive the item or service.

In addition to submitting the information described above to the HHS Secretary, each plan would be required to provide specific information to (a) prospective providers or suppliers, (b) providers and suppliers who have entered into a contract with the MA plan, and (c) to plan enrollees.

For each provider or supplier seeking to enter into a contract with the MA plan, the plan would be required to provide a list of all applicable items and services subject to PA and any policies or procedures used for making PA determinations. For each provider or supplier who has a contract with the MA plan, the plan would be required to provide access to the criteria used for making determinations, including an itemization of the medical or other documentation required to be submitted by the provider or supplier. For each enrollee subject to PA, MA plans would be required to provide access to the criteria for making determinations. The HHS Secretary would be required to promulgate regulations regarding the provision of prior authorization criteria to contract providers and suppliers, and beneficiaries.

The HHS Secretary would be required to publish the transparency requirement information listed above on the MA plan level, on the public website of the Centers for Medicare & Medicaid Services (CMS). The information may also be published in an aggregated manner as determined appropriate by the HHS Secretary.

The Medicare Payment Advisory Committee would be required to submit a report to Congress, which would include a descriptive analysis of the use of prior authorization. As appropriate, the report would be required to include statistics on the frequency of appeals and overturned decisions, and would be required to include recommendations, as appropriate, on any improvement that should be made to the MA electronic PA program. The report would be required to be submitted not later than 3 years after the date information is first submitted to the Secretary as part of the transparency requirements.

Enrollee Protection Standards

This provision would require MA plans meet the following requirements with respect to their use of prior authorization for applicable items and services:

1. Adoption of transparent programs developed in consultation with enrollees and contracted providers and suppliers.
2. Allowance for the waiver or modification of PA requirements for contracted providers and suppliers, based on their performance and demonstration of compliance with requirements, such as adherence to evidence-based medical guidelines and other criteria.
3. Conducting of annual reviews of the items and services subject to PA requirements through a process that takes into account input from enrollees and contracted providers and suppliers. The review would be required to be based on consideration of PA data from previous plan years and analyses of current coverage criteria.

Applicable Items or Service Defined

This provision defines the term “applicable item or service” with respect to an MA plan as any item or service for which benefits are available under the plan, other than a covered Part D drug.

Reports to Congress

This provision requires several public reports to evaluate the effectiveness and efficiency of the electronic PA program and provide recommendations to improve it.

Program Evaluation of Electronic Prior Authorization Program

The Government Accountability Office would be required to submit a report to Congress evaluating the implementation of the electronic PA program established under this Act, along with an analysis of issues faced by MA plans in implementing these requirements. The report would be required to be submitted no later than January 1, 2028.

Evaluation of Report Requirements

The HHS Secretary would be required to submit a series of reports to Congress describing the information submitted under the new transparency requirements. The HHS Secretary would be required to submit the first report not later than the end of the fifth plan year beginning after the date of enactment; that report would be required to describe data for the fourth plan year beginning after the date of enactment. Thereafter, the reports would be required to be submitted biennially through the date that is 10 years after the date of enactment; those reports would be required to describe data for the 2 plan years preceding the year of the submission of the report.

Analysis of Establishing Real-Time Decisions

CMS and the Office of National Coordinator for Health Information Technology would be required to submit a report to Congress and publish it on the CMS website. The report would be required to:

- a. Define the term “real-time decision” and detail how the definition could be updated based on technological advances.

- b. Detail a process for real-time decisions for items and services routinely approved (based on data collected through the transparency requirement) for the purposes of the required electronic prior authorization program.
- c. Analyze the following:
 - i. The items and services that are routinely approved.
 - ii. The routinely approved items and services that could be eligible for real-time decisions.
 - iii. How establishing real-time decisions for routinely approved items and services could improve enrollee access to benefits, produce operational efficiencies, and reduce health disparities for MA enrollees in rural and low-income communities.
- d. Determine how the use of automated decision-making and artificial intelligence by MA plans impacts patient access to routinely approved items and services, and how it impacts disparities in access for rural and low-income beneficiaries.

Secretary Authority to Enforce Timely Responses

This provision would allow the HHS Secretary to establish different timeframes for MA plans to respond to different types of prior authorization requests.

The types of prior authorizations to which the different timeframes could apply are (a) a request for expedited determination, (b) a real-time decision for routinely approved items and services, and (c) any other prior authorization request.

The provision cites “24 hours” as an example of a timeframe the HHS Secretary could establish.