117TH CONGRESS 2D SESSION

H. R. 8078

To ensure that prior authorization medical decisions under Medicare are determined by physicians.

IN THE HOUSE OF REPRESENTATIVES

June 15, 2022

Mr. Green of Tennessee 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 ensure that prior authorization medical decisions under Medicare are determined by physicians.

- 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 "Reducing Medically
- 5 Unnecessary Delays in Care Act of 2022".
- 6 SEC. 2. DEFINITIONS.
- 7 In this Act:
- 8 (1) Adverse determination.—The term "ad-
- 9 verse determination" means a decision by a medicare

administrative contractor, Medicare Advantage plan, or prescription drug plan that administers prior authorization programs under the Medicare program under title XVIII of the Social Security Act or such plan that the health care services furnished or proposed to be furnished to an individual entitled to benefits or enrolled under the Medicare program are not medically necessary, or are experimental or investigational; and benefit coverage under such program or plan for such services is therefore denied, reduced, or terminated.

(2) Authorization.—The term "authorization" means a determination by a medicare administrative contractor, Medicare Advantage plan, or prescription drug plan that administers prior authorization programs under the Medicare program under title XVIII of the Social Security Act or such plan that a health care service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made under the Medicare program under title XVIII of the Social Security Act or such plan for that health care service.

- (3) CLINICAL CRITERIA.—The term "clinical criteria" means the written policies, written screen-ing procedures, drug formularies, or lists of covered drugs, decision rules, decision abstracts, clinical pro-tocols, practice guidelines, and medical protocols used by a medicare administrative contractor, Medi-care Advantage plan, or prescription drug plan to determine the necessity and appropriateness of health care services.
 - (4) Final adverse determination.—The term "final adverse determination" means an adverse determination that has been upheld by a medicare administrative contractor, Medicare Advantage plan, or prescription drug plan at the completion of the contractor's appeals process.
 - (5) HEALTH CARE SERVICE.—The term "health care service" means a health care item, service, procedure, treatment, or prescription drug provided by a facility licensed in the State involved or provided by a doctor of medicine, a doctor of osteopathy, or a health care professional licensed in such State.
 - (6) Medically necessary health care services" means health care services that a prudent physician would provide to a patient for the

1	purpose of preventing, diagnosing, or treating an ill-
2	ness, injury, disease, or its symptoms in a manner
3	that is—
4	(A) in accordance with generally accepted
5	standards of medical practice;
6	(B) clinically appropriate in terms of type,
7	frequency, extent, site, and duration; and
8	(C) not primarily for the economic benefit
9	of the health plans and purchasers or for the
10	convenience of the patient, treating physician,
11	or other health care provider.
12	(7) Medicare administrative con-
13	TRACTOR.—The term "medicare administrative con-
14	tractor" means a medicare administrative contractor
15	with a contract under section 1874A of the Social
16	Security Act (42 U.S.C. 1395kk-1).
17	(8) Medicare advantage plan.—The term
18	"Medicare Advantage plan" means a Medicare Ad-
19	vantage plan under part C of title XVIII of the So-
20	cial Security Act.
21	(9) Preauthorization.—The term
22	"Preauthorization"—
23	(A) means the process by which a medicare
24	administrative contractor, Medicare Advantage
25	plan, or prescription drug plan determines the

medical necessity or medical appropriateness of
health care services for which benefits are otherwise provided under the Medicare program
under title XVIII of the Social Security Act or
such plan prior to the rendering of such health
care services, including preadmission review,
pretreatment review, utilization, and case management; and

- (B) includes any requirement that a patient or health care provider notify the Centers for Medicare & Medicaid Services prior to providing a health care service.
- 13 (10) PRESCRIPTION DRUG PLAN.—The term
 14 "prescription drug plan" means a prescription drug
 15 plan under part D of title XVIII of the Social Secu16 rity Act.
- 17 SEC. 3. CONTRACT REQUIREMENTS FOR PRIOR AUTHOR-
- 18 IZATION MEDICAL DECISIONS FOR MEDI-
- 19 CARE ADMINISTRATIVE CONTRACTORS,
- 20 MEDICARE ADVANTAGE PLANS, AND PRE-
- 21 SCRIPTION DRUG PLANS.
- Any contract that applies on or after the date that
- 23 is 90 days after the date of the enactment of this Act,
- 24 between the Secretary of Health and Human Services and
- 25 a medicare administrative contractor under section 1874A

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- 1 of the Social Security Act, a Medicare Advantage organi-
- 2 zation under section 1857 of such Act with respect to the
- 3 offering of a Medicare Advantage plan, or a PDP sponsor
- 4 under section 1860D-12 of such Act with respect to the
- 5 offering of a prescription drug plan shall require such
- 6 medicare administrative contractor, Medicare Advantage
- 7 plan, or prescription drug plan, respectively, to comply
- 8 with each of the following requirements:
- 9 MEDICAL NECESSITY.—Any restriction, 10 preauthorization, adverse determination, or final ad-11 verse determination that the medicare administrative 12 contractor, Medicare Advantage plan, or prescription 13 drug plan, respectively, places on the provision of a 14 health care service for the purposes of coverage or 15 payment of such service under the Medicare pro-16 gram under title XVIII of such Act, or under such 17 plan, shall be based on the medical necessity or ap-
 - (2) EVIDENCE-BASED STANDARDS.—If no independently developed evidence-based standards exist for a particular health care service, the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, may not deny coverage of the health care service based solely on

propriateness of such service and on written clinical

criteria.

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the grounds that the health care service does not meet an evidence-based standard.

> (3) Input from Physicians.—Prior to establishing, or substantially or materially altering, written clinical criteria for purpose of preauthorization review, the medicare administrative contractor. Medicare Advantage plan, or prescription drug plan, respectively, shall obtain input from actively practicing physicians within the service area where the written clinical criteria are to be employed. Such physicians must represent major areas of specialty and be certified by the boards of the American Board of Medical Specialties. The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan shall seek input from physicians who are not employees of the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan.

> (4) Written clinical criteria.—The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, shall apply written clinical criteria for the purpose of preauthorization review consistently. Such written clinical criteria must—

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1	(A) be based on nationally recognized
2	standards;
3	(B) be developed in accordance with the
4	current standards of national accreditation enti-
5	ties;
6	(C) reflect community standards of care;
7	ensure quality of care and access to needed
8	health care services;
9	(D) be evidence-based;
10	(E) be sufficiently flexible to allow devi-
11	ations from norms when justified on case-by-
12	case bases; and
13	(F) be evaluated and updated if necessary
14	at least annually.
15	(5) Website posting.—The medicare adminis-
16	trative contractor, Medicare Advantage plan, or pre-
17	scription drug plan, respectively, shall make any cur-
18	rent preauthorization requirements and restrictions
19	readily accessible on its website to subscribers,
20	health care providers, and the general public. This
21	includes the written clinical criteria. Such require-
22	ments must be described in detail but also in easily
23	understandable language.
24	(6) Notice required for New Require-
25	MENTS OR RESTRICTIONS.—If the medicare adminis-

trative contractor, Medicare Advantage plan, or prescription drug plan, respectively, decides to implement a new preauthorization requirement or restriction, or amend an existing requirement or restriction, the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan shall provide contracted health care providers written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented and shall ensure that the new or amended requirement has been updated on the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan's website.

(7) AVAILABILITY OF DETERMINATIONS.—The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, utilizing preauthorization shall make statistics available regarding preauthorization approvals and denials for coverage or payment of health care services under the Medicare program under title XVIII of the Social Security Act or such plan on their website in a readily accessible format. The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan shall include categories for—

(A) physician specialty;

1	(B)	medication	or	diagnostic	test/proce-
2	dure;				

(C) indication offered; and

(D) reason for denial.

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(8) Determinations made by Physicians.— The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, shall ensure that all preauthorizations and adverse determinations are made by a physician who possesses a current and valid non-restricted license to practice medicine in a State, and must be board certified or eligible in the same specialty as the health care provider who typically manages the medical condition or disease or provides the health care service. The physician must make the adverse determination under the clinical direction of one of the medicare administrative contractor's, Medicare Advantage plan's, or prescription drug plan's medical directors who is responsible for the provision of health care services and who is licensed in such State.

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