

118TH CONGRESS
2D SESSION

S. _____

To amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans.

IN THE SENATE OF THE UNITED STATES

Mr. MARSHALL (for himself, Ms. SINEMA, Mr. THUNE, and Mr. BROWN) introduced the following bill; which was read twice and 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.

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 “Improving Seniors’
5 Timely Access to Care Act of 2024”.

1 **SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO**
2 **THE USE OF PRIOR AUTHORIZATION UNDER**
3 **MEDICARE ADVANTAGE 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) PRIOR AUTHORIZATION REQUIREMENTS.—

8 “(1) IN GENERAL.—In the case of a Medicare
9 Advantage plan that imposes any prior authorization
10 requirement with respect to any applicable item or
11 service (as defined in paragraph (5)) during a plan
12 year, such plan shall—

13 “(A) beginning with plan years beginning
14 on or after January 1, 2027—

15 “(i) establish the electronic prior au-
16 thorization program described in para-
17 graph (2); and

18 “(ii) meet the enrollee protection
19 standards specified pursuant to paragraph
20 (4); and

21 “(B) beginning with plan years beginning
22 on or after January 1, 2026, meet the trans-
23 parency requirements specified in paragraph
24 (3).

25 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
26 GRAM.—

1 “(A) IN GENERAL.—For purposes of para-
2 graph (1)(A), the electronic prior authorization
3 program described in this paragraph is a pro-
4 gram that provides for the secure electronic
5 transmission of—

6 “(i) a prior authorization request
7 from a provider of services or supplier to
8 a Medicare Advantage plan with respect to
9 an applicable item or service to be fur-
10 nished to an individual and a response, in
11 accordance with this paragraph, from such
12 plan to such provider or supplier; and

13 “(ii) any supporting documentation
14 relating to such request or response.

15 “(B) ELECTRONIC TRANSMISSION.—

16 “(i) EXCLUSIONS.—For purposes of
17 this paragraph, a facsimile, a proprietary
18 payer portal that does not meet standards
19 specified by the Secretary, or an electronic
20 form shall not be treated as an electronic
21 transmission described in subparagraph
22 (A).

23 “(ii) STANDARDS.—An electronic
24 transmission described in subparagraph
25 (A) shall comply with applicable technical

1 standards and other requirements to pro-
2 mote the standardization and streamlining
3 of electronic transactions adopted by the
4 Secretary.

5 “(3) TRANSPARENCY REQUIREMENTS.—

6 “(A) IN GENERAL.—For purposes of para-
7 graph (1)(B), the transparency requirements
8 specified in this paragraph are, with respect to
9 a Medicare Advantage plan, the following:

10 “(i) The plan, annually and in a man-
11 ner specified by the Secretary, shall submit
12 to the Secretary the following information:

13 “(I) A list of all applicable items
14 and services that were subject to a
15 prior authorization requirement under
16 the plan during the previous plan
17 year.

18 “(II) The percentage and number
19 of specified requests (as defined in
20 subparagraph (F)) approved during
21 the previous plan year by the plan in
22 an initial determination and the per-
23 centage and number of specified re-
24 quests denied during such plan year
25 by such plan in an initial determina-

1 tion (both in the aggregate and cat-
2 egorized by each item and service).

3 “(III) The percentage and num-
4 ber of specified requests that were de-
5 nied during the previous plan year by
6 the plan in an initial determination
7 and that were subsequently appealed.

8 “(IV) The number of appeals of
9 specified requests resolved during the
10 preceding plan year, and the percent-
11 age and number of such resolved ap-
12 peals that resulted in approval of the
13 furnishing of the item or service that
14 was the subject of such request, cat-
15 egorized by each applicable item and
16 service and categorized by each level
17 of appeal (including judicial review).

18 “(V) The percentage and number
19 of specified requests that were denied,
20 and the percentage and number of
21 specified requests that were approved,
22 by the plan during the previous plan
23 year through the utilization of deci-
24 sion support technology, artificial in-
25 telligence technology, machine-learn-

1 ing technology, clinical decision-mak-
2 ing technology, or any other tech-
3 nology specified by the Secretary.

4 “(VI) The average and the me-
5 dian amount of time (in hours) that
6 elapsed during the previous plan year
7 between the submission of a specified
8 request to the plan and a determina-
9 tion by the plan with respect to such
10 request for each such item and serv-
11 ice, excluding any such requests that
12 were not submitted with the medical
13 or other documentation required to be
14 submitted by the plan.

15 “(VII) The percentage and num-
16 ber of specified requests that were ex-
17 cluded from the calculation described
18 in subclause (VIII) based on the
19 plan’s determination that such re-
20 quests were not submitted with the
21 medical or other documentation re-
22 quired to be submitted by the plan.

23 “(VIII) Information on each oc-
24 currence during the previous plan
25 year in which, during a surgical or

1 medical procedure involving the fur-
2 nishing of an applicable item or serv-
3 ice with respect to which such plan
4 had approved a prior authorization re-
5 quest, the provider of services or sup-
6 plier furnishing such item or service
7 determined that a different or addi-
8 tional item or service was medically
9 necessary, including a specification of
10 whether such plan subsequently ap-
11 proved the furnishing of such dif-
12 ferent or additional item or service.

13 “(IX) A disclosure and descrip-
14 tion of any technology described in
15 subclause (V) that the plan utilized
16 during the previous plan year in mak-
17 ing determinations with respect to
18 specified requests.

19 “(X) The number of grievances
20 (as described in subsection (f)) re-
21 ceived by such plan during the pre-
22 vious plan year that were related to a
23 prior authorization requirement.

24 “(XI) Such other information as
25 the Secretary determines appropriate.

1 “(ii) The plan shall provide—

2 “(I) to each provider or supplier
3 who seeks to enter into a contract
4 with such plan to furnish applicable
5 items and services under such plan,
6 the list described in clause (i)(I) and
7 any policies or procedures used by the
8 plan for making determinations with
9 respect to prior authorization re-
10 quests;

11 “(II) to each such provider and
12 supplier that enters into such a con-
13 tract, access to the criteria used by
14 the plan for making such determina-
15 tions and an itemization of the med-
16 ical or other documentation required
17 to be submitted by a provider or sup-
18 plier with respect to such a request;
19 and

20 “(III) to an enrollee of the plan,
21 upon request, access to the criteria
22 used by the plan for making deter-
23 minations with respect to prior au-
24 thorization requests for an item or
25 service.

1 “(B) OPTION FOR PLAN TO PROVIDE CER-
2 TAIN ADDITIONAL INFORMATION.—As part of
3 the information described in subparagraph
4 (A)(i) provided to the Secretary during a plan
5 year, a Medicare Advantage plan may elect to
6 include information regarding the percentage
7 and number of specified requests made with re-
8 spect to an individual and an item or service
9 that were denied by the plan during the pre-
10 ceding plan year in an initial determination
11 based on such requests failing to demonstrate
12 that such individuals met the clinical criteria
13 established by such plan to receive such items
14 or services.

15 “(C) REGULATIONS.—The Secretary shall,
16 through notice and comment rulemaking, estab-
17 lish requirements for Medicare Advantage plans
18 regarding the provision of—

19 “(i) access to criteria described in
20 subparagraph (A)(ii)(II) to providers of
21 services and suppliers in accordance with
22 such subparagraph; and

23 “(ii) access to such criteria to enroll-
24 ees in accordance with subparagraph
25 (A)(ii)(III).

1 “(D) PUBLICATION OF INFORMATION.—

2 The Secretary shall publish information de-
3 scribed in subparagraph (A)(i) and subpara-
4 graph (B) on a public website of the Centers
5 for Medicare & Medicaid Services. Such infor-
6 mation shall be so published on an individual
7 plan level and may in addition be aggregated in
8 such manner as determined appropriate by the
9 Secretary.

10 “(E) MEDPAC REPORT.—Not later than 3
11 years after the date information is first sub-
12 mitted under subparagraph (A)(i), the Medicare
13 Payment Advisory Commission shall submit to
14 Congress a report on such information that in-
15 cludes a descriptive analysis of the use of prior
16 authorization. As appropriate, the Commission
17 should report on statistics including the fre-
18 quency of appeals and overturned decisions.
19 The Commission shall provide recommenda-
20 tions, as appropriate, on any improvement that
21 should be made to the electronic prior author-
22 ization programs of Medicare Advantage plans.

23 “(F) SPECIFIED REQUEST DEFINED.—For
24 purposes of this paragraph, the term ‘specified
25 request’ means a prior authorization request

1 made with respect to an applicable item or serv-
2 ice.

3 “(4) ENROLLEE PROTECTION STANDARDS.—
4 For purposes of paragraph (1)(A)(ii), with respect
5 to the use of prior authorization by Medicare Advan-
6 tage plans for applicable items and services, the en-
7 rollee protection standards specified in this para-
8 graph are—

9 “(A) the adoption of transparent prior au-
10 thorization programs developed in consultation
11 with enrollees and with providers and suppliers
12 with contracts in effect with such plans for fur-
13 nishing such items and services under such
14 plans;

15 “(B) allowing for the waiver or modifica-
16 tion of prior authorization requirements based
17 on the performance of such providers and sup-
18 pliers in demonstrating compliance with such
19 requirements, such as adherence to evidence-
20 based medical guidelines and other quality cri-
21 teria; and

22 “(C) conducting annual reviews of such
23 items and services for which prior authorization
24 requirements are imposed under such plans
25 through a process that takes into account input

1 from enrollees and from providers and suppliers
2 with such contracts in effect and is based on
3 consideration of prior authorization data from
4 previous plan years and analyses of current cov-
5 erage criteria.

6 “(5) APPLICABLE ITEM OR SERVICE DE-
7 FINED.—For purposes of this subsection, the term
8 ‘applicable item or service’ means, with respect to a
9 Medicare Advantage plan, any item or service for
10 which benefits are available under such plan, other
11 than a covered part D drug.

12 “(6) REPORTS TO CONGRESS.—

13 “(A) GAO.—Not later than January 1,
14 2028, the Comptroller General of the United
15 States shall submit to Congress a report con-
16 taining an evaluation of the implementation of
17 the requirements of this subsection and an
18 analysis of issues in implementing such require-
19 ments faced by Medicare Advantage plans.

20 “(B) HHS.—

21 “(i) THE SECRETARY.—Not later than
22 the end of the fifth plan year beginning
23 after the date of the enactment of this sub-
24 section, and biennially thereafter through
25 the date that is 10 years after such date

1 of enactment, the Secretary shall submit to
2 Congress a report containing a description
3 of the information submitted under para-
4 graph (3)(A)(i) during—

5 “(I) in the case of the first such
6 report, the fourth plan year beginning
7 after the date of the enactment of this
8 subsection; and

9 “(II) in the case of a subsequent
10 report, the 2 plan years preceding the
11 year of the submission of such report.

12 “(ii) CMS.—Not later than January
13 1, 2027, the Centers for Medicare & Med-
14 icaid Services and the Office of National
15 Coordinator for Health Information Tech-
16 nology shall submit to Congress and pub-
17 lish on the Internet website of the Centers
18 for Medicare & Medicaid Services a report
19 that—

20 “(I) defines the term ‘real-time
21 decision’ and details how the defini-
22 tion for such term may be updated
23 based on any technological advances;

24 “(II) using the data submitted to
25 the Secretary under paragraph

1 (3)(A)(i), details a process for real-
2 time decisions for items and services
3 for routinely approved services for
4 purposes of the electronic prior au-
5 thorization program described in
6 paragraph (2); and

7 “(III) includes an analysis of—

8 “(aa) items and services
9 that are routinely approved;

10 “(bb) items and services
11 identified in item (aa) that could
12 be eligible for real-time decisions;

13 “(cc) how establishing real-
14 time decisions for such items and
15 services could—

16 “(AA) improve enrollee
17 access to benefits under this
18 part;

19 “(BB) produce oper-
20 ational efficiencies for pro-
21 viders of services and sup-
22 pliers and Medicare Advan-
23 tage plans; and

24 “(CC) reduce health
25 disparities for Medicare Ad-

1 vantage enrollees in rural
2 and low-income commu-
3 nities; and

4 “(dd) how the use of auto-
5 mated decision-making and artifi-
6 cial intelligence by Medicare Ad-
7 vantage plans impact patient ac-
8 cess, including disparities in ac-
9 cess for rural and low-income
10 beneficiaries, to routinely ap-
11 proved items and services.”.

12 (b) PROVIDING THE SECRETARY AUTHORITY TO EN-
13 FORCE TIMELY RESPONSES FOR ALL PRIOR AUTHORIZA-
14 TION REQUESTS SUBMITTED UNDER PART C.—Section
15 1852(g) of the Social Security Act (42 U.S.C. 1395w-
16 22(g)) is amended—

17 (1) in paragraph (1)(A), by inserting “and in
18 accordance with any timeframe established by the
19 Secretary under paragraph (6)” after “paragraph
20 (3)”;

21 (2) in paragraph (3)(B)(iii), by inserting “(or,
22 subject to subsection (o), with respect to prior au-
23 thorization requests submitted on or after the first
24 day of the third plan year beginning after the date
25 of the enactment of the Improving Seniors’ Timely

1 Access to Care Act of 2024, any timeframe estab-
2 lished by the Secretary under paragraph (6))” after
3 “72 hours”; and

4 (3) by adding at the end the following new
5 paragraph:

6 “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-
7 THORIZATION REQUESTS.—Subject to paragraph (3)
8 and subsection (o), the Secretary may establish, for
9 purposes of an organization determination made
10 with respect to a prior authorization request for an
11 item or service to be furnished to an individual,
12 timeframes, such as 24 hours, for the organization
13 to notify the enrollee (and the physician involved, as
14 appropriate) of such determination for—

15 “(A) a request for expedited determination
16 described in paragraph (3)(A);

17 “(B) a real time decision for routinely ap-
18 proved items and services; and

19 “(C) any other prior authorization re-
20 quest.”.

.....
(Original Signature of Member)

118TH CONGRESS
2D 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.

IN THE HOUSE OF REPRESENTATIVES

Mr. KELLY of Pennsylvania introduced the following bill; which was referred to the Committee on _____

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2 *tives of the United States of America in Congress assembled,*

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4 This Act may be cited as the “Improving Seniors’
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2 **THE USE OF PRIOR AUTHORIZATION UNDER**
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6 the end the following new subsection:

7 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

8 “(1) IN GENERAL.—In the case of a Medicare
9 Advantage plan that imposes any prior authorization
10 requirement with respect to any applicable item or
11 service (as defined in paragraph (5)) during a plan
12 year, such plan shall—

13 “(A) beginning with plan years beginning
14 on or after January 1, 2027—

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16 thorization program described in para-
17 graph (2); and

18 “(ii) meet the enrollee protection
19 standards specified pursuant to paragraph
20 (4); and

21 “(B) beginning with plan years beginning
22 on or after January 1, 2026, meet the trans-
23 parency requirements specified in paragraph
24 (3).

25 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
26 GRAM.—

1 “(A) IN GENERAL.—For purposes of para-
2 graph (1)(A), the electronic prior authorization
3 program described in this paragraph is a pro-
4 gram that provides for the secure electronic
5 transmission of—

6 “(i) a prior authorization request
7 from a provider of services or supplier to
8 a Medicare Advantage plan with respect to
9 an applicable item or service to be fur-
10 nished to an individual and a response, in
11 accordance with this paragraph, from such
12 plan to such provider or supplier; and

13 “(ii) any supporting documentation
14 relating to such request or response.

15 “(B) ELECTRONIC TRANSMISSION.—

16 “(i) EXCLUSIONS.—For purposes of
17 this paragraph, a facsimile, a proprietary
18 payer portal that does not meet standards
19 specified by the Secretary, or an electronic
20 form shall not be treated as an electronic
21 transmission described in subparagraph
22 (A).

23 “(ii) STANDARDS.—An electronic
24 transmission described in subparagraph
25 (A) shall comply with applicable technical

1 standards and other requirements to pro-
2 mote the standardization and streamlining
3 of electronic transactions adopted by the
4 Secretary.

5 “(3) TRANSPARENCY REQUIREMENTS.—

6 “(A) IN GENERAL.—For purposes of para-
7 graph (1)(B), the transparency requirements
8 specified in this paragraph are, with respect to
9 a Medicare Advantage plan, the following:

10 “(i) The plan, annually and in a man-
11 ner specified by the Secretary, shall submit
12 to the Secretary the following information:

13 “(I) A list of all applicable items
14 and services that were subject to a
15 prior authorization requirement under
16 the plan during the previous plan
17 year.

18 “(II) The percentage and number
19 of specified requests (as defined in
20 subparagraph (F)) approved during
21 the previous plan year by the plan in
22 an initial determination and the per-
23 centage and number of specified re-
24 quests denied during such plan year
25 by such plan in an initial determina-

1 tion (both in the aggregate and cat-
2 egorized by each item and service).

3 “(III) The percentage and num-
4 ber of specified requests that were de-
5 nied during the previous plan year by
6 the plan in an initial determination
7 and that were subsequently appealed.

8 “(IV) The number of appeals of
9 specified requests resolved during the
10 preceding plan year, and the percent-
11 age and number of such resolved ap-
12 peals that resulted in approval of the
13 furnishing of the item or service that
14 was the subject of such request, cat-
15 egorized by each applicable item and
16 service and categorized by each level
17 of appeal (including judicial review).

18 “(V) The percentage and number
19 of specified requests that were denied,
20 and the percentage and number of
21 specified requests that were approved,
22 by the plan during the previous plan
23 year through the utilization of deci-
24 sion support technology, artificial in-
25 telligence technology, machine-learn-

1 ing technology, clinical decision-mak-
2 ing technology, or any other tech-
3 nology specified by the Secretary.

4 “(VI) The average and the me-
5 dian amount of time (in hours) that
6 elapsed during the previous plan year
7 between the submission of a specified
8 request to the plan and a determina-
9 tion by the plan with respect to such
10 request for each such item and serv-
11 ice, excluding any such requests that
12 were not submitted with the medical
13 or other documentation required to be
14 submitted by the plan.

15 “(VII) The percentage and num-
16 ber of specified requests that were ex-
17 cluded from the calculation described
18 in subclause (VIII) based on the
19 plan’s determination that such re-
20 quests were not submitted with the
21 medical or other documentation re-
22 quired to be submitted by the plan.

23 “(VIII) Information on each oc-
24 currence during the previous plan
25 year in which, during a surgical or

1 medical procedure involving the fur-
2 nishing of an applicable item or serv-
3 ice with respect to which such plan
4 had approved a prior authorization re-
5 quest, the provider of services or sup-
6 plier furnishing such item or service
7 determined that a different or addi-
8 tional item or service was medically
9 necessary, including a specification of
10 whether such plan subsequently ap-
11 proved the furnishing of such dif-
12 ferent or additional item or service.

13 “(IX) A disclosure and descrip-
14 tion of any technology described in
15 subclause (V) that the plan utilized
16 during the previous plan year in mak-
17 ing determinations with respect to
18 specified requests.

19 “(X) The number of grievances
20 (as described in subsection (f)) re-
21 ceived by such plan during the pre-
22 vious plan year that were related to a
23 prior authorization requirement.

24 “(XI) Such other information as
25 the Secretary determines appropriate.

1 “(ii) The plan shall provide—

2 “(I) to each provider or supplier
3 who seeks to enter into a contract
4 with such plan to furnish applicable
5 items and services under such plan,
6 the list described in clause (i)(I) and
7 any policies or procedures used by the
8 plan for making determinations with
9 respect to prior authorization re-
10 quests;

11 “(II) to each such provider and
12 supplier that enters into such a con-
13 tract, access to the criteria used by
14 the plan for making such determina-
15 tions and an itemization of the med-
16 ical or other documentation required
17 to be submitted by a provider or sup-
18 plier with respect to such a request;
19 and

20 “(III) to an enrollee of the plan,
21 upon request, access to the criteria
22 used by the plan for making deter-
23 minations with respect to prior au-
24 thorization requests for an item or
25 service.

1 “(B) OPTION FOR PLAN TO PROVIDE CER-
2 TAIN ADDITIONAL INFORMATION.—As part of
3 the information described in subparagraph
4 (A)(i) provided to the Secretary during a plan
5 year, a Medicare Advantage plan may elect to
6 include information regarding the percentage
7 and number of specified requests made with re-
8 spect to an individual and an item or service
9 that were denied by the plan during the pre-
10 ceding plan year in an initial determination
11 based on such requests failing to demonstrate
12 that such individuals met the clinical criteria
13 established by such plan to receive such items
14 or services.

15 “(C) REGULATIONS.—The Secretary shall,
16 through notice and comment rulemaking, estab-
17 lish requirements for Medicare Advantage plans
18 regarding the provision of—

19 “(i) access to criteria described in
20 subparagraph (A)(ii)(II) to providers of
21 services and suppliers in accordance with
22 such subparagraph; and

23 “(ii) access to such criteria to enroll-
24 ees in accordance with subparagraph
25 (A)(ii)(III).

1 “(D) PUBLICATION OF INFORMATION.—

2 The Secretary shall publish information de-
3 scribed in subparagraph (A)(i) and subpara-
4 graph (B) on a public website of the Centers
5 for Medicare & Medicaid Services. Such infor-
6 mation shall be so published on an individual
7 plan level and may in addition be aggregated in
8 such manner as determined appropriate by the
9 Secretary.

10 “(E) MEDPAC REPORT.—Not later than 3
11 years after the date information is first sub-
12 mitted under subparagraph (A)(i), the Medicare
13 Payment Advisory Commission shall submit to
14 Congress a report on such information that in-
15 cludes a descriptive analysis of the use of prior
16 authorization. As appropriate, the Commission
17 should report on statistics including the fre-
18 quency of appeals and overturned decisions.
19 The Commission shall provide recommenda-
20 tions, as appropriate, on any improvement that
21 should be made to the electronic prior author-
22 ization programs of Medicare Advantage plans.

23 “(F) SPECIFIED REQUEST DEFINED.—For
24 purposes of this paragraph, the term ‘specified
25 request’ means a prior authorization request

1 made with respect to an applicable item or serv-
2 ice.

3 “(4) ENROLLEE PROTECTION STANDARDS.—
4 For purposes of paragraph (1)(A)(ii), with respect
5 to the use of prior authorization by Medicare Advan-
6 tage plans for applicable items and services, the en-
7 rollee protection standards specified in this para-
8 graph are—

9 “(A) the adoption of transparent prior au-
10 thorization programs developed in consultation
11 with enrollees and with providers and suppliers
12 with contracts in effect with such plans for fur-
13 nishing such items and services under such
14 plans;

15 “(B) allowing for the waiver or modifica-
16 tion of prior authorization requirements based
17 on the performance of such providers and sup-
18 pliers in demonstrating compliance with such
19 requirements, such as adherence to evidence-
20 based medical guidelines and other quality cri-
21 teria; and

22 “(C) conducting annual reviews of such
23 items and services for which prior authorization
24 requirements are imposed under such plans
25 through a process that takes into account input

1 from enrollees and from providers and suppliers
2 with such contracts in effect and is based on
3 consideration of prior authorization data from
4 previous plan years and analyses of current cov-
5 erage criteria.

6 “(5) APPLICABLE ITEM OR SERVICE DE-
7 FINED.—For purposes of this subsection, the term
8 ‘applicable item or service’ means, with respect to a
9 Medicare Advantage plan, any item or service for
10 which benefits are available under such plan, other
11 than a covered part D drug.

12 “(6) REPORTS TO CONGRESS.—

13 “(A) GAO.—Not later than January 1,
14 2028, the Comptroller General of the United
15 States shall submit to Congress a report con-
16 taining an evaluation of the implementation of
17 the requirements of this subsection and an
18 analysis of issues in implementing such require-
19 ments faced by Medicare Advantage plans.

20 “(B) HHS.—

21 “(i) THE SECRETARY.—Not later than
22 the end of the fifth plan year beginning
23 after the date of the enactment of this sub-
24 section, and biennially thereafter through
25 the date that is 10 years after such date

1 of enactment, the Secretary shall submit to
2 Congress a report containing a description
3 of the information submitted under para-
4 graph (3)(A)(i) during—

5 “(I) in the case of the first such
6 report, the fourth plan year beginning
7 after the date of the enactment of this
8 subsection; and

9 “(II) in the case of a subsequent
10 report, the 2 plan years preceding the
11 year of the submission of such report.

12 “(ii) CMS.—Not later than January
13 1, 2027, the Centers for Medicare & Med-
14 icaid Services and the Office of National
15 Coordinator for Health Information Tech-
16 nology shall submit to Congress and pub-
17 lish on the Internet website of the Centers
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19 that—

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21 decision’ and details how the defini-
22 tion for such term may be updated
23 based on any technological advances;

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25 the Secretary under paragraph

1 (3)(A)(i), details a process for real-
2 time decisions for items and services
3 for routinely approved services for
4 purposes of the electronic prior au-
5 thorization program described in
6 paragraph (2); and

7 “(III) includes an analysis of—

8 “(aa) items and services
9 that are routinely approved;

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11 identified in item (aa) that could
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14 time decisions for such items and
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16 “(AA) improve enrollee
17 access to benefits under this
18 part;

19 “(BB) produce oper-
20 ational efficiencies for pro-
21 viders of services and sup-
22 pliers and Medicare Advan-
23 tage plans; and

24 “(CC) reduce health
25 disparities for Medicare Ad-

1 vantage enrollees in rural
2 and low-income commu-
3 nities; and

4 “(dd) how the use of auto-
5 mated decision-making and artifi-
6 cial intelligence by Medicare Ad-
7 vantage plans impact patient ac-
8 cess, including disparities in ac-
9 cess for rural and low-income
10 beneficiaries, to routinely ap-
11 proved items and services.”.

12 (b) PROVIDING THE SECRETARY AUTHORITY TO EN-
13 FORCE TIMELY RESPONSES FOR ALL PRIOR AUTHORIZA-
14 TION REQUESTS SUBMITTED UNDER PART C.—Section
15 1852(g) of the Social Security Act (42 U.S.C. 1395w-
16 22(g)) is amended—

17 (1) in paragraph (1)(A), by inserting “and in
18 accordance with any timeframe established by the
19 Secretary under paragraph (6)” after “paragraph
20 (3)”;

21 (2) in paragraph (3)(B)(iii), by inserting “(or,
22 subject to subsection (o), with respect to prior au-
23 thorization requests submitted on or after the first
24 day of the third plan year beginning after the date
25 of the enactment of the Improving Seniors’ Timely

1 Access to Care Act of 2024, any timeframe estab-
2 lished by the Secretary under paragraph (6))” after
3 “72 hours”; and

4 (3) by adding at the end the following new
5 paragraph:

6 “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-
7 THORIZATION REQUESTS.—Subject to paragraph (3)
8 and subsection (o), the Secretary may establish, for
9 purposes of an organization determination made
10 with respect to a prior authorization request for an
11 item or service to be furnished to an individual,
12 timeframes, such as 24 hours, for the organization
13 to notify the enrollee (and the physician involved, as
14 appropriate) of such determination for—

15 “(A) a request for expedited determination
16 described in paragraph (3)(A);

17 “(B) a real time decision for routinely ap-
18 proved items and services; and

19 “(C) any other prior authorization re-
20 quest.”.