

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.

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IN THE SENATE OF THE UNITED STATES

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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 \_\_\_\_\_

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**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.

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IN THE HOUSE OF REPRESENTATIVES

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

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**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”.

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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  
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25 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-  
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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  
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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  
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20 form shall not be treated as an electronic  
21 transmission described in subparagraph  
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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  
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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:

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12 to the Secretary the following information:

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14 and services that were subject to a  
15 prior authorization requirement under  
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24 sion support technology, artificial in-  
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16 ber of specified requests that were ex-  
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25                 (A)(ii)(III).

1           “(D) PUBLICATION OF INFORMATION.—  
2           The Secretary shall publish information de-  
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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.”.