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118TH CONGRESS
1ST SESSION

H. R. 4968

To amend title XVIII of the Social Security Act to exempt qualifying physicians from prior authorization requirements under Medicare Advantage plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 2023

Mr. BURGESS (for himself and Mr. VICENTE GONZALEZ of Texas) 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

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A BILL

To amend title XVIII of the Social Security Act to exempt qualifying physicians from prior authorization requirements under Medicare Advantage plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Getting Over Lengthy Delays in Care As Required by Doctors Act of 2023'' or the ''GOLD CARD Act of 2023''.

SEC. 2. EXEMPTION FOR QUALIFYING PHYSICIANS FROM PRIOR AUTHORIZATION REQUIREMENTS UNDER MA PLANS.

(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:

''(o) EXEMPTION FOR QUALIFYING PHYSICIANS FROM PRIOR AUTHORIZATION REQUIREMENTS.—

''(1) IN GENERAL.—

''(A) EXEMPTION.—

''(i) IN GENERAL.—In the case of an MA organization which utilizes a prior authorization process (as defined in subparagraph (B)) with respect to a plan year (beginning with the second plan year beginning after the date of the enactment of this subsection), subject to the succeeding provisions of this subsection, a physician shall be exempt from the prior authorization requirements under such process for the period of such plan year with respect to a specific item, service, or group of similar services, if during the preceding plan year at least 90 percent of prior authorization requests submitted to such organization by such physician for such item, serv-

ice, or group were approved by such organization (including any approval granted after an appeal). Such exemption shall continue to apply with respect to such physician furnishing such item, service, or group of similar services in subsequent plan years until the earlier of—

''(I) the date on which such exemption is revoked under paragraph (5); or

''(II) the date on which such physician opts out of such exemption under paragraph (3)(C).

''(ii) SPECIAL RULES.—For purposes of determining whether a physician qualifies for an exemption under clause (i) for a plan year for an item, service, or group of services, in calculating whether at least 90 percent of prior authorization requests submitted by such physician for such item, services, or group during the preceding plan year were approved, an MA organization shall—

''(I) subject to subclause (II), treat any such claim that was initially

denied, subsequently appealed, and that remains pending appeal at the time of such calculation as having been approved if more than 30 days have elapsed since the date such appeal was filed; and

"(II) in the case that, during such plan year, such organization changed any terms of coverage for such item, service, or group of services, not take into account any claims for such item, service, or group of services that were submitted during the 90-day period beginning on the date of such change.

"(B) PRIOR AUTHORIZATION PROCESS.—For purposes of this subsection, the term 'prior authorization process' means, with respect to coverage and payment for items and services (other than a covered part D drug) under an MA plan offered by an MA organization for a plan year, a process under which such organization (or a contractor of such organization) determines the medical necessity or medical appropriateness of such items and services prior

to the furnishing of such items and services or that otherwise requires an individual enrolled under such plan, or a provider of services or supplier scheduled to furnish items and services to such individual, to notify such plan (or such contractor) prior to such individual receiving such items and services.

''(2) FREQUENCY OF DETERMINATION OF ELIGIBILITY FOR EXEMPTION.—An MA organization may not evaluate a physician for the exemption described in paragraph (1) more than once during any plan year.

''(3) NOTIFICATION REQUIREMENTS.—

''(A) QUALIFICATION.—An MA organization shall, not later than 30 days before the first day of each plan year, notify each physician who qualifies for the exemption described in paragraph (1) of such qualification and the items, services, or group of similar services with respect to which such exemption applies for such physician. Nothing in this subparagraph shall preclude an MA organization from notifying a physician of such exemption at additional times throughout a plan year.

"(B) REQUESTS UNDER EXEMPTION.—In the case of a physician described in subparagraph (A) who submits a prior authorization request to an MA organization for an item or service with respect to which an exemption applies under this subsection, such organization shall notify such physician of such exemption as soon as possible (but in no case later than 24 hours after receiving such request).

"(C) OPT OUT.—Any physician eligible for an exemption under paragraph (1) may voluntarily waive such exemption by providing written notice to the applicable MA organization.

"(4) REQUIREMENT FOR COVERAGE AND PAYMENT.—In the case of a physician who qualifies for the exemption described in paragraph (1) with respect to an item, service, or group of similar services, an MA organization may not deny or reduce coverage and payment for such an item, service, or group based on medical necessity or appropriateness of care.

"(5) PROTECTIONS PERTAINING TO REVOCATION OF GOLD CARD.—

"(A) IN GENERAL.—An MA organization may revoke an exemption described in para-

graph (1) granted with respect to a physician for an item, service, or group of similar services for a plan year only if—

"(i) the MA organization—

"(I) determines that—

"(aa) less than 90 percent of claims submitted by such physician for such item, service, or group during the 90-day period ending on the date of such revocation would have been approved under the prior authorization process employed by such plan had such process applied with respect to such claims; or

"(bb) in the case that fewer than 10 claims were submitted by such physician for such item, service, or group during the 90-day period ending on the date of such revocation, less than 90 percent of the last 10 claims submitted by such physician for such item, service, or group as of the

date of such revocation would have been so approved;

''(II) furnishes such physician with a notice of such revocation containing the claim information (including identification of specific items and services and the individual to whom such items and services were furnished) on which the determination under subclause (I) was made; and

''(III) includes in such notice a plain-language description of how such physician may appeal such determination in accordance with the rules promulgated under subparagraph (B); and

''(ii) the individual conducting the determination under clause (ii)(I)—

''(I) is a physician;

''(II) possesses a current and nonrestricted license to practice medicine in the State in which the items, services, or group of services to which such exemption applies were furnished;

''(III) is actively engaged in the practice of medicine in the same or similar specialty as a physician that would typically furnish such item, service, or group of services; and

''(IV) is knowledgeable about the furnishing of, and has experience furnishing, such item, service, or group of services.

''(B) APPEAL OF EXEMPTION.—The Secretary shall, through notice and comment rulemaking, establish a process under which a physician may appeal a revocation under subparagraph (A). Such process shall ensure that any such appeal is resolved within 30 days of such appeal being submitted under such process.

''(C) TREATMENT OF UNRESOLVED CLAIMS.—The provisions of paragraph (1)(A)(ii) shall apply with respect to the treatment of claims for a determination made under subparagraph (A) in the same manner as such provisions apply with respect to the treatment of claims for a determination made under paragraph (1)(A).''.

(b) RULEMAKING.—The Secretary of Health and Human Services shall, through rulemaking, specify requirements with respect to the use of prior authorization by Medicare Advantage plans for items and services described in subsection (o)(1) of section 1852 of the Social Security Act (42 U.S.C. 1395w–22), as added by subsection (a), to ensure continuity of care for individuals transitioning to, or between, coverage under such plans in order to minimize any disruption to ongoing treatment attributable to prior authorization requirements under such plans.

(c) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the potential impacts of the amendment made by this section on communities at high risk for health disparities.

SEC. 3. OPPORTUNITY FOR PROVIDERS TO PRESENT CASES FOR COVERAGE AND PAYMENT DURING THE PRIOR AUTHORIZATION PROCESS UNDER MA PLANS.

Section 1852 of the Social Security Act (42 U.S.C. 1395w–22), as amended by section 2, is further amended by adding at the end the following new subsection:

"(p) OPPORTUNITY FOR PROVIDERS TO PRESENT CASES FOR COVERAGE AND PAYMENT DURING THE PRIOR AUTHORIZATION PROCESS.—

"(1) IN GENERAL.—For plan years beginning with the second plan year beginning after the date of the enactment of this subsection, any prior authorization process (as defined in subsection (o)(1)(B)) with respect to the coverage and payment for items and services (other than a covered part D drug) under an MA plan offered by an MA organization shall provide, prior to any coverage or payment determination with respect to an item or service subject to such process, for an opportunity for a provider of services or supplier seeking prior authorization to furnish such item or service to discuss with a qualifying physician (as defined in paragraph (2))—

"(A) the treatment plan for the individual who would be furnished such item or service; and

"(B) the clinical basis on which the organization will determine coverage or payment for such item or service.

"(2) QUALIFYING PHYSICIAN DEFINED.—For purposes of paragraph (1), the term 'qualifying phy-

sician' means, with respect to an item or service subject to a process described in such paragraph that a provider of services or supplier is seeking to furnish to an individual, a physician that—

"(A) possesses a current and nonrestricted license to practice medicine in the State in which such item or service is to be furnished;

"(B) is actively engaged in the practice of medicine in the same or similar specialty as a provider of services or supplier that would typically furnish such item or service; and

"(C) is knowledgeable about the furnishing of, and has experience furnishing, such item or service.".

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