Massachusetts Division of Insurance

KEY CHANGES TO PRIOR AUTHORIZATION REGULATIONS
211 CMR 52.00 (DRAFT CHANGES)

Below is a summary of draft regulations proposed to streamline and right size prior authorization (PA) requirements. **A virtual public hearing** will be held **on February 19th at 1:00 PM. We strongly encourage physicians to participate in the hearing; to do so you must submit a Notice of Intent to Comment to doidocket.mailbox@mass.gov no later than February 17th, 2026 at 5:00 PM.**

Please share your feedback with the MMS advocacy team (**advocacy@mms.org**) to ensure our regulatory advocacy and comments reflect your practical experience and anticipated concerns based. **The summaries below contain discussion questions to help direct constructive feedback.**

SERVICES EXEMPT FROM PRIOR AUTHORIZATION

Discussion Questions:

- How impactful will these categorical prohibitions on PA be for your practice?
- Does the in-network requirement introduce unnecessary barriers?
- Do these proposed categories truly reduce prior authorization requirements, or do they largely reflect current practice?
- Is Chronic Disease Management too limited? What, if any, additional services should be included?

Carriers/UROs may not require PA for the following services when provided *in network*, unless otherwise noted:

Category *All categories can be found in 52.07(5)(a)	**Services**
Emergency	Emergency services for emergency medical conditions (in- or out-of-network)
Inpatient	Inpatient acute care services
Post-Acute	Post-acute care on weekends or holidays
Urgent Care	Urgent care services
Primary Care	Primary Care Services
Chronic Disease Management	Services, devices, and prescription drugs covered pursuant to Chapter 342 of the Acts of 2024, **limited to the following**:

	• Diabetes • Asthma • 2 most prevalent heart conditions among members
Preventive Care	Preventive Health Services and vaccinations
Abortion Care	Abortion and abortion-related care

INITIAL DETERMINATION REQUIREMENTS

Discussion Question: Is working days or calendar days more appropriate?

Scenario	Requirement
Deemed Approval 52.07 (4)(b)	If a Carrier/URO fails to use or accept the designated form, or fails to issue a decision within required timeframes after receiving all "necessary information" (including required clinical evaluations), **the PA request is deemed approved.**
Expedited Decision (Serious Jeopardy) 52.07 (4)(c)	If delay would seriously jeopardize the insured's health or well-being, and the provider submits supporting documentation, the carrier/URO must issue and communicate an initial decision **within 24 hours** of receiving all necessary information.

CONTINUITY OF CARE

Discussion Questions:

- Do the *in-network and covered benefit* requirements for honoring a PA when a patient switches plans unnecessarily disrupt continuity of care?
- Is a 90-day period or the end of the benefit year adequate for continuity of care, or should PAs be valid for the duration of treatment or at least 1 year?

Issue	Requirement
Length of PA Validity 52.07 (4)(e)	Approved PAs must remain valid for **at least 90 days or until the end of the benefit year**, whichever is first.
Patients Switching Plans 51.07(4)(f)	When an Insured moves to a new plan, an existing PA must be honored by the new Carrier **for at least 90 days after enrollment**; *provided that the original requesting Provider is in network and the service is a covered benefit under the new Health Benefit Plan.*
Formulary Changes 52.07(4)(g)	If service/drug is removed from the formulary or subject to new restrictions after enrollment, coverage for stable patients must continue coverage for **at least 90 days or until the end of the benefit year**, whichever occurs first.

CONTRACTUAL PROVISIONS

Discussion Questions:

- How will your practice be impacted by these new proposed contracting requirements?
- Are the proposed requirements consistent with current contracting practices, or are they disruptive?
- Is two years too long for retrospective review/audits? What is industry standard/best practice for medical necessity documentation retention?

Area	Requirement
Payment Protection 52.11 (1)	Carrier–provider contracts may include provisions to **prevent payments exceeding the maximum allowable amount** under the applicable payment method, provided the contract complies with 211 CMR 38.04(1)–(2) (Coordination of Benefits rules).
Provider Incentives 52.11 (1)(a)	Contracts may include **financial incentives** to reinforce prohibitions on improper billing practices.
Prohibited Billing Practices 52.11 (1)(a)	**Duplicate billing**; **upcoding** or **overstating/misrepresenting** services; submitting **inappropriate claims** under a practitioner's provider ID.
Medical Necessity Records 52.11 (19)	Contracts must notify providers of their responsibility to maintain **medical necessity documentation** for at least **2 years**, subject to Carrier audit.
Retrospective Audits 52.11 (20)	Contracts must **describe audit processes** and the Carrier's right to **seek repayment** of improper payments.
Timely Filing 52.11 (21)	Contract must provide clear notice to Providers about **timely filing requirements** and processes for late claims submission.

RECONSIDERATION OF PA RESTRICTIONS

Topic	Details
Limited Reintroduction of PA 52.07 (5)(b)	**For physical therapy, occupational therapy, speech therapy, and chronic condition services,** a carrier may apply to the Division to reinstate limited PA if it demonstrates a **significant, risk-adjusted utilization increase for 2 consecutive quarters.**

TRANSPARENCY & REPORTING

Discussion Questions:

- Is excluding proprietary criteria appropriate, and what is the best way to ensure physicians receive underlying medical necessity criteria proactively from plans?
- Is 3-year DOI reporting cycle adequate or should reporting occur annually or at least biennially to coincide with the accreditation cycle?

Requirement Area	Details
Accessibility of UR Criteria 52.07 (3)(b)	**UR criteria**, including lists of Health Services, supplies, and pharmaceuticals requiring PA or Prospective Review, must be current, applied consistently, and **publicly**

	available in a searchable electronic format on the Carrier's website.
Proprietary Criteria 52.07 (3)(c)	Carriers are not required to publicly post licensed or proprietary criteria; however, such criteria **must be disclosed upon request** to a Provider or subscriber.
Advance Notice of Changes 52.07 (3)(c)	New or amended PA or Prospective Review requirements **may not be implemented** unless the Carrier's website has been updated to clearly reflect the change and **providers are notified at least 60 days prior** to the effective date.
DOI Reporting Obligation 52.07 (5)(c)	The Division must examine and report **at least every 3 years** on the financial, administrative, and clinical impacts of maintaining or eliminating PA, including cost, quality, utilization, and health equity.
Biennial Carrier Reporting 52.07 (12)(a)	As part of biennial managed care accreditation under 211 CMR 52.05, **Carriers must submit** a medical officer–signed **report** detailing **services subject to Prospective Review** (with service codes), **utilization and outcomes data** (approvals, denials, modifications, appeals), identification of **services with >98% approval rates**
Annual Insured Satisfaction Survey 52.07 (13)	Carriers must conduct an **annual insured satisfaction survey** on access to covered services and pharmaceuticals and UR processes, and submit results to DOI as part of the biennial managed care accreditation filing under 211 CMR 52.05.

AUTOMATION/ELECTRONIC PA REQUIREMENTS

Discussion Question:

- Is it appropriate to authorize plans to use financial incentives to *require* providers to participate in automated, electronic processing of PA requests

Area	Requirement
Electronic PA – Automation & Tech Standards 52.07 15 (a)- 52.07 (15)(c)	Carriers/UROs ***may*** implement a PA API to allow providers to determine PA requirements, identify documentation and forms, and submit requests electronically; **effective January 1, 2027**, any API must meet federal HHS and HIPAA standards and communicate approval (with expiration), denial (with reason), or requests for additional information; **effective January 1, 2028**, APIs must comply with the latest NCPDP SCRIPT (or successor) standard, and **Carriers/UROs may use financial incentives to *require* provider participation.**