MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

To: **Kevin P. Beagan**
Deputy Commissioner, Health Care Access Bureau
From: **Massachusetts Medical Society**
Re: **Comments re: Filing Guidance Bulletins 2026-J, 2026-K, and 2026-L**

The Medical Society appreciates the opportunity to provide further comment regarding the filing guidance released by the Division of Insurance to implement prospective review (aka prior authorization or "PA") reforms within 211 CMR 52.00. The comments below are intended to highlight specific issues in which further clarification would support effective implementation and ensure that the regulations and associated implementation guidance achieve their intended benefit. Additionally, we support and underscore the general questions and concerns raised by our colleagues from MHA regarding implementation and enforcement timelines, consistent application across carriers, and clear communication from plans distinguishing fully insured members from self-insured members.

Filing Guidance Notice: 2026-J

- **Changes to Prospective Review Requirements — 211 CMR 52.07(3)(c)**
  - The 60-day notice requirement applies to changes that materially restrict access to covered services, including new PA requirements, new step therapy requirements, or revised clinical criteria imposing new utilization management restrictions. We recommend clarifying that this requirement also applies when a carrier removes coverage for a health service or supplies or pharmaceuticals from their formulary, apart from the continuity of coverage protections addressed guidance K, 52.07(4)(g)).
  - During the listening sessions, carriers and providers expressed concern that 60-day notification requirements may unintentionally delay access to newly approved medications or services. The regulations do not prohibit or otherwise limit coverage without notice but rather, they prohibit plans from applying prospective review within the required notice period. Providing adequate notice of future utilization review requirements should not impede access to medication or care within the required notice period. An FAQ document should clarify that patients can access medications, services, or supplies during the notice period.

- **"Necessary Information" for Prospective Review — 211 CMR 52.07(4)(b)**
  - To reduce unnecessary back-and-forth, an FAQ should require plans to confirm receipt of PA requests within one day and limit repeated requests for further information before a submission is deemed complete.
  - The FAQ should also address situations in which a PA form is not available for a particular service or medication, offering guidance on how plans should proactively

identify the information required to complete the PA, including relevant medical necessity criteria, so that physicians and health care teams can provide it with the initial submission.

Filing Guidance Notice: 2026-K

- **Prospective Review for Cases of Serious Jeopardy — 211 CMR 52.07(4)(c)**
    - We greatly appreciate the guidance here that requires a clearly marked checkbox or designated area for providers to identify serious jeopardy requests. We also support the language indicating that determinations should be based on the clinical consequences of delay, not diagnosis alone. This approach ensures that there's due deference to a provider's clinical judgment regarding serious jeopardy posed to an individual patient. We would suggest stating more explicitly that carriers should defer to provider's clinical judgment when expedited review is requested. This is consistent with how the Office of Patient Protection ratifies a properly executed certification that a serious threat to the insured exists for purposes of r expedited external review under 958 CMR 3.401.
    - We further recommend clarifying the timeframe within which a carrier can reasonably request additional information, thereby tolling the 24-hour response period. To effectuate the spirit and intent of this provision, it's important that these expedited requests are addressed as soon as possible. – We appreciate that carriers need complete information to respond appropriately. However, permitting a carrier to wait until near the end of the 24-hour period before requesting additional information, and then tolling the response period, could defeat the purpose of the expedited timeline.
    - Lastly, we would underscore questions posed by MHA to further clarify circumstances when a carrier can appropriately request additional information under the serious jeopardy definition. Specifically, the guidance should address:
        - How receipt of all necessary information will be determined, especially if carriers are expected to defer to the clinical judgment of the requesting provider;
        - How requests submitted on a weekend/holiday/non-business day will be handled by the carrier; and
        - Will the carriers be required to have appropriate staffing to handle these requests?
    - Lastly, we also seek clarification on enforcement of this provision to understand how the DOI will ensure that carriers are compliant with this provision.
- **PA for Chronic Disease Management — 211 CMR 52.07(4)(e)**
    - When an insured is stable on an evidence-based treatment plan, an existing authorization for a health service, supply, or pharmaceutical must remain valid for the

course of treatment, including routine dosage adjustments, while the patient's condition remains stable. We would appreciate further clarification that this definition of stable, including meeting specific treatment goals established by the provider, does not create a new documentation requirement.

- DOI identifies a broad range of chronic conditions for which it expects carriers to comply with this provision, and we understand from the listening session that for now – this list is intended to be exhaustive. We support the request from gastroenterologists to add "ulcerative colitis, Crohn's disease, and decompensated cirrhosis", as each of which meets the regulatory definition of "other chronic conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both."
- We also strongly recommend striking the language in the guidance that notes that the regulations do "not prohibit the Carrier from requiring transitions, when appropriate, to a therapeutically equivalent or clinically appropriate alternative." This could be interpreted as the Division affirmatively authorizing carriers to make clinical decisions that override the treating physician's professional judgment, without appropriately accounting for the patient's medical history and the risks associated with disrupting an effective course of treatment
- The filing guidance provides that a new PA may generally be required only when the patient's condition changes; active treatment ends, or a new service, supply, or pharmaceutical is needed. We would recommend additional clarification regarding what constitutes a change in a patient's condition or the end of active treatment.

- **Continuation of PA from a Prior to a New Health Plan — 211 CMR 52.07(4)(f)**
  - Carriers are required to honor prior authorization for a health service, supply, or pharmaceutical under the new health benefit plan **for at least 90 days** following enrollment, provided that the health service, supply, or pharmaceutical is a covered benefit under the Carrier's plan. We recommend clarification regarding who is expected to provide documentation of the previous prior authorization to the carrier, particularly when the original prescribing provider is not in-network with the new plan. We caution against placing additional burden on patients and would urge the Division to explore the appropriate role of pharmacies in providing the necessary information to meet these expectations.
  - The guidance should also address situations in which the previous carrier did not require prior authorization for a health service, supply, or pharmaceutical. The Division's examination report documented significant variation among carriers in utilization of PA and it's reasonable to expect there will be instances where the previous carrier did not require PA. MMS therefore recommends clarifying in an FAQ that where the previous carrier did not require a PA, the new carrier cannot require documentation in order for the patient to benefit from this continuity of care protection.

Filing Guidance: 2026-L

- **Limitations on PA for Inpatient Acute Care Services — 211 CMR 52.07(5)(a)(2)**
    - It is not clear from the guidance that this limitation applies to inpatient mental health acute treatment, as the language only explicitly references medical treatment. Further clarification as to the application to mental health should be included, cross referencing requirements under Chapter 177 of the Acts of 2022, as well as any related guidance regarding PA prohibitions for mental health acute treatment and stabilization services for adults and children.
- **Limitations on PA for Certain Primary Care Services — 211 CMR 52.07(5)(a)(5)**
    - At the listening session, the Division clarified that the scope of application for the prohibition on prior authorization for primary care services is indeed limited to services actually *delivered by*, not ordered or prescribed, by primary care clinicians. However, the guidance specifically includes routine laboratory testing and diagnostic testing and imaging within its definition of primary care services. Limiting the exemption only to services "provided by'" the primary care clinician narrows the practical value of this provision. Primary care clinicians generally order, rather than directly furnish, tests and imaging as part of evaluating and managing their patients. Applying the exemption only to instances when a service is physically provided by the clinician will not actually reduce the unnecessary burden prior authorization poses to primary care clinicians. Additionally, an FAQ should clarify what the Division meant in the filing guidance by referencing "routine services provided by a primary care practitioner within the scope of the in-network provider's *primary care practice*" – does this prohibit PA in multi-specialty provider organizations that have onsite, in-house lab and imaging services that are provided within the *practice*, but not directly by the primary care clinician.
- **Limitations on PA for Certain Maternity Care — 211 CMR 52.07(5)(a)(10)**
    - Based on the statutory cross-references in the regulation, MMS recommends the Division explicitly clarify, that the exemption from prospective review applies to covered in-network maternity services regardless of the setting in which they are delivered, or the type of licensed or authorized practitioner providing the service, consistent with appropriate coverage and scope of practice requirements.
    - Footnote 2 of the guidance indicates prospective review may be appropriate for certain non-routine maternity services, including those associated with high-risk pregnancies or pregnancy complications. We recommend clarifying that a patient's designation as having a high-risk pregnancy, or delivery of care from a maternal-fetal medicine specialist, does not, by itself, make every service provided to that patient nonroutine. Otherwise, routine maternity services should remain exempt from prospective review even when provided during a high-risk pregnancy. The applicability of the exemption should be determined by the specific service being provided rather than the patient's risk classification alone or specialty of the treating clinician.