To: Kevin P. Beagan
Deputy Commissioner, Health Care Access Bureau
From: Massachusetts Medical Society
Re: Implementation of 211 CMR 52.07 (12)-(15); 52.11(1), (19)-(21)

52.07(12)(a)(1) Prospective Review Submissions

- We recommend that guidance from the Division clarify that the threshold for evaluating the continued use of PA is distinct from the 98% approval threshold. A 98% approval threshold is an extraordinarily high bar and does not meaningfully evaluate the overuse of low-value PA. When this was raised during the listening session, the Division indicated an expectation that carriers would evaluate the effectiveness of PA under the 98% reporting threshold, and we strongly urge that guidance explicitly communicate that expectation. Specifically, we recommend DOI guidance adopt an PA evaluation threshold of 90%, a more reasonable and measured standard that reflects exceptionally high compliance and more effectively captures low-value PA. A 90% evaluation threshold aligns with most states' gold carding programs, which exempt physicians from PA requirements based on previous approval records. Federal proposals to implement gold carding for Medicare Advantage plans also use a 90% threshold. These consistent state and federal standards underscore 90% as a reasonable threshold and we strongly recommend guidance directing evaluation of PA effectiveness adopt this threshold.

52.07(15)(c) Application Programming Interface.

- We recommend guidance clarifying that carriers are prohibited from using financial incentives to penalize providers for not participating. Our understanding of the spirit of the regulatory language is to authorize the use of financial incentives as a positive measure to encourage providers to participate and would strong encourage this be clarified in guidance. We recognize provider participation is desirable and reasonable. However, while most physician practices utilize electronic health records (EHR), a small number do not and have been grandfathered into e-prescribing requirements and would therefore be negatively impacted by a mandatory participation requirement. Clear guidance is needed that the use of financial incentives should not be interpreted to include penalizing providers for

lack of participation. Further, positive measures could help those practices on EHRs afford the cost of participating.

52.11(1) Provider Contracts

- The Medical Society supports and strongly reinforces the comments offered by the Massachusetts Health & Hospital Association pertaining to this section, particularly regarding financial incentives, duplicate claims and overstating or misrepresenting services, including provider upcoding. Additionally, we see in practice and are deeply concerned by the increasing trend of payors aggressively, and in some instances automatically, downcoding evaluation and management services and other types of visits as administrative denials, thereby precluding appeals based on the actual merits and medical necessity of a claim. We appreciate the Division's efforts to investigate the practice of health plans' downcoding initiatives and welcome a conversation about its findings about how best to appropriately regulate this practice.
- Further, MMS shares MHA's objection to use of the term "upcoding" as it is not a defined term in the Division's regulation, and the term has different interpretations by payers and providers. MMS further reinforces MHA's concerns that guidance is needed to ensure clarity and uniformity of interpretation of many key terms in this section, and that the Division should work with payors and providers to establish consensus definitions and protect providers when there are disagreements.

52.11(19), (20)

- We strongly recommend that guidance clarify how the Division defines "medical necessity records." We urge clarification that this provision does not create a duplicative record-keeping requirement that distinguishes the medical record from "medical necessity records", as clinicians are currently required to maintain a patient's medical records for 7 years. It is imperative that this section is not interpreted to create new or duplicative record keeping requirements for clinicians.
- It is also unclear why the final regulations extended the recordkeeping requirement from two years to six years. The implication of this extended record-keeping requirements is that carriers may audit claims for any reason within that period. Such an unrestricted audit period would be unprecedented, creating administrative burden for practices and injecting instability and unnecessary financial vulnerability. To promote stability and predictability, we strongly recommend that guidance

outline reasonable limitations for retrospective audits in line with CMS parameters for Medicare audits, which notably only has a 3-year look-back window. Under CMS authority, Medicare Recovery Audit Contractors (RACs) cannot selectively or randomly target claims, but instead they must have documented "good cause" and CMS-approved targets to review claims. Similarly, the Division should clarify that audits within one year are allowable for any reason; after one year and within a 3-year period total, carriers should be required to show good cause for an audit, such as when new and material evidence is discovered that was not previously available and that might have altered the outcome or evidence that shows an obvious error was made. To audit for alleged fraud, carriers should be required to demonstrate reliable evidence of fraud that is relevant, credible, and material. A shorter audit window would reduce prolonged financial uncertainty for physician practices while preserving carriers' ability to identify and recover improper payments.

52.11(21)

- This section requires carriers to provide clear contractual notice to providers about timely filing requirements and processes to consider claims submitted outside established timely requirements. We recommend guidance clarifying that carriers must provide clear notice to providers about the appeals process to appeal claim denial.