MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

To: Kevin P. Beagan
Deputy Commissioner, Health Care Access Bureau
From: Massachusetts Medical Society
Re: Implementation of 211 CMR 52.07 (5)

General Comments

- We underscore comments offered by our colleagues from the Hospital Association and urge the Division to issue guidance requiring that once a patient has been approved for out-of-network (OON) care, related services should be treated as in-network and not subject to prior authorization consistent with the requirements of these regulations. We would also reiterate our comments that for patients with a Preferred Provider Organization (PPO) plan or that have other out-of-network (OON) benefits, they are paying more to be able to access OON care and should not be penalized by having PA apply for care sought OON.

52.07(5)(a)(1) - Emergency Services

- We recommend guidance not limit the prohibition of prior authorization (PA) for emergency services solely to care delivered in emergency departments. Emergency services is inclusive of behavioral health services. As part of the Mental Health ABC Act (Chapter 177 of Acts of 2022), the law already prohibits insurance companies (including MassHealth) from requiring PA for mental health acute treatment and stabilization services for adults and children and this is not exclusive to emergency departments, as the law contemplates access to community crisis stabilization services (CSS) an alternative to inpatient hospitalization for people in need of short-term, overnight crisis care. CSS programs are available through Community Behavioral Health Centers (CBHCs) for both adults (18+) and youth (18 and under).

- Relatedly, Chapter 177 defines a "Community crisis stabilization program", as a program providing crisis stabilization services with the capacity for *diagnosis, initial management, observation, crisis stabilization and follow-up referral services* to all persons in a home-like environment, including, but not limited to, emergency service providers and restoration centers.

- For understanding and more clearly defining stabilization services, as well as for (a)(14) outpatient substance use disorder services, we recommend looking to the American Society for Addiction Medicine's Criteria, a comprehensive set of

guidelines that use a holistic, person-centered approach to developing treatment plans for patients with addiction and co-occurring conditions. The Criteria provides clear definitions for levels of care and should be instructive for further sub-regulatory guidance.

- In sum, we recommend DOI guidance:
    - Explicitly not limit PA for emergency services only to care delivered in EDs
    - Cross reference requirements under Chapter 177 of the Acts of 2022 and any related guidance regarding PA prohibitions for mental health acute treatment and stabilization services for adults and children
    - Look to definitions within Chapter 177 and ASAM's Criteria to more clearly define stabilization services in the context of mental health and substance disorder care

(a)(3) Post-Acute Care Services

- We recommend that the Division's guidance clarify that inpatient acute care services include post-acute services provided, regardless of the setting. The pilot program established in Section 24 of Chapter 197 of the Acts of 2024 is inclusive of care provided at post-acute facilities or agencies, which the statute defines as "any: (i) facility licensed under chapter 111 of the General Laws to provide inpatient post-acute care services, including, but not limited to skilled nursing facilities, long-term care hospitals, intermediate care facilities, or rehabilitation facilities; or (ii) a home health agency certified by the federal Centers for Medicare and Medicaid Services."

52.07(5)(a)(4) Urgent Care Services

- Urgent care services should be defined and clarified to differentiate between what is prohibited from prior authorization under this section, and what may require expedited prior authorization review under 52.07(4)(c). We propose inclusion of the MGL C.111 Section 51O definition of "Urgent care services", as "a model of episodic care for the diagnosis, treatment, management or monitoring of acute and chronic disease or injury that is: (i) for the treatment of illness or injury that is immediate in nature but does not require emergency services; (ii) provided on a walk-in basis without a prior appointment; (iii) available to the general public during times of the day, weekends or holidays when primary care provider offices are not customarily open; and (iv) is not intended and should not be used for preventative or routine

services." Urgent care services may be provided in urgent care centers, licensed clinics, and should be inclusive of urgent behavioral health care, which may be delivered in CBHCs.

52.07(5)(a)(5) Primary Care Services

- **We recommend the Division issue guidance offering an expansive definition of "primary care services".** In the listening session, the health plans urged adoption of a narrow definition of "primary care services" limited to offices visits in primary care. Prohibiting prior authorization only for services "delivered" by a participating primary care provider does not address the full scope of services subject to prior authorization within the ambit of primary care and has limited practical effect and undermines the spirit of the provision, which is to reduce the overutilization of prior authorization on high-value primary care services and . meaningfully reduce the burden associated with prior authorization.
- In practice, primary care offices visits are not subject to Prior Authorization. The primary administrative burden arises from ordering laboratory testing, imaging, and treatments or prescribing medications. **We strongly recommend that "primary care services" be defined as inclusive of, but not limited to, laboratory testing, diagnostic testing and imaging, medication, or treatment ordered, delivered, prescribed, or provided by a primary care clinician."**
- We also recommend the Division clearly delineate an expansive definition of primary care clinician, that includes family medicine practitioners, internists, pediatricians, geriatricians, and obstetrician-gynecologists.
- An expansive definition of primary care services and primary care provider would be consistent with CHIA's current definition and measurement of primary care spending in Massachusetts. CHIA's Data Specification Manual is instructive.

52.07(5)(a)(6) – Pharmaceuticals for Chronic Conditions

- A question was asked at the listening session as to how this prohibition for PA for pharmaceuticals identified under the PACT Act for limited or no-cost sharing is applied relative to other continuity of care provisions. It would be valuable for the DOI guidance to clarify that the continuity of care provisions, for example, requiring authorization for the duration of treatment for patients stable on evidence-based treatment under 52.07(4)(e), apply to this section. Given that this section applies to pharmaceuticals with no/limited co-pay under C.342, DOI guidance should clarify that in addition to putting this information on their website, carriers should

simultaneously notify clinicians and practices about the co-pay and that these pharmaceuticals are not subject to prior authorization.

52.07(5)(a)(7) – Preventive Health Services

- The Division defines Preventives Health Services as "any periodic, routine, screening or other services designed for the prevention and early detection of illness that a Carrier is required to provide pursuant to Massachusetts or federal law." Massachusetts at times requires more expansive coverage of preventive services than federal law and guidance should specify that the prohibition on prior authorization for preventive services applies to the broadest set of services.
- Section 56 of Chapter 28 of the Acts of 2023 established Section 47UU of Chapter 175, which codifies coverage requirements for existing preventive services under the Affordable Care Act as of 2023. Additionally, the MA Health Connector voted to amend state Minimum Creditable Coverage standards for insurance plans to include the prevention services under threat by a 2023 federal ruling, including, for example, lung and skin cancer screenings, PrEP for HIV prevention, hepatitis B and C screenings, statins to lower cholesterol, and medications and certain screenings for breast cancer.
- Guidance should also specify that PA prohibitions under this section shall apply to any additional preventive services identified for coverage under Massachusetts or federal law, whichever is more expansive.

52.07(5)(a)(8) – Vaccinations

- We support the recommendation from the health plans to align PA prohibition with previous guidance issued jointly by the Division and DPH regarding vaccine coverage**.** This comports with statutory changes established in Sections 26-28, inclusive, of Chapter 73 of the Acts of 2025 giving DPH greater authority over vaccination recommendations.

52.07(5)(a)(9) – Abortion & Abortion-Related Care

- Chapter 127 of the Acts of 2022 mandates coverage for abortion and abortion-related services. The Division has previously issued sub-regulatory guidance defining abortion and abortion-related care. We support recommendations to align with that previous guidance.

- "Abortion-related care" includes services defined under 130 CMR 484.005 that are "provided in conjunction with a payable abortion procedure: (1) pre-operative evaluation and examination; (2) pre-operative counseling; (3) laboratory services, including pregnancy testing, blood type, and Rh factor; (4) Rh (D) immune globulin (human); (5) anesthesia (general or local); (6) post-operative care; (7) follow-up; and (8) advice on contraception or referral to family planning services." The Division considers ultrasounds, pre-abortion evaluation and examination, and post-abortion care provided in conjunction with a covered surgical or medication-based abortion to be "abortion-related care."

52.07(5)(a)(10) – Maternity Services

- Maternity services should be defined expansively and inclusive of prenatal, intrapartum, and postpartum care, including postpartum mental health screening, diagnosis, and treatment. MGL Chapter 112 Section 291 refers to maternity care provided across the spectrum, including during the preconception period and the antepartum, intrapartum and postpartum periods. The American College of Obstetrics and Gynecology's Clinical Guidance on Maternal Levels of Care similarly denotes that maternal care refers to all aspects of antepartum, intrapartum, and postpartum care.
    - **Prenatal Care:** Medical care, screenings (medical and genetic), anticipatory guidance, and support provided throughout the antepartum period to monitor maternal and fetal health. (*See* ACOG Clinical Guidance on Prenatal Care)
    - **Intrapartum Care:** Labor management, continuous monitoring, and delivery services, including emergency procedures and anesthesia available in inpatient settings or birth centers.
    - **Postpartum Care:** Care for the birthing individual in the months following birth, including ongoing medical evaluations, transition to primary care for chronic issues, and social/material support. (*See* ACOG's Committee Opinion on Optimizing Postpartum Care)
- Maternity services should be inclusive of care delivered regardless of the setting, including but not limited to physician practices, hospitals, clinics, and licensed birth centers; maternity services should also include care delivered by any maternal health practitioners, including but not limited to physicians, nurse practitioners,

certified nurse-midwives (CNMs), certified professional midwives, maternal-fetal medicine (MFM) specialists, and doulas.

- Maternity services need not be defined based on how they are paid for and whether they are bundled or paid separately.

52.07(5)(a)(11) – Confirmed Cancer Diagnosis

- We defer to and would like to underscore the comments submitted on behalf of the Dana Farber Cancer Institute.

52.07(5)(a)(13) – Pharmaceuticals for Serious Persistent Mental Illness

- "Serious mental illness" is defined as a condition, as described by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, in which an individual over the age of 18 has a diagnosable mental, behavioral or emotional disorder that causes serious functional impairment, substantially interfering with or limiting 1 or more major life activities.
- We strongly recommend against listing out medications in any sub-regulatory guidance, as pharmacologic treatment is always evolving. Instead, we would recommend that the guidance is clear that prior authorization should not apply to any drugs approved by the FDA for the treatment of serious mental illness.

52.07(5)(a)(14) – Outpatient Substance Use Disorder Services

- We similarly recommend deferring to ASAM's Levels of Care Criteria noted above. DPH's Bureau of Substance Addiction Services maintains a dashboard of licensed programs and beds that are separated by the ASAM levels of care, delineating a standardized approach for outpatient SUD services.

52.07(5)(b) – Carrier Application to Reinstate for Limited Use of PA

Notwithstanding the foregoing, with regard to services within [specified] categories…if a Carrier experiences and can demonstrate to the Division's satisfaction that there has been ***a significant increase in the risk-adjusted utilization of a specific Health Services****, supplies or pharmaceuticals for two consecutive quarters, the Carrier may submit an application with corresponding supportive data to the Division for consideration of a limited use of Prospective Review requirements for a designated, time-limited period. The notice*

and website provisions set forth in this regulation shall otherwise apply to the introduction of the new limited period Prospective Review requirements so approved by the Division.

- To ensure consistent implementation across carriers and uniform compliance, we recommend that the Division further clarify how it will define a "significant increase" in utilization and establish transparent criteria for evaluating whether that threshold has been met.
- While we understand the rationale for including this provision, its application could unintentionally undermine the goals of the regulations. For example, the regulations eliminate prior authorization for medications used to treat several common chronic conditions, including asthma, diabetes, and the two most prevalent cardiovascular conditions. It is both expected and appropriate that utilization of these medications may increase following removal of prior authorization, which may reflect previously unmet patient need. Individuals who may have previously delayed or gone without treatment because of prior authorization barriers may gain access to evidence-based therapies. Utilization of a carrier's preferred medication may also increase simply because patients shift from one drug to another because its more accessible under the new rules limiting both cost-sharing and administrative barriers.
- Importantly, increased use of clinically appropriate treatments should not, by itself, be viewed as evidence of inappropriate utilization. On the contrary, improved access to effective treatment is associated with better disease control and can reduce downstream health care utilization and expenditures, including emergency department visits, hospitalizations, and other avoidable care.
- We are also concerned that evaluating utilization on a quarterly rather than annual basis will introduce substantial variability and make it difficult to determine whether changes are attributable to removal of prior authorization or to other factors, such as seasonal disease patterns, fluctuations in patient volume, or normal variation in clinical practice. For example, inhaler utilization predictably increases during the winter months. As DOI's own prior authorization examination report demonstrates, considerable year-to-year variation exists even when prior authorization requirements remain in place. For these reasons, while carriers may submit applications for reinstatement with data from two consecutive quarters, we recommend the DOI establish a higher threshold – a year or more - before allowing for the reinstatement of prior authorization. A higher threshold more appropriately accounts for standard fluctuations in utilization that may not be indicative of inappropriate use.

- In addition, any determination should not rely solely on a utilization threshold, which is principally an economic measure. DOI should also require carriers to evaluate the clinical appropriateness and overall impact of the increased utilization. Relevant considerations should include the number of previously untreated patients who are now receiving stable, evidence-based treatment, changes in emergency department and urgent care utilization, hospitalization rates, medication adherence, and the potential impact that reimposing prior authorization requirements would have on patient access, quality, continuity of care, and health outcomes.
- Additionally, the Division should define what will constitute "limited use" for a "time-limited period." We also recommend specifying that a reinstated PA authorized under this section be subject to the notice requirements under section 52.07(3)(c).