MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

February 26, 2026

Honorable Michael T. Caljouw
Commissioner, Massachusetts Division of Insurance
One Federal Street
Suite 700
Boston, MA 02110-2012

Re: Docket No. G2026-01
Proposed Amendments to 211 CMR 52.00
Managed Care Consumer Protections and Accreditation of Carriers

Dear Commissioner Caljouw:

The MMS is a professional association of over 23,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. Physicians are committed to providing timely, high-quality care for their patients. However, growing administrative complexity, particularly prior authorization (PA), increasingly impedes this goal. PA requirements routinely delay or deny necessary care, disrupt stable treatment, and consume substantial practice resources that could otherwise be devoted to direct patient care. Physician practices have reached a crisis point and PA is widely identified as a key driver of burnout, financial strain, and diminished patient access.

We therefore commend the significant efforts of the Division in undertaking a comprehensive examination of PA and proposing amendments to 211 CMR 52.00. The Division's report appropriately identifies the need for greater rigor, transparency, and consistency in the use of PA. Right-sizing PA is imperative to protect patients, support physicians, and promote efficiency in health care delivery. While the proposed amendments represent a strong initial effort to effectuate responsible utilization of PA, we believe there are opportunities to further address the significant care disruptions and administrative complexities associated with PA. These comments identify such opportunities to clarify and strengthen the draft regulations with the shared goals of protecting patients' timely access to medically necessary care and meaningfully reducing the administrative burden on physician practices and health systems.

While we acknowledge and appreciate ongoing voluntary efforts by health plans to streamline prior authorization processes, experience has demonstrated that such initiatives, absent clear regulatory standards, often result in uneven adoption and limited accountability. Automation was a focus of several testifiers at the hearing; while automation may improve efficiency, it does not meaningfully address the foundational issues of unnecessary or repetitive authorization requirements, plan transition disruptions, inconsistent carrier practices, or delays in access to care. Given the documented variation across carriers in the Division examination report and the real-world patient harm described in testimony and the Division's examination report, regulatory clarity and enforceable minimum standards are necessary.

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Patients and physicians should not be required to wait for voluntary efforts to mature before receiving basic continuity and access protections. Regulatory reform does not impede modernization; rather, they establish the guardrails within which modernization efforts can operate effectively and consistently.

We also caution against relying on studies or analyses premised on the complete elimination of prior authorization to assess these reforms and the potential impact on premiums. The Division's proposal is targeted and does not eliminate prior authorization. Moreover, the study cited during the public testimony acknowledges that wide variation in current PA practices across carriers limited reliable cost projections, reinforcing the need for greater standardization and transparency. It also fails to account for the administrative savings, improved access to care, and reduced downstream costs that would result from streamlined PA requirements and processes. Accordingly, projections premised on the wholesale elimination of prior authorization should not be viewed as an accurate measure of the likely impact of these carefully calibrated reforms.

Although we support the overall direction of the proposed regulations, we believe several provisions warrant further clarification and strengthening. Additionally, we strongly support passage of complementary legislation (H.4616/S.1403), which would codify many of these reforms in statute and provide the Division with additional statutory authority to more comprehensively regulate prior authorization practices beyond the scope of these proposals.

As such, the Medical Society respectfully submits the following comments:

Transparency Requirements

- **52.07(3)(b)** – we applaud the proposed language to promote transparency around utilization review criteria, including listing all health services, supplies, and/or pharmaceuticals requiring prior authorization. A significant challenge for physicians is accessing and navigating varying medical necessity criteria, which differs among plans and could even differ by plan for the same carrier. We strongly recommend additional language to this provision that: 1) requires medical necessity criteria be shared automatically with physicians following contracting to eliminate unnecessary steps and provide more transparency; and 2) language that clarifies that a prior authorization request is not valid if the service, supply, or pharmaceutical is not appropriately listed publicly on the carrier's website in compliance with this subsection.

- **52.07(3)(c)** – under this draft language, changes to prior authorization requirements are appropriately treated like material changes and carriers are newly required to notify clinicians at least 60 days in advance prior to the effective date of the new or amended requirement or restriction. We applaud this provision, which will meaningfully improve transparency. In addition to notifying clinicians, we strongly recommend that impacted patients be directly notified of changes to PA requirements that will affect their care. Lastly, we recommend clarification that a prior authorization request or a denial of a claim is not valid if the carrier did not meet the notification requirements under this section.

- **52.07(4)(b)** – we support the provision that deems a prior authorization granted if the carrier fails to respond to a completed request, including all necessary information, within the required timeframe; we would recommend additional language that clarifies a prior authorization is deemed granted if a carrier fails to respond or request additional information in the required time period.

Promoting Timely Access to Care

- **52.07(4)(c) –** we are very grateful for inclusion of this provision to encourage timely access to urgently needed care. In the absence of this expedited processing, many physicians are forced to send their patients to emergency departments to access urgently needed care in a timely manner, so this provision can help address overcrowding and capacity constraints in emergency departments by promoting access to care in outpatient settings. However, we do not support additional documentation requirements to prove urgency beyond the standard necessary information required for an authorization. Establishing urgency should be at the discretion of the treating clinician, requiring additional burdens to otherwise prove urgency defeats the purpose of an expedited review and response.

Continuity of Care Provisions

- **Duration of PA – 52.07(4)(e) –** requires a PA to be valid for at least 90 days or until the end of the benefit year, whichever is earlier. While this represents progress, it is not sufficient, particularly for patients with chronic conditions who are on stable long-term treatment. Repeated prior authorization for unchanged chronic conditions requiring ongoing medications or services is unnecessary, burdensome, and often results in harmful delays or interruptions as was consistently mentioned at the hearing. We strongly recommend extending PA validity to the course of treatment to meaningfully promote continuity of care. Patients with established, evidence-based treatment plans should not be required to seek annual reauthorization for well managed chronic illnesses. These treatment plans do not materially change year-to-year. For example, a patient with Cystic Fibrosis (CF) who is stable on treatment should not have to seek annual reauthorization – medical necessity has been established by the chronic condition and treatment does not reset annually, but rather is titrated based on objective, clinical metrics. For patients with CF, treatment disruption carries great risk of pulmonary exacerbation, accelerated lung function decline, and increased probability of expensive and unnecessary hospitalization. Patients and physician practices are overwhelmed during annual reauthorization cycles, typically every January and July, when plans routinely require renewed approval for stable treatment. Eliminating unnecessary reauthorization, particularly not requiring annual reauthorization for those on stable treatment, will significantly reduce patient harm and physician burden. Additionally, the Division should prohibit requiring a PA for routine dosage adjustments of an already approved medication prescription, as such PAs are unnecessary and delay clinically appropriate care.

- **Switching Plans – 52.07(4)(f) –** appropriately requires that a new plan honor an existing PA for at least 90 days after enrollment. We appreciate this provision and recognize it is already widely adopted by many plans, as it promotes treatment adherence and short-term continuity of care during plan transitions. However, the additional conditions that the original requesting provider be in-network with the new carrier and that the service, treatment, or medication be a covered benefit under the new plan substantially weaken the protection. The goal is to create a bridge that allows patients to remain stable while navigating the new plan's network and benefit structure and these limitations undermine that goal and will result in unnecessary disruptions in care. We therefore recommend removing these restrictions to ensure that transitional continuity protections function as intended.

- **Formulary Changes – 52.07(4)(g) –** we appreciate the requirement that carriers continue coverage for a defined period in the event of a formulary change. To strengthen the intended effect of ensuring continuity of care, however, the regulation should require coverage for the

approved drug or medical service without restrictions for the rest of the benefit year or 90 days, whichever is *longer*, not shorter. In addition, when a formulary change occurs, carriers should be required to notify both the patient and treating physician and identify covered therapeutic alternatives. Transparency regarding formulary changes is essential to facilitate safe and timely transitions of care.

Prohibition of PA for Certain Health Services, Supplies, and Pharmaceuticals

- **52.07(5)(a)** – we applaud the recognition that PA is inappropriate for many kinds of services and the proposal to prohibit the use of PA for certain services. Many of the services listed here reflect current practices for which prior authorization typically does not apply, but codifying this in regulation will ensure standardized application of these rules for all carriers, which promotes uniformity and decreases confusion and burden. This section could benefit from clarifying additional amendments that will appropriately limit PA in certain cases. Specifically:

    - ***Emergency and Urgent Care Services*** – is this intended to apply to services delivered in an emergency department or urgent care center, respectively? There could be confusion between expedited PA review (24 hours) for urgently needed care verses a prohibition on PA for emergency services for emergency medical conditions or urgent care services (which is not otherwise defined in the regulations).

    - ***Inpatient Acute Care Services*** – As was described by many testifiers at the hearing, prior authorization for inpatient behavioral health is a barrier to care for patients and contributes significantly to the boarding crisis in our emergency departments, especially in pediatrics. The Mental Health ABC Act 2.0, Chapter 177 of the Acts of 2022, prohibits PA for mental health acute treatment and stabilization services for adults and children, recognizing that acute mental health crises require immediate treatment in an appropriate setting and that clinical determinations should be made by the treating clinician. In that spirit and to appropriately effectuate the law, we recommend clarifying the definition of inpatient acute care services to explicitly include acute behavioral health care.

    - ***Primary Care Services*** – is defined as "services delivered by a primary care provider." Would labs, tests, or other treatments prescribed or ordered, but not *delivered*, by a primary care provider meet this definition and therefore PA would be limited in those instances? If not, the restriction on PA for primary care services as defined reflects the current status quo and has limited practical effect on meaningfully reducing the burden associated with PA that is contributing significantly to burnout amongst the primary care workforce. Patients do not need a prior authorization to see primary care physicians – it is the imaging, laboratory testing, medications, and treatments ordered where prior authorization impacts patients and primary care physicians. Inclusion of *preventive services* on this list also does little to address the burden associated with prior authorization, as it largely codifies current practice where PA is not broadly applied for many preventive services. To be more impactful, we strongly recommend clarifying the definition of primary care services to be explicit that it is inclusive of care ordered or prescribed by primary care clinicians.

    - ***Chronic Disease Management Services*** – for purposes of Chapter 342 "chronic disease management" is limited to the following conditions: 1) diabetes; 2) asthma; and 3)

the two most prevalent heart conditions among a carrier's members. The goal of this provision of Chapter 342 was to address affordability barriers to prescription medications, not access barriers and administrative challenges. Applying the limits of Chapter 342 here is too narrow – it would be appropriate and more impactful to restrict PA from applying to a broader scope of chronic illness. Chronic disease management broadly – not just in the case of diabetes, asthma, and heart conditions – are subject to the same risk of disruption to needed care. Managing chronic illness effectively requires continuous, uninterrupted medication and treatment – PA threatens to unnecessarily disrupt care which is standard and well-established for a broader scope of chronic illness. Patients who are stable on medications or biologics for illnesses like Attention-Deficit/Hyperactivity Disorder, rheumatoid arthritis, ulcerative colitis, Crohn's disease, eczema, to name a few, should not have to seek annual reauthorization, especially where their condition and treatment is not changing. Instead of narrowing the definition, the PA restriction should apply to the more comprehensive definition of Chronic Disease Management in subsection 52.02 and applied throughout the rest of the regulations.

- ***In-network Restrictions*** – we recommend eliminating the qualifying restriction that all prohibitions on the use of PA in this section be limited to care that is in-network, especially for patients with a Preferred Provider Organization (PPO) plan or that have other out-of-network (OON) benefits since they are paying more to be able to access OON care and should not be penalized by having PA apply for care sought OON. Moreover, many SUD treatment programs and independent abortion clinics exist outside of insurance networks and so the impact of this change will be undermined if only applied to in-network providers.

Authorization to Reinstate PA Requirements

- **52.07(5)(b)** – this section authorizes carriers that demonstrate two consecutive quarters of a "significant increase" in the risk-adjusted utilization of a specific health services (physical therapy, occupational therapy, speech therapy, and chronic condition services) to apply for reinstatement of PA on a limited, time-bound basis. To ensure uniform compliance, we recommend further clarification on how the Division will define or determine what constitutes a "significant increase" in utilization and establish clear criteria for how such determinations will be evaluated. We also recommend specifying that a reinstated PA authorized under this section be subject to the notice requirements under section 52.07(3)(c).

DOI Review of PA Data

- **52.07(5)(c) –** directs the Division to examine, at least every 3 years, the financial, administrative, and clinical impacts of maintaining or eliminating PA for specific health services, supplies, pharmaceuticals. While we support the inclusion of a review requirement, a three-year interval is insufficient to ensure meaningful oversight of a constantly evolving utilization management tool. We therefore recommend requiring review on an annual basis for closer scrutiny. At a minimum, the review should align with the biennial accreditation cycle to allow for more timely evaluation, transparency, and corrective action where necessary.

- **52.07(12)(a) –** we support comprehensive, timely submission of PA-related data. However, subsection (12)(a) should be expanded to include the amount of time between PA submissions and determinations, as well as the time required to process appeals. Anecdotally, physicians report

overwhelmingly that carriers exceed current statutory timeframes for processing PAs. Collecting and publishing these data elements is essential to determine whether carriers are meeting their statutory obligations and to promote compliance. Additionally, subsection (12)(a)(1) requires submission for all health services, supplies, and pharmaceuticals subject to PA where the carrier approved over 98% of requests (including upon appeal), along with a proposed justification for continued use of PA, presumably to determine whether continued use of PA for such care is warranted. A 98% approval threshold is an extraordinarily high bar and does not meaningfully evaluate the overuse of low-value PA. We recommend modifying the reporting threshold to 90%, a more reasonable and measured standard that reflects exceptionally high compliance and more effectively captures low-value PA. Most states with gold carding programs, which exempt physicians from PA requirements based on previous approval records, use a 90% threshold. 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 amending the reporting requirement accordingly.

Adverse Determinations

- **52.07(7) –** in addition to the criteria listed in this section to be included in a written notice of an adverse determination, we strongly recommend inclusion of a providers NPI and credentials. Including this information promotes transparency, ensures accountability, and allows treating physicians to meaningfully evaluate whether the determination was made by an appropriately qualified clinical peer.

- **52.07(8) –** requires that the reconsideration process for an adverse determination occur within one working day of the receipt of the request and be conducted by the treating Provider and the Clinical Peer Reviewer, or a designee, within one working day. While we appreciate the intent to expedite reconsiderations and resolve disputes promptly, this timeframe is impracticable in many clinical settings. We appreciate timeframes to expedite processes to ensure timely resolution of adverse determinations, but in practice, physicians are often unable to accommodate scheduling within one working day, especially when calls come during patient visits. Physicians often have full patient schedules and limited availability for same-day or next-day peer-to-peer discussions. Rigid timeframes may inadvertently create procedure noncompliance despite good faith efforts by providers to participate. We would recommend additional flexibility to require that reconsideration be conducted between the provider and the peer reviewer within one working day if practicable but otherwise shall be scheduled within one working day to occur within a reasonable timeframe that accommodates the physician's clinical obligations.

ePA - Automation and Technology Standards

- **52.07(15) –** this section authorizes carriers/UROs to implement and maintain an Application Programming Interface (API) for automated processing of PA requests. We strongly recommend that adoption of an API for automated processing of PAs be mandatory rather than merely allowed. Similar Centers for Medicare & Medicaid Services (CMS) reporting requirements will go into effect in 2026; hence, carriers in Massachusetts will largely be subject to those standards. Aligning DOI regulations with CMS requirements will reduce administrative complexities and confusion. With respect to subsection (c), we recommend the language authorize carriers to use financial incentives to encourage providers to participate, rather than to require participation. 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. Lastly, the language should more clearly distinguish between PA standards applicable to PA for medical services and those applicable for prescription drug benefits. Subsections (a) and (b) should explicitly delineate these categories to avoid ambiguity and ensure technical compliance. Respectively. We recommend the following revisions:

- **52.07(15)(a) (*medical services*):** No later than January 1, 2027, a health insurer must have and maintain a prospective review application programming interface (API) that automates the prospective review process for providers to determine whether a prospective review is required for health care services, identify prospective review information and documentation requirements, and facilitate the exchange of prospective review requests and determination from its electronic health records or practice management systems. The API must use the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard in accordance with 45 CFR 170.215(a)(1).

- **52.07(15)(b) (*prescription benefit*):** No later than January 1, 2027, a health insurer must accept and respond to prospective review requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement 45 CFR 170.215(a)(1).

Provider Contracts

- **52.11(1)** – the Medical Society supports and strongly reinforces the comments offered by the Massachusetts Health & Hospital Association pertaining to this section, particularly in regard to 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 supports MHA's recommendation to remove the term "upcoding" and to work with payors and providers to establish consensus definitions and protect providers when there are disagreements.

- **52.11(19), (20)** – this subsection requires clear contractual notice to providers regarding the obligation to retain appropriate medical necessity records for at least 2 years for the purposes of fraud, waste, or abuse audits conducted by carriers. We respectfully request clarification of how the Division defines "medical necessity records." Currently, clinicians are required to maintain a patient's medical records for 7 years. It is unclear whether "medical necessity records" are intended to be distinct from a patient's medical record. It is imperative that this section not be interpreted to create new or duplicative record keeping requirements for clinicians. Moreover, we recommend limiting retrospective audit authority to 1 year, consistent with statutory limitations on retrospective denials for behavioral health and substance use disorder claims (per Chapter 41 of the Acts of 2019). A shorter audit window would reduce prolonged financial uncertainty for physician practices while still preserving carriers' ability to identify 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 additional language to require carriers to provide clear notice to providers about the appeals process to appeal claim denial.

We stand ready to work with the Division to ensure these reforms translate into real-world improvements for patients and physicians and restore balance to the prior authorization process. Thank you for your continued leadership on this issue and for your consideration of our comments. For any questions, please contact Leda Anderson, Director of Advocacy & Government Relations, at landerson@mms.org and Yael Miller, Executive Director, Practice Solutions & Strategic Planning, at ymiller@mms.org.