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COMMONWEALTH OF MASSACHUSETTS

DIVISION OF INSURANCE

DOI Docket No. G2026-01

Proposed Amendments to 211 CMR 52.00

COMMENT LETTER OF THE MASSACHUSETTS HEALTH DATA CONSORTIUM (MHDC)

Re: Prior Authorization Modernization and Standards-Based Electronic Prior Authorization

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Submitted via: doidocket.mailbox@mass.gov (per Notice of Hearing instructions)

MHDC contact: Denny Brennan, President and Executive Director, Massachusetts Health Data Consortium

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Commissioner Caljouw and DOI colleagues:

The Massachusetts Health Data Consortium (MHDC) appreciates the opportunity to provide comments on the Division of Insurance's proposed amendments to 211 CMR 52.00 in DOI Docket No. G2026-01. MHDC supports DOI's stated objectives to standardize and streamline prior authorization (PA) practices; improve consistency and predictability for consumers; address unnecessary prior authorizations; and reduce administrative costs in the health care system.

MHDC's central recommendation is that Massachusetts should pair policy reform (eliminating low-value PA, strengthening timeliness and continuity protections, and improving transparency) with a standards-based digital modernization strategy explicitly aligned with the federal interoperability baseline established by the CMS Interoperability & Prior Authorization Final Rule (CMS-0057-F). Alignment to CMS-0057-F is essential to avoid creating a Massachusetts-specific "one off" that increases burden for providers and payers operating across multiple markets, and to leverage the national vendor ecosystem converging on a common set of standards.

At the same time, modernization must be implemented in a way that strengthens—rather than dilutes—Massachusetts' consumer protection framework. Administrative simplification for providers is a critical goal, but it must not be achieved by shifting costs or risk to patients. A streamlined PA process that

results in more patient delays, more out-of-network routing, more opaque denials, or more post-service billing exposure is not simplification in practice—it is cost shifting. DOI should therefore ensure that consumer protections remain explicit guardrails for how any electronic PA approach is designed, operated, and enforced.

MASSACHUSETTS HAS A STRONG FOUNDATION—AND NOW NEEDS AN EXPLICIT COMPUTABLE EXCHANGE REQUIREMENT

Massachusetts already has unusually strong levers for PA standardization and accountability, including deemed approval consequences associated with timely responses and robust adverse determination notice requirements. These baseline protections are an important foundation for modernization.

However, modernization will not be fully realized if the Commonwealth's "uniform" standard remains anchored to a paper artifact (including a standardized two-page paper form). A paper form—even when standardized—does not scale to modern workflows, cannot reliably support automation, and cannot produce the computable data needed for measurement, transparency, and enforcement.

MHDC therefore recommends DOI move Massachusetts from **"uniform forms" to "uniform transactions"** by requiring that PA requests and responses be conducted through a **required computable exchange**—a structured, machine-readable transaction that supports automated workflows, standardized status and decision reporting, and reliable performance measurement. In practical terms, Massachusetts can continue to define a uniform dataset and required fields, but the required implementation should be a computable exchange (not a 2-page paper form that is scanned, faxed, re-keyed, or manually processed).

NEHEN-FHIR SHOULD BE RECOGNIZED AS THE STATE-BASED MECHANISM FOR AUTOMATED PRIOR AUTHORIZATION

To operationalize standards-based electronic prior authorization at scale across carriers and providers, MHDC recommends DOI recognize **NEHEN-FHIR as the Massachusetts state-based mechanism for automated prior authorization**.

This recommendation is intended to provide **a clear, statewide implementation pathway** that supports interoperability and automation consistent with CMS-0057-F and HL7 Da Vinci implementation guides (CRD, DTR, PAS). A state-based mechanism can also support consistent onboarding practices, conformance expectations, and measurable performance across carriers, while enabling providers and their EHR vendors to integrate PA into clinical workflows rather than relying on portals, phone/fax, or duplicative manual processes.

DOI should be explicit that "NEHEN" does not refer to a single exchange. **NEHEN-EDI and NEHEN-FHIR are separate exchanges with distinct purposes and technical capabilities.** NEHEN-EDI supports EDI exchange for X12 administrative transactions (e.g., claims and related transactions). **NEHEN-FHIR is a distinct FHIR-based exchange designed to support modern, API-enabled interoperability, including automated prior authorization.** Conflating these pathways risks selecting an implementation approach that cannot support the workflow-integrated automation Massachusetts is seeking.

Accordingly, MHDC recommends DOI require that carriers support electronic PA through NEHEN-FHIR (or a functionally equivalent FHIR-based mechanism) as the baseline for automated PA—while acknowledging that NEHEN-EDI remains relevant for EDI transactions outside the scope of automated PA workflows.

STANDARDS ALIGNMENT: FHIR R4.0.1 BASELINE AND DA VINCI CRD/DTR/PAS

CMS-0057-F establishes a national baseline for electronic PA modernization. As reflected in CMS-0057-F, **impacted payers must implement and maintain FHIR-based APIs (including a Prior Authorization API)** and meet operational requirements related to timeliness, specificity in denial reasons, and public reporting of key PA metrics.

For Massachusetts, the most important implementation consequence is that DOI should align state requirements to the same foundational standards and workflow patterns:

- **HL7 FHIR R4.0.1** as the baseline version for payer APIs and electronic PA exchange; and
- the **HL7 Da Vinci implementation guides** that support end-to-end workflow integration:
  - **CRD (Coverage Requirements Discovery)** to make coverage rules and PA requirements discoverable at the point of ordering;
  - **DTR (Documentation Templates and Rules)** to enable structured documentation capture using FHIR Questionnaires (and associated logic where applicable); and
  - **PAS (Prior Authorization Support)** to structure the PA request/response exchange so that determinations, statuses, and required documentation are computable and interoperable.

In MHDC's view, the highest-value outcome from adopting these standards is not merely electronic submission; it is workflow integration that prevents unnecessary PA requests, reduces "missing documentation" deferrals, and produces computable data to support oversight and improvement.

PATIENT PROTECTION: SIMPLIFICATION MUST NOT SHIFT COSTS TO PATIENTS

MHDC urges DOI to make explicit that administrative simplification and modernization must not shift costs to patients. In practice, cost shifting can occur when PA processes create predictable delays in care, force avoidable out-of-network pathways, or increase the likelihood that patients receive bills because a payer's requirements were not discoverable, not communicated clearly, or were operationalized through manual friction rather than structured exchange.

DOI should therefore ensure that any electronic PA approach—particularly one positioned as "simplification"—includes enforceable guardrails such as:

- PA requirements and documentation rules must be **computably discoverable** and **transactionally supported**, so that providers can comply without manual re-entry or portal-only workflows.
- Carriers must not use process design (including restrictive onboarding terms, fees, or operational constraints) to create barriers that "materially discourage" appropriate exchange and compliance.
- Where payer operational failures contribute to delays or avoidable deferrals, those failures should not translate into patient financial exposure.
- Electronic PA must not become "electronic submission followed by manual redirect to phone/fax," except during defined downtime or contingency circumstances.

These protections are essential to ensure the Commonwealth's modernization objectives translate into improved patient access and predictability—not merely administrative rearrangement.

DENIAL TRANSPARENCY MUST BE COMPUTABLE—AND MUST DISTINGUISH PA DENIALS FROM CLAIMS DENIALS

MHDC supports DOI's emphasis on requiring specific denial reasons and strengthening transparency. However, DOI's regulatory approach should also ensure that denial transparency is both (a) meaningful to providers and consumers and (b) computable for measurement and oversight.

MHDC recommends DOI require that PA determinations include:

- a narrative **clinical explanation** appropriate for consumer and provider understanding;
- a standardized **PA decision disposition** (e.g., approved, denied, partially approved, pended for additional information, withdrawn); and
- a standardized **PA denial rationale category** (e.g., medical necessity criteria not met; benefit not covered; incomplete documentation; administrative/format error; duplicate request; non-network/site-of-service; step therapy/alternatives; safety/contraindication; experimental/investigational).

DOI should also clearly distinguish, in both regulatory text and reporting requirements, between **prior authorization denials** and **claims denials**:

- **Prior authorization denials** are pre-service utilization management decisions about whether a proposed service will be authorized. These should be communicated through the PA exchange (e.g., PAS-aligned responses) with computable disposition and PA-specific rationale categories plus narrative explanation.
- **Claims denials** are post-service payment adjudication outcomes after a claim is submitted. Claims denials frequently use claims-adjudication code sets and reflect billing/payment logic that is not the same as PA decisioning.

These are different decision points with different remediation pathways. Conflating them undermines transparency, impairs corrective action, and reduces the Commonwealth's ability to target oversight and improvement. Reporting and analytics should therefore treat PA denials and claims denials as distinct categories with distinct code structures and accountability mechanisms.

REPORTING AND ACCOUNTABILITY: MEASURABLE ELECTRONIC PA REQUIRES COMPUTABLE DATA

To ensure that modernization delivers measurable results, MHDC recommends DOI require public reporting in a machine-readable format that supports comparison and accountability across carriers. At a minimum, reporting should include:

- **total PA requests** (stratified by standard/expedited and any urgent categories recognized by DOI);
- **approval and denial rates**;
- **median and average turnaround times**;
- **percent computably electronic submission and response (FHIR-based exchange) versus manual modalities;**
- **deferrals for missing documentation and subsequent outcomes;**

- **appeal rates and appeal overturn rates;**
- **top coded PA denial reasons (disposition + PA rationale category); and**
- **a comprehensive PA list with a date-stamped change log (additions/removals and rationale).**

This reporting framework reinforces that the objective is not merely digitizing intake, but enabling measurable improvements in timeliness, appropriateness, predictability, and burden reduction.

RECOMMENDED REGULATORY CONCEPTS FOR 211 CMR 52.00

MHDC recognizes that DOI will determine the appropriate drafting structure within 211 CMR 52.00. To support enforceable modernization, MHDC recommends DOI incorporate concepts along the following lines within utilization review and PA-related provisions:

1. **Required computable exchange (replace paper form as the standard):**

   Carriers that require PA must support PA requests and responses through a computable, machine-readable exchange aligned with CMS-0057-F and HL7 Da Vinci PAS (FHIR R4.0.1 baseline). The "uniform" standard should be expressed as required data elements and transaction requirements—not a paper form.

2. **State-based mechanism for automated PA:**

   Recognize **NEHEN-FHIR** as the Massachusetts state-based mechanism for automated prior authorization and require carriers to support exchange through NEHEN-FHIR (or a functionally equivalent FHIR-based mechanism), including nondiscriminatory onboarding and published conformance documentation.

3. **Workflow integration expectations:**

   Require support for CRD/DTR/PAS patterns so PA requirements are computably discoverable at ordering time and documentation can be captured in structured form, reducing avoidable deferrals and resubmissions.

4. **Denial clarity and domain separation:**

   Require both narrative and computable PA denial outputs and require explicit labeling and reporting that distinguishes **PA denials** from **claims denials**.

5. **No cost-shift guardrails:**

   Require that modernization and simplification must not increase patient financial exposure through avoidable delays, administrative barriers, or restrictive access terms.

CLOSING

MHDC appreciates DOI's leadership in pursuing prior authorization modernization and respectfully urges DOI to ensure that the final amendments to 211 CMR 52.00 pair strong consumer protections with a clear, standards-based digital pathway that can scale across the Massachusetts market. In MHDC's view, recognizing NEHEN-FHIR as the state-based mechanism for automated prior authorization—together with a required computable exchange aligned to CMS-0057-F and HL7 Da Vinci CRD/DTR/PAS—offers a practical and interoperable approach that can reduce administrative burden while improving predictability and access for patients.

Respectfully submitted,

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