To: Commissioner of the Division of Insurance
Re: Proposed Amendments to 211 CMR 52.00 (Prior Authorization)
DOI Docket No. G2026-01

Comments of the Home Care Alliance of Massachusetts

On behalf of the Home Care Alliance of Massachusetts (HCA) and its more than 200 provider members—including home health, home care, and hospice organizations, we appreciate the opportunity to provide comments on the Division of Insurance's proposed amendments to 211 CMR 52.00. These comments are informed primarily by HCA's Medicare-certified home health agency members, which collectively serve more than 110,000 patients each year across urban, suburban, and rural communities throughout the Commonwealth.

Our members provide critical, skilled, and compassionate care to individuals of all ages, supporting recovery at home, management of chronic and complex conditions, and avoiding unnecessary hospitalization or institutional care. The policies outlined in the proposed amendments have direct and significant implications for patient access to timely services, continuity of care, and the ability of home-based providers to deliver safe and effective care in the community.

HCA strongly supports the stated purposes of the proposed amendments, as outlined in the public hearing notice: to standardize and streamline health insurers' prior authorization practices, enhance consistency and predictability for consumers, address unnecessary prior authorizations, and reduce administrative costs across the health care system. These objectives closely align with the operational realities of home-based care delivery and the needs of patients who require prompt access to medically necessary services.

Alignment with the Division's Prior Authorization Examination

HCA appreciates that the proposed amendments to 211 CMR 52.00 are grounded in the Division's examination of insurer prior authorization practices conducted in 2023 and 2024. The findings of that examination reflect what providers experience daily, including substantial variation in prior authorization requirements among carriers, growth in the number of services subject to authorization, and approval rates exceeding 90 percent for many services.

These findings underscore that prior authorization is frequently applied in ways that generate administrative burden without commensurate clinical value or program integrity assurances. HCA commends the Division for advancing evidence-based reforms in response to these conclusions.

Home Health Agency Experience with Prior Authorization Requirements

To better understand the operational impact of prior authorization requirements, HCA conducted a rapid survey of Massachusetts home health agencies in February 2026. While not intended to be exhaustive, the survey responses were highly consistent and reinforce that the challenges associated with prior authorization are systemic rather than isolated.

Agencies reported that prior authorization requirements remain highly inconsistent across payers and continue to create avoidable administrative burden and disruptions to patient care. Respondents consistently identified delays in care initiation, particularly around weekends and holidays, as well as challenges related to inconsistent approval timelines, frequent and unnecessary reauthorization requirements, payer portal limitations, and the lack of meaningful retroactive approval mechanisms. Collectively, these issues increase administrative burden, create financial risk for providers, and delay access to medically necessary home-based services.

HCA strongly supports the proposed requirement for automatic continuity-of-care authorizations of at least three months. For home health and hospice providers, this is particularly important because services are often initiated immediately following hospital discharge and may span changes in coverage, benefit periods, or plan administration. Automatic continuity-of-care authorizations help prevent unnecessary disruptions to active episodes of care, reduce administrative churn, and protect patients from delays or gaps in medically necessary services once care has already begun.

Support for Elimination of Prospective Review for Post-Acute Care Services Provided on Weekends or Holidays, and Considerations Specific to Home Health

HCA strongly supports the proposed amendment to 211 CMR 52.00 that would prohibit carriers and utilization review organizations from requiring prospective review for post-acute care services provided on weekends or holidays to insured individuals in network. This provision addresses a significant source of delay in hospital-to-home transitions and is of particular importance to home health and hospice providers.

In addition, HCA respectfully urges the Division to recognize that home health services are fundamentally different from other post-acute care settings, and that prospective review requirements pose unique challenges for home health agencies regardless of when a referral is received.

Home health services are delivered in patients' homes—an inherently uncontrolled environment where psychosocial, environmental, and family dynamics play a substantial role in determining the scope, frequency, and intensity of services required. At the time of referral, the ordering provider may have limited visibility into these factors, which can significantly affect the ability of the home health agency to safely and effectively implement the ordered plan of care.

Unlike facility-based post-acute settings, home health agencies must first assess the patient in the home to identify environmental safety risks, caregiver availability, functional limitations, and psychosocial barriers that may necessitate modifications to the treatment plan. As a result, requiring prospective review based solely on referral information—before an in-home assessment can occur—does not accurately reflect the clinical realities of home-based care and can delay initiation of medically necessary services.

To address these challenges while preserving appropriate utilization review oversight, HCA recommends eliminating prospective review at the initiation of home health services and instead providing an initial, time-limited authorization period of approximately 10 to 14 days for all ordered disciplines. This approach would allow home health agencies to complete required in-home assessments and develop a clinically appropriate plan of care, after which standard utilization review processes could be applied based on complete and accurate information.

This model balances timely access to care with responsible oversight, supports safe and effective care delivery in the home, and advances the Division's goals of reducing unnecessary administrative burden while maintaining accountability within the health care system.

Importance of Home-Based Care in the Post-Acute Continuum

Home health and hospice providers are essential components of the post-acute care continuum and are frequently responsible for initiating services immediately following hospital discharge, **regardless of weekend admissions.** Home health agencies are required by regulation to begin services within 48 hours of discharge unless otherwise ordered. In complying with this 48-hour requirement, agencies may have to initiate care before authorization is finalized, making timely prior authorization determinations essential to prevent services from being delivered that may ultimately not be authorized. Hospice services are commonly initiated in response to urgent changes in patient condition or goals of care.

Need to Explicitly Define "Post-Acute Providers"

While HCA supports the elimination of prior authorization for post-acute care services provided on weekends or holidays, we respectfully recommend that the final amendments to 211 CMR 52.00 explicitly define the term post-acute providers. As currently drafted, references to post-acute care are broad and undefined, creating uncertainty regarding which provider types are intended to be included.

Absent a clear definition, there is a substantial risk that home health agencies—and potentially hospice providers—could be excluded from key reforms due to narrow or inconsistent payer interpretation. Historically, the term "post-acute care" has at times been applied primarily to institutional settings, despite the central role of home-based care in post-hospital recovery and system capacity.

To ensure consistent application and to fully achieve the Division's stated goals, HCA recommends that the final regulations specify that post-acute providers include, at a minimum:

- Medicare-certified and MassHealth-enrolled home health agencies
- Hospice providers
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Long-term acute care hospitals
- Other providers delivering medically necessary services following an acute hospital stay

Explicit inclusion of home health agencies is essential to ensure that prior authorization reforms apply equitably across care settings and support timely access to services delivered in the home.

Conclusion

HCA commends the Division for advancing thoughtful, evidence-based reforms through the proposed amendments to 211 CMR 52.00 and for recognizing the administrative and clinical burden imposed by current prior authorization practices. With the addition of a clear definition of post-acute providers and limited, time-bound flexibility around prospective review for home health services, the proposed amendments will more fully achieve their intended purpose of improving access, reducing administrative inefficiencies, and supporting patient-centered care across the Commonwealth.

HCA appreciates the opportunity to provide comments and welcomes continued engagement with the Division as these amendments are finalized.

Respectfully submitted,

Jake Krilovich
Chief Executive Officer
Home Care Alliance of Massachusetts