Maryland
Hospital Association

July 23, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
Chair, Workgroup to Study the Rise in Adverse Decisions
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Pamela Beidle:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, we appreciate the opportunity to comment on the questions raised at the July 9 meeting of the Workgroup to Study the Rise in Adverse Decisions.

Hospitals continue to experience a significant increase in payer denials that delay medically necessary care, increase administrative burden, and create financial uncertainty for providers and patients alike. Between 2019 and 2024, the total dollars denied for care in Maryland hospitals rose by 47%, an increase of approximately $166 million. In 2024, one in every eight inpatient hospital claims experienced a denial. More than half of adverse decisions appealed to the state have historically been overturned, suggesting that there are opportunities to strengthen oversight of utilization review practices and improve the accuracy of initial coverage determinations.[1]

Data on denials should not be collected solely for reporting purposes; it should also serve as a tool for the Maryland Insurance Administration (MIA), Maryland Department of Health (MDH), Health Services Cost Review Commission (HSCRC) and policymakers. By systematically reviewing trends in denials and appeals across payers, state agencies can identify systemic issues, evaluate utilization review practices, and implement targeted regulatory and policy changes to improve accountability, reduce inappropriate denials, and enhance patient access to care. MHA offers the following comments for the Workgroup's consideration as it prepares recommendations to improve reporting on—and reduce the number of—adverse decisions.

Enhanced Data Collection

MHA strongly supports robust data collection on adverse decisions to understand the scope of these practices and inform effective oversight. Limiting data collection and reporting to appeals and denials related to medical necessity, however, provides an incomplete picture of the barriers patients and providers face in accessing and delivering care as adverse decisions represent only a fraction of all denials. Therefore, we encourage the state to consider broadening its data

[1] Maryland Hospital Association, "Preserve Access and Affordability for Maryland Patients," March 2026, mhaonline.org/index.php?pda_v3_pf=/_pda/2026/03/Preserve-Access-and-Affordability-for-MarylandPatients.pdf.

collection framework to capture the full spectrum of denials including administrative and partial denials, in addition to denials for medical necessity. A more comprehensive and standardized dataset would enable policymakers and other stakeholders to better understand the prevalence and drivers of denials across payers, identify opportunities to reduce unnecessary administrative burden, assess the impact of denials on patient access and outcomes, and develop more targeted, evidence-based policy solutions.

The reporting elements included in this data collection framework should be sufficiently broad to help stakeholders identify and understand trends in denials and utilization review practices. Key data elements include the responsible payer, initial denial date, site of care, service category, time to initial determination, and most importantly, the reason for denial. The framework could also capture data on review type (prior authorization, concurrent review, retrospective review) and information on appeals including the reason for appeal, appeal outcome, and time to appeal decision. Importantly, for consistency, these reporting requirements should be aligned with other state data collection efforts, including those of the Maryland Health Care Commission (MHCC) and HSCRC to the extent possible.

MHA supports expanding medical service categories that commercial carriers are required to submit to MIA in future appeals and grievance reports to include post-acute service categories, including skilled nursing facilities, inpatient rehabilitation facilities, inpatient mental and behavioral health, and inpatient substance use treatment services. We also recommend MIA consider including reporting on outpatient service categories in future iterations of the report.

We encourage MIA to consider whether it or another agency is best positioned to collect and report on this more comprehensive set of data on denials beyond adverse decisions. Regardless of the lead agency, it will be important to ensure that the data is collected and reported on a regular basis and in a timely manner, standardized across payers, and organized in a way that is understandable to the public. To support these aims, we suggest including the data in a publicly accessible dashboard that allows consumers, providers, and policymakers to monitor trends in denials across payers and evaluate the impact of policy reforms in real time.

Standardized Utilization Review Practices

MHA recommends consideration of standardized utilization review practices, including prior authorization requirements, that apply to all payers to address the issues described below.

Medicaid Managed Care Organizations: Medicaid MCO denials and utilization review practices are a significant challenge for Maryland hospitals that strain operations and create unnecessary barriers for patients seeking timely access to care. MCOs and their contracted vendors apply standards and procedures that produce inaccurate findings and impose inconsistent and unreasonable timelines and opportunities for review. Audit vendors are engaging in algorithm-based denials and pre-payment audits that delay reimbursement and apply criteria that are inconsistent with Maryland regulatory standards.[2] To address these concerns, MHA requested

[2] Members reported that audits have denied payment for medical or surgical supplies citing non-compliance with CMS regulations; however, in Maryland, hospitals are required to comply with HSCRC regulations, as reaffirmed in the March 2026 HSCRC Memorandum: Denial of Payments for Billable Medical Supplies & Drugs in Maryland.

that MDH establish and consistently communicate uniform audit and billing standards, including clear oversight, escalation pathways, and full vendor compliance with state guidelines.

Hospitals also face significant discharge planning delays due to slow Medicaid MCO approvals for post-acute services, including skilled nursing facilities, rehabilitation, and home health care. As a result, patients who are clinically ready for discharge remain in the hospital while awaiting authorization, a challenge documented in MHCC's July 2026 report on post-acute care.[3] They result in avoidable inpatient stays that strain hospital capacity, disrupt patient flow, and increase uncompensated care costs. Requiring MCO determinations for prior authorization requests within 48 hours would avoid workflow disruptions and ensure that hospitals are not left to absorb the financial and operational consequences of delayed MCO decision-making.

Medicare Advantage: In recent years, Maryland hospitals have experienced a troubling and persistent increase in inappropriate and excessive Medicare Advantage denials. From FY 2019 to FY 2024, medical necessity denials for MA plans in Maryland increased by 233%, delaying patients' access to timely care and imposing significant administrative and financial burden on hospitals. The new Medicare Advantage stabilization program established by the state's multi-agency Regulatory Working Group will reduce hospital costs for qualified plans beginning in 2027. This provides an opportunity to ensure that plans receiving state-funded subsidies are adhering to reasonable utilization review standards, including compliance with benchmarks for medical necessity determinations, prior authorization processes, and minimal rates of prior authorization and claims denials.

Uniform Prior Authorization Standards: Maryland has taken important steps to improve the prior authorization process for patients and providers through the enactment of SB 791/Chapter 848 HB 932/Chapters 847 of 2024, which established greater transparency, timeliness, accountability, and electronic prior authorization requirements for commercial carriers. To promote a more consistent and equitable utilization review process, MHA recommends the state explore opportunities to extend comparable prior authorization standards across all payers, including Medicaid MCOs and Medicare Advantage plans, to the greatest extent permitted by state and federal law. Establishing uniform prior authorization requirements—including consistent decision timelines, continuity of care protections, and transparency and reporting requirements—would reduce administrative complexity for providers, improve patient experience, and ensure more equitable access to medically necessary care for Marylanders regardless of coverage type.

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Enhanced data collection and reporting will help improve transparency of and accountability for denials across payers. A comprehensive reporting framework should enable regulators and policymakers to identify outlier payers, evaluate utilization review reforms, monitor trends in patient access, and support future regulatory and legislative action to reduce unnecessary administrative burden and protect timely access to medically necessary care.

[3] "Strengthening Post-Acute Care towards Meeting the Goals of AHEAD," Maryland Health Care Commission, 2026, mhcc.maryland.gov/sites/default/files/documents/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

Thank you for the opportunity to comment and for your efforts to address this important issue affecting hospitals and the patients they care for. MHA looks forward to continuing to work collaboratively with MIA, HSCRC, and members of the Workgroup to Study the Rise in Adverse Decisions as it develops its recommendations in the coming months.

Sincerely,

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