Maryland
Hospital Association

September 3, 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 Chair Beidle:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, we appreciate the opportunity to comment on the topics covered during the Aug. 20 meeting of the Workgroup to Study the Rise in Adverse Decisions (Workgroup). The suggestions and recommendations discussed at the meeting reflect many of the concerns raised by MHA and other stakeholders, including the need for comprehensive data collection and reporting and greater transparency into payer utilization review practices.

Improving reporting on adverse decisions and reducing their frequency are critical to protecting patients' access to medically necessary care. These efforts should be part of a broader strategy to address inappropriate denials through greater transparency and stronger oversight of utilization review practices.

MHA offers the following comments for consideration as the Workgroup prepares its report to the General Assembly. These comments supplement those offered in MHA's July 23 letter to the Workgroup.

Strengthen Data Collection and Reporting

MHA supports strengthening data collection and transparency around adverse decisions, including through the Maryland Insurance Administration's (MIA) annual report on appeals and grievances. In particular, the high rate at which adverse decisions are overturned—49.9% of those challenged through the grievance process in 2024—underscores the importance of understanding why these decisions were ultimately reversed.[1] Future reporting should provide insight into why decisions are reversed, including whether reversals result from the submission of new information, reconsideration of the clinical evidence or criteria, or other factors. Understanding the reasons for reversals can help identify opportunities to improve the accuracy of initial coverage determinations and inform effective oversight of utilization review practices.

[1] Maryland Insurance Administration. Health Care Appeals & Grievance Law 2024 Report, available here

Adverse decisions represent only a fraction of the denials that affect patients' access to care. To provide a more complete picture of denial activity, we respectfully encourage the state to develop a comprehensive, standardized data framework that captures administrative and partial denials, as well as those related to medical necessity. This data would complement existing and planned reporting efforts and provide a more complete picture of denials and their impact on patient access and outcomes. It would also help stakeholders better understand trends in denials and utilization review and support data-driven policies to reduce denials.

Additionally, as part of broader efforts to improve access to care, we encourage the state to examine denials trends in other states, particularly those demonstrating comparatively lower rates, and assess the factors that may be contributing to those differences. This analysis should consider whether specific statutory or regulatory requirements, oversight approaches, utilization review reforms, or other policies have reduced avoidable denials. This could help Maryland identify promising strategies and inform future efforts to reduce unnecessary denials and associated administrative burden.

Enhance and Standardize Prior Authorization Practices

MHA urges the state to standardize utilization review practices, including prior authorization requirements, that apply to all payers. Maryland has made important progress by establishing stronger requirements around the transparency, timeliness, and administration of prior authorization for commercial carriers. We ask the state to extend comparable standards to Medicaid managed care organizations (MCOs) and Medicare Advantage plans where possible to reduce administrative complexity for providers, improve patient experience, and ensure equitable access to care regardless of coverage type.

Greater accountability for timely prior authorization decisions should be a central component of these efforts as delays can postpone medically necessary care, impede timely transitions to post-acute settings, and create significant operational and administrative burden for providers. MHA supports requiring prior authorization determinations within 48 hours for non-urgent requests and 24 hours for urgent requests. As noted in our prior letter, this is of particular importance for prior authorization requests for post-acute services given the impact of slow approvals on hospital discharge planning delays and avoidable inpatient stays. We also recommend that the state require prior authorization requests to be deemed approved if a payer fails to respond within the required timeframe: an approach adopted by other states, as discussed at a prior Workgroup meeting.[2] Such a requirement would help ensure that payer inaction does not delay medically necessary care.

In addition, MHA urges the state to adopt a gold carding policy that exempts qualifying providers with consistently high prior authorization approval rates from these requirements for applicable services. Requiring providers to repeatedly obtain prior authorization for routinely approved services diverts clinicians and staff from patient care, increases administrative expenses, and can delay treatment while requests are being processed. Gold carding would align oversight with demonstrated performance by reducing unnecessary review for providers whose

[2] Mental Health Association of Maryland's July 30, 2026 Presentation to the Workgroup, available here

prior authorization decisions consistently reflect payers' approval standards, while preserving requirements for services where they are needed most.

Standards for State-Subsidized Medicare Advantage Plans

The Centers for Medicare and Medicaid Services (CMS), through the AHEAD Model State Agreement, authorized the state to advance policies to support the stabilization of Maryland's Medicare Advantage market. Using this authority, the multi-agency Regulatory Working Group established a policy that provides qualifying Medicare Advantage plans a discount on hospital rates approved by the Health Services Cost Review Commission (HSCRC) starting in 2027.[3]

As noted in our prior comments, the state should ensure Medicare Advantage plans that receive state-funded discounts under this program 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 claim denials. The state could condition eligibility for state support under this program on utilization review standards in the same way that, under the current policy, qualifying plans must have at least 3.5 stars in the Medicare Stars quality program and cover a certain number of beneficiaries residing in select jurisdictions in the state.[4, 5] In doing so, the state would *not* be establishing new standards on all plans offered in the state but only for plans offered by carriers that choose to participate in the program. Good payer practices and reasonable utilization review standards are necessary to maintain and increase beneficiary participation in Medicare Advantage plans in the state.

These standards should include timely access to peer-to-peer review as this would improve the utilization review process and reduce unnecessary denials. Direct discussions between clinicians can help ensure that decisions are informed by individual clinical circumstances, allow providers to clarify information that may not be fully reflected in the medical record, and resolve questions before they result in adverse decisions and other denials, supporting clinically informed and efficient decision-making in the utilization review process.

Artificial Intelligence in Utilization Review

Discussions at prior Workgroup meetings have also highlighted the need for greater transparency about the use of artificial intelligence (AI) in utilization review and whether its use is contributing to the significant rise in denials in recent years. Clarity on how and where in the utilization process AI is being used will help determine whether these technologies are being used appropriately or if additional oversight may be warranted. It is critically important to understand whether payers are using AI to identify claims for review, apply clinical criteria, recommend or make coverage determinations, or support other components of utilization review.

MHA agrees that all adverse decisions must be made by a physician and that carriers must identify whether AI, an algorithm, or another software tool was used to make an adverse decision in the data they submit quarterly to MIA. We also recognize that Chapter 747 of 2025 (House Bill 820) established important standards governing the use of AI in utilization review for

[3] Approved AHEAD Regulatory Working Group Proposal on Cost-Shifting and Medicare Advantage, available here
[4] The established criteria for "Qualified Plans" are further described on pgs. 17-18 of the approved policy
[5] While qualified plans for CY 2027 have already been selected, these standards could apply in future years

carriers and explicitly prohibits AI from denying, delaying, or modifying health care services. However, these requirements do not extend to Medicaid MCOs. While we understand that there are broad AI governance requirements in HealthChoice MCO agreements, we urge the state to consider extending utilization review-specific AI protections such as those established under Chapter 747 to Medicaid MCOs.

Use of Clinical Criteria in Utilization Review

Clinical criteria are intended to promote consistent, evidence-based decision-making in utilization review. Audits can provide an important mechanism to identify instances in which clinical criteria are not being applied correctly or consistently, which can result in inappropriate denials or delays in care. When audits reveal recurring or systemic issues, effective enforcement levers must be in place and used to ensure issues are addressed through appropriate corrective action. This is essential to promote greater consistency in utilization review practices, reduce administrative burden, and avoid delays in patient care.

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MHA appreciates the Workgroup's efforts to translate the robust discussion among stakeholders over the past several months into actionable recommendations. We encourage the state to consider opportunities to reduce adverse decisions and inappropriate denials more broadly to protect patients' access to medically necessary care.

Thank you for the opportunity to comment and for your continued attention to this important matter. MHA looks forward to continuing to work collaboratively with MIA, HSCRC, MDH, and members of the Workgroup as it develops its recommendations.

Sincerely,

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cc: Marie Grant, Insurance Commissioner, MIA
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