



Maryland
Hospital Association

October 19, 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, thank you for the opportunity to comment on the recommendations discussed at the Oct. 5 meeting of the Workgroup to Study the Rise in Adverse Decisions in the State Health Care System (Workgroup).

The recommendations under consideration reflect many of the suggestions made by MHA and other stakeholders, including the need for comprehensive data collection on denials and greater transparency into payer utilization review practices. MHA offers the following comments for consideration by the Workgroup as it prepares its report to the General Assembly, in addition to those offered in our July 23 and September 3 letters to the Workgroup.

MHA supports the recommendations to expand data collection and reporting on claims denials through the Medical Claims Data Base (MCDB), increase transparency around the clinical criteria payers use for prior authorization, and strengthen oversight through routine audits. MHA also supports establishing prior authorization standards for Medicare Advantage plans receiving subsidies under the state's stabilization program; extending federal electronic prior authorization requirements to commercial payers; and strengthening payer accountability through improved coordination, monitoring, and enforcement among state agencies.

We respectfully urge the Workgroup to go further in its recommendations and propose adoption of a gold carding policy, standardized response timelines for prior authorization requests, more transparency into the use of artificial intelligence in utilization review, and inclusion of information on the reason for overturned adverse decisions in future reporting.

Data Collection and Reporting

The Maryland Health Care Commission's (MHCC) adoption of regulations that allow for the collection of more comprehensive data on denials through Maryland's MCDB is an important step to ensure policymakers and other stakeholders have visibility into the fuller spectrum of denials not limited to adverse decisions related to medical necessity. In particular, we appreciate

that MHCC will collect information on the reason for denial as part of this effort as understanding why claims were denied is essential to identifying trends, evaluating payer practices, and informing targeted policy interventions. We also back MHCC's plans to publish periodic reports on the types of services denied and reasons for denials and coordinate with Maryland Medicaid to improve reporting on denied claims. In addition to these reports, the state should include this data in a public dashboard that allows stakeholders to monitor denial trends across payers and evaluate the impact of policy reforms in real time.

Transparency and Oversight of Clinical Criteria

MHA supports requiring public disclosure of the clinical criteria used by private review agents during the utilization review process on behalf of commercial insurers, pharmacy benefit managers, and Medicaid managed care organizations (MCOs). We are also supportive of the recommendation that the Maryland Insurance Administration (MIA) and Maryland Department of Health (MDH) conduct routine audits to assess compliance with these clinical criteria and identify overly restrictive utilization review practices. To promote transparency and payer accountability, we recommend MIA and MDH publish annual reports summarizing their audit findings.

As noted in our September letter, while audits help identify when clinical criteria are misapplied, resulting in inappropriate denials or delays in care, effective oversight requires enforcement when audits reveal recurring or systemic issues. To that end, we encourage the Workgroup to recommend clear corrective action and enforcement processes to ensure audit findings lead to meaningful improvements.

MDH's audits should include a review of the criteria Medicaid MCOs use to determine which emergency services qualify for automatic payment, as well as the standards applied to claims subject to additional review. Such a review would help identify overly restrictive or inconsistent criteria that may result in inappropriate payment delays or denials for medically necessary emergency care and ensure MCO payment practices align with the prudent layperson standard.

Medicare Advantage Stabilization Program Standards

MHA endorses the recommendation that the MIA and Health Services Cost Review Commission (HSCRC) explore conditioning eligibility for the state's Medicare Advantage (MA) stabilization program on compliance with prior authorization standards for post-acute care and applicable federal requirements beginning in 2028. We encourage the state to also consider ensuring qualifying MA plans receiving state subsidies adhere to broader utilization review standards including compliance with benchmarks for medical necessity determinations and minimal rates of prior authorization and claims denials. These standards should also include timely access to peer-to-peer review, allowing providers to discuss individual claims with payer medical reviewers before decisions result in unnecessary denials or delays in medically necessary care.

Federal Electronic Prior Authorization Requirements

MHA supports extending the application programming interface (API) requirements established under the Centers for Medicare & Medicaid Services' interoperability and prior authorization rule to Maryland's commercial payers by July 1, 2028. These requirements currently apply to certain

Medicare, Medicaid, and federal Exchange plans. Standardizing electronic prior authorization processes across payers could reduce administrative complexity for providers, improve the exchange of clinical information, and support more efficient authorization processes to ensure timely access to care.

Complaints and Appeals Process

MHA endorses the recommendation to simplify the complaints and appeals process for consumers and providers, including developing a uniform, plain-language appeal form and electronic process and improving alignment across state programs. The administrative burden associated with appealing adverse decisions and other denials can discourage providers and consumers from pursuing appeals, even when they believe a denial is inappropriate. Streamlining these processes could help ensure more denials are appropriately challenged and that patterns of inappropriate denials are identified. We also recommend MHCC, MIA, and Maryland Medicaid coordinate to identify payer outliers, understand the causes of variability in denial rates, and pursue enforcement where appropriate. Effective enforcement should remain a central component of these efforts to reduce inappropriate denials.

Gold Carding Policy

MHA urges the Workgroup to recommend adoption of a gold carding policy to reduce the administrative burden of prior authorization requirements, which can divert valuable resources away from direct patient care and delay medically necessary care.

Requiring repeated authorization for services that are routinely approved diverts clinicians from patient care, increases administrative burden, and can ultimately delay medically necessary care. Therefore, we support a gold carding policy that exempts qualifying providers with consistently high prior authorization approval rates from these requirements for applicable services. Such a policy would align oversight with demonstrated performance by reducing unnecessary review for providers whose prior authorization decisions consistently reflect payers' approval standards, while preserving requirements for services where they are needed most.

At least 10 states, including Colorado and Louisiana, have a gold carding policy that could inform Maryland's approach. Colorado requires insurers to establish programs that eliminate or substantially modify prior authorization requirements for qualifying providers based on adherence to evidence-based guidelines, quality, and other criteria. The law also allows for period reassessment of provider eligibility and public reporting on prior authorization exemptions.¹ Louisiana similarly requires insurers to implement programs that reduce prior authorization requirements based on provider performance and adherence to evidence-based guidelines but gives insurers discretion to determine eligibility criteria and covered services.²

At the Oct. 5 Workgroup meeting, concerns were raised regarding the administrative complexity of gold carding policies and potential unintended consequences for patient safety. These considerations can be addressed through a policy framework that includes well-defined

¹ [Colorado House Bill 1149 \(2024\)](#)

² [Louisiana Senate Bill 112 \(2022\)](#)

eligibility standards, periodic reassessment, routine monitoring, and reasonable reporting and compliance standards.

Timelines for Prior Authorization Response

We ask the Workgroup to further consider standardizing prior authorization timelines across payers and requiring future reports to include the reasons adverse decisions were overturned. These changes would promote timely coverage decisions and strengthen oversight.

Establishing standards that promote timely prior authorization decisions across all payers is critical to prevent unnecessary delays in medically necessary care. As noted in our September letter, MHA supports requiring prior authorization determinations within 48 hours for nonurgent requests and 24 hours for urgent requests, including weekends and holidays. We also favor requiring prior authorization requests to be deemed approved when a payer fails to respond within the required timeframe, which would help ensure that payer inaction does not delay medically necessary care and provide greater accountability for timely determinations.

These protections are particularly important for prior authorization requests for post-acute services given the impact of delayed approvals on hospital discharge planning delays and avoidable inpatient stays. Post-acute prior authorization standards should not be limited to qualifying Medicare Advantage plans under the state's stabilization program, and we ask the Workgroup to consider extending comparable standards across all payers.

Use of AI in Utilization Review

MHA encourages the Workgroup to advance a recommendation that would provide transparency into how artificial intelligence is used in utilization review and insight into whether it is the cause of the significant rise in payer denials in recent years.

MHA appreciates the Workgroup's continued consideration of the use of artificial intelligence (AI) in the utilization review process. Information on whether payers are using AI and automated tools to identify claims for review, apply clinical criteria, make coverage determinations, or perform other components of the utilization review practice would help determine whether these technologies are being used appropriately and if additional oversight may be warranted. As noted in our September letter, we also urge the state to consider extending the standards governing the use of AI in utilization review established by Chapter 747 of 2025 (House Bill 820) that are currently applicable to carriers to Medicaid MCOs.

Discussions at prior Workgroup meetings have also highlighted the importance of distinguishing how payers use AI in utilization review from how hospitals use it to support clinical documentation and administrative processes. Hospitals across the nation are using AI-enabled tools to improve clinical care and operational efficiency. These include ambient listening technologies that help clinicians capture and organize information from patient encounters, scheduling tools that optimize clinical operations, and algorithms to assist clinicians in interpreting medical images.³ Such applications can reduce administrative burdens, improve efficiency, and allow clinicians to devote more time to direct patient care.

³ February 2026 American Hospital Association response to HHS RFI on AI in Health Care, available [here](#)

At the Oct. 5 meeting, a question was raised about whether hospitals are using AI to facilitate inappropriate upcoding or inflate reimbursement. While hospitals use AI-assisted technologies to ensure the medical record more accurately reflects the care provided, they are not using these technologies to engage in improper billing practices such as upcoding. AI tools can help capture clinical information more completely to improve the accuracy of coding. However, AI-assisted clinical documentation remains subject to provider review and signoff, and certified medical coders are responsible for assigning codes based solely on the documentation in the medical record and applicable coding and billing standards.⁴ Federal and state law expressly prohibit providers from submitting false claims or reporting a diagnosis, service, or level of complexity not supported by the medical record to obtain higher reimbursement.^{5, 6}

Reporting on Overturned Adverse Decisions

As noted in our September letter, MIA's 2024 appeals and grievances report found that 49.9% of adverse decisions challenged through the grievance process were overturned. Future reporting should include information on why adverse decisions are overturned. Understanding whether these reversals result from new clinical information, reconsideration of existing evidence, application of clinical criteria, or other factors would provide important insight into the accuracy of initial coverage determinations. This information would complement the expanded denial reporting requirements and help regulators identify opportunities to improve utilization review practices and strengthen oversight.

MHA appreciates the Workgroup's efforts to reduce the number of adverse decisions and its consideration of our comments as it finalizes recommendations for its report to the General Assembly.

Given the complexity of these issues and the need to evaluate future reforms, MHA supports continuing the Workgroup's efforts beyond the submission of its final report. Continued collaboration among state agencies, hospitals and other providers, payers, and other stakeholders would provide an opportunity to assess progress and identify additional opportunities for improvement. MHA looks forward to continuing to partner with the Workgroup to protect patients' access to medically necessary care.

Sincerely,



Patrick D. Carlson
Vice President, Care Transformation & Finance

⁴ August 2026 American Hospital Association: Artificial Intelligence and Coding Intensity, available [here](#)

⁵ Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a); False Claims Act (31 U.S.C. §§ 3729–3733)

⁶ Maryland False Health Claims Act (Title 7; Subtitle 6 of the Health General Article)

cc: Marie Grant, Insurance Commissioner, MIA
Jamie Sexton, Associate Commissioner, External Affairs & Policy Initiatives, MIA
Janice Lepore, Chief, Policy and Government Affairs, HSCRC
Meghan Lynch, Director, Office of Government Affairs, MDH