Maryland
Hospital Association

Sept. 4, 2026

Marie Grant
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Re: MHA Responses to Questions from the Aug. 18, 2026 Clean Claims Public Meeting

Dear Commissioner Grant:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, thank you for the opportunity to provide additional comments regarding potential revisions to Maryland's clean claims regulations following the Maryland Insurance Administration's Aug.18 public meeting.

Timely and predictable claims payment supports hospitals' ability to maintain access to the services patients and communities rely on. Unnecessary delays and administrative burdens consume resources that could otherwise support clinical staff and patient care.

MHA recommends updates that would make the claims process more transparent, reliable, and timely for both providers and carriers. These include appropriate oversight of automated decisions, dependable electronic submission and tracking, clear documentation requirements, review of emergency claims based on presenting symptoms, and reciprocal deadlines that bring claims to resolution.

At its core, the clean claims process should be simple, transparent, and reliable. Carriers should clearly identify the information needed to adjudicate a claim, provide dependable electronic methods for submitting that information, confirm receipt, explain their determinations, and resolve claims within required timeframes. Hospitals should not have to search across multiple systems to determine what is being requested, resubmit records because a carrier failed to track or associate them with the claim, or pursue claim-by-claim appeals when the same carrier issue affects multiple claims. Technology should improve the process—not create new barriers, reduce accountability, or allow claims to be delayed, reduced, or denied without meaningful review.

MHA offers the following responses to questions raised at the Aug. 18 meeting for your consideration:

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**1. Should the regulations be updated to align with current technological advancements in claim processing? If yes, what updates should be made?**

Yes. The regulations should be updated to reflect the increasing use of automated rules, claims-review software, algorithms, artificial intelligence, and other technology in claim processing. These tools may improve efficiency, but they should be subject to clear standards to ensure they make the claims process faster, more transparent, and more reliable—not more burdensome for providers or increasing unexplained delays, reductions, or denials.

The regulations should require carriers to disclose when an automated tool materially contributes to a denial, reduction, inquiry, or other action that delays resolution of a claim. The regulations should require meaningful review by a qualified individual when a provider disputes an initial determination. Automated tools should not be the final authority on disputed claims, and carriers should remain responsible for decisions produced or informed by their systems.

Carriers should be required to clearly explain the reason a claim was not approved, the criteria applied in making the determination, and what the provider must do to resolve the issue. When a technical issue affects multiple claims from the same provider, carriers should be required to notify the provider of the issue and allow all affected claims to be reprocessed without requiring separate appeals for each claim. These communications should be detailed enough for providers to understand and address the problem.

The regulations should also establish clear timeframes for carriers to respond to claim submissions, appeals, and requests for information so technology supports timely resolution rather than prolonged pending status.

**2. Should the regulations be updated to align with current technological advancements in claim submission and receipt, including verification of standard data elements, attachments, and confirmation of receipt? If yes, what updates should be made?**

Yes. The regulations should be updated to reflect modern electronic claim submission and receipt processes and should establish consistent minimum standards across carriers. Claim submission requirements, attachment capabilities, data-element verification, receipt confirmation, and claim-status tracking should be standardized to the fullest extent possible so technology improves the process rather than creating carrier-specific administrative burdens.

Providers should have reliable electronic methods to submit original claims, corrected claims, appeals, reconsideration requests, and supporting documentation, including medical records, itemized bills, and other attachments when needed. Carriers should be permitted to use clearinghouses, provider portals, or other electronic systems, but each system should be secure, capable of accepting complete records and large files, and able to confirm that submissions were received, associated with the correct claim, and available to the person reviewing the claim. Requiring carriers to accept electronic attachments should not mean hospitals must submit medical records with every claim.

The regulations should require clear electronic verification of standard claim data elements. Carriers should identify missing or invalid information within a defined period, such as one to three business days, and distinguish technical or data errors from acceptance of the claim for adjudication. Electronic notices should clearly identify whether the carrier is acknowledging receipt, accepting the claim for review, rejecting the claim because of a technical or data error, or requesting additional information.

Each electronic notice should include the date and time, a tracking number, the claim status, and any action the provider must take. Carriers also should maintain an accessible record showing when claims, attachments, notices, and provider responses were sent and received, and should provide real-time or near-real-time claim status information. Consistent receipt and tracking standards are necessary to ensure that electronic submission actually supports timely claim resolution.

**3. What specific documentation do carriers require when submitting a claim, and how do providers know in advance what documentation may be needed for efficient adjudication?**

Documentation requirements vary significantly by carrier, service, and claim. Commonly requested documentation includes medical records, triage and nursing assessments, physician documentation, diagnostic results, itemized bills, operative reports, authorization records, discharge summaries, primary-payer explanations of benefits, coordination-of-benefits information, and documentation supporting medical necessity.

Providers generally do not know in advance with certainty what specific documentation a carrier will require for efficient adjudication. They often learn only through denial notices, provider manuals, portal messages, past experience, or repeated disputes. In some cases, carrier requests do not clearly identify the specific portion of the record needed or explain why the information is necessary. Hospitals also report broad or duplicative requests, including requests triggered by claim value, requests for complete medical records when limited documentation would be sufficient, and requests for information about unrelated services.

The regulations should be updated to give providers clearer advance notice of documentation requirements. Carriers should maintain clear and publicly accessible policies explaining documentation requirements by type of service, criteria used to determine medical necessity, circumstances likely to require medical records or other documentation, and the methods for submitting those materials. If a carrier regularly requires a particular permissible document for a type of claim, the carrier should tell hospitals in advance so the document can be submitted with the initial claim rather than requested only after payment has been delayed or denied.

At the same time, advance notice should not expand what carriers are permitted to require. Carriers should not impose additional or undisclosed requirements beyond those permitted by regulation. When additional information is needed, each request should identify the claim and affected line item, state the precise information needed, explain why it is necessary and how it relates to the carrier’s decision, provide the submission method and deadline, and avoid demanding an entire medical record when a limited portion would resolve the issue. Carriers also

should not request information already submitted or available through prior authorization, concurrent review, or a prior claim submission unless they provide a documented reason.

**4. What further information should third-party payors be permitted to request when there is a reasonable belief that an emergency services claim may not satisfy the criteria under Health-General Article § 19-701(e)? Should providers be required to attach a list of presenting symptoms to the original claim?**

Third-party payors should be permitted to request only the additional information reasonably necessary to evaluate whether the claim satisfies Maryland's prudent layperson standard. Carriers already receive coded information about the patient's signs or presenting symptoms with the original emergency department claim. Providers therefore should not be required to attach a separate list of presenting symptoms to every original claim.

If a carrier reviews the claim information and has a reasonable, claim-specific basis to question whether the emergency services criteria are met, the carrier may request targeted portions of the medical record needed to answer that question. Depending on the issue, relevant information may include the chief complaint, triage assessment, initial vital signs, acuity level, initial provider assessment, and diagnostic information available when treatment decisions were made. The request should identify the specific question being evaluated, explain why the information is necessary, and be limited to the relevant portions of the record. A complete medical record should be requested only when the carrier explains why more targeted information would be insufficient.

Furthermore, carrier auto-code lists should not be treated as the exclusive definition of an emergency. Those lists may help identify claims for automatic payment, but Maryland's prudent layperson standard requires consideration of the patient's symptoms as they reasonably appeared when care was sought, not whether a particular diagnosis code appears on a carrier's list.

Finally, providers should not be required to attach a list of presenting symptoms to the original claim. That requirement would duplicate information already reported through diagnosis and symptom codes, create additional administrative burden, and risk turning routine emergency claims into documentation-heavy submissions. Instead, carriers should use the information already available on the claim and request additional, targeted documentation only when there is a specific reason to do so.

**5. Should providers be required to respond to requests for additional information within a set period, such as 30 days, and should carriers then issue a final determination based on the information originally submitted if the provider does not respond?**

Yes. The regulations should establish a 30-day provider response deadline and enforce the existing 30-day carrier deadline, so both parties have clear responsibilities, and every claim reaches a final resolution.

When a provider submits a claim, the carrier must either pay it or notify the provider within 30 days as to why all or part of the claim is not being paid, including any specific additional

information needed. The hospital must then locate and submit the requested records or other documentation. Once that information is received, the carrier must complete its review and, within 30 days, pay the claim or issue a full or partial denial.

During this process, carriers may describe a claim as "pending," "under review," or "awaiting information." Unfortunately, hospitals report that claims may remain in this unresolved status for 60, 90, or 120 days or longer, including after the requested records have been submitted. The regulations should establish a 30-day provider response deadline and enforce the existing 30-day carrier deadline, so both parties have clear expectations. The provider's 30-day period should begin upon confirmed receipt of a clear request for more information. Reasonable extensions should be granted for complex or voluminous requests or circumstances outside the provider's control.

**Enforcement**

Regulations are only impactful to the extent they are enforced. Any regulations that result from this process must ensure that violations can be identified and corrected. Repeated or systemic violations should be subject to appropriate penalties. We also respectfully ask MIA to enforce the existing requirement that interest be included automatically with late payments of clean claims. Carriers should also remain responsible for the actions of their vendors and automated systems.

**Conclusion**

These recommendations would create a clear path from claim submission to final resolution. Technology should make claims review more efficient, allowing for clear and timely communication. It should not multiply the number of unresolved claims. Well defined regulatory requirements will improve the claims process, enhance transparency, and conserve resources for patient care.

MHA appreciates MIA's efforts to modernize Maryland's clean claims regulations and for this opportunity to comment. We look forward to continuing to work with you on this important issue.

Sincerely,



Andrew Nicklas
Senior Vice President, Government Affairs & Policy
General Counsel