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Medicaid Adverse Determinations Oversight

Adverse Determinations Workgroup Meeting

June 11, 2026

Outline

- Overview of Medicaid: Current reimbursement structure of Fee-for-service and Managed Care
- Major historical events impacting Medicaid
- National and local trends in adverse determinations
- Maryland Medicaid regulations and oversight
- Next steps and best practices

Medicaid

Fee-for-service and HealthChoice

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Why is Managed Care Needed?

Launched 1997:

- Address rising healthcare costs - cost control and sustainability
- Apply coordination of care through primary and preventive care to improve health outcomes
- Expanded coverage through CHIP and 1115 waivers
- Efficiency that aligns with the Total Cost of Care all-payor hospital system model

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Comparison of Medicaid Reimbursement by Coverage and Populations

Fee-for-Service	Managed Care
Members with highly specialized and complex health care needs	Covers majority of Medicaid population
• Specialty Behavioral Health Services	• Primary Care and Preventive Screenings
• Rare and Expensive Care Management (REM)	• Well-woman care
• Dual Eligibles	• Family planning and reproductive health
• Long Term Care	• Primary Behavioral Health Services
• Physically and Intellectually Disabled	
• Dental Services	
• Limited EPSDT services: PT/OT/ST	

Major Shifts

Events Impacting Medicaid

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The Pandemic and “Unwinding”

- Early 2020: Global Coronavirus Pandemic began
- March 2020 - 2023: Feds provided enhanced match to states for keeping members enrolled regardless of eligibility changes throughout the public health emergency
- April 2023 - 2024: Medicaid began redeterminations to “unwind” the federal continuous coverage requirement

H.R.1 Changes Target ACA Adult Group

325,866 Marylanders were part of the Affordable Care Act (ACA) expansion group in November 2025, which represents **22.01% of the total Medicaid population.**

This is the coverage category that will experience the most significant changes under H.R. 1.

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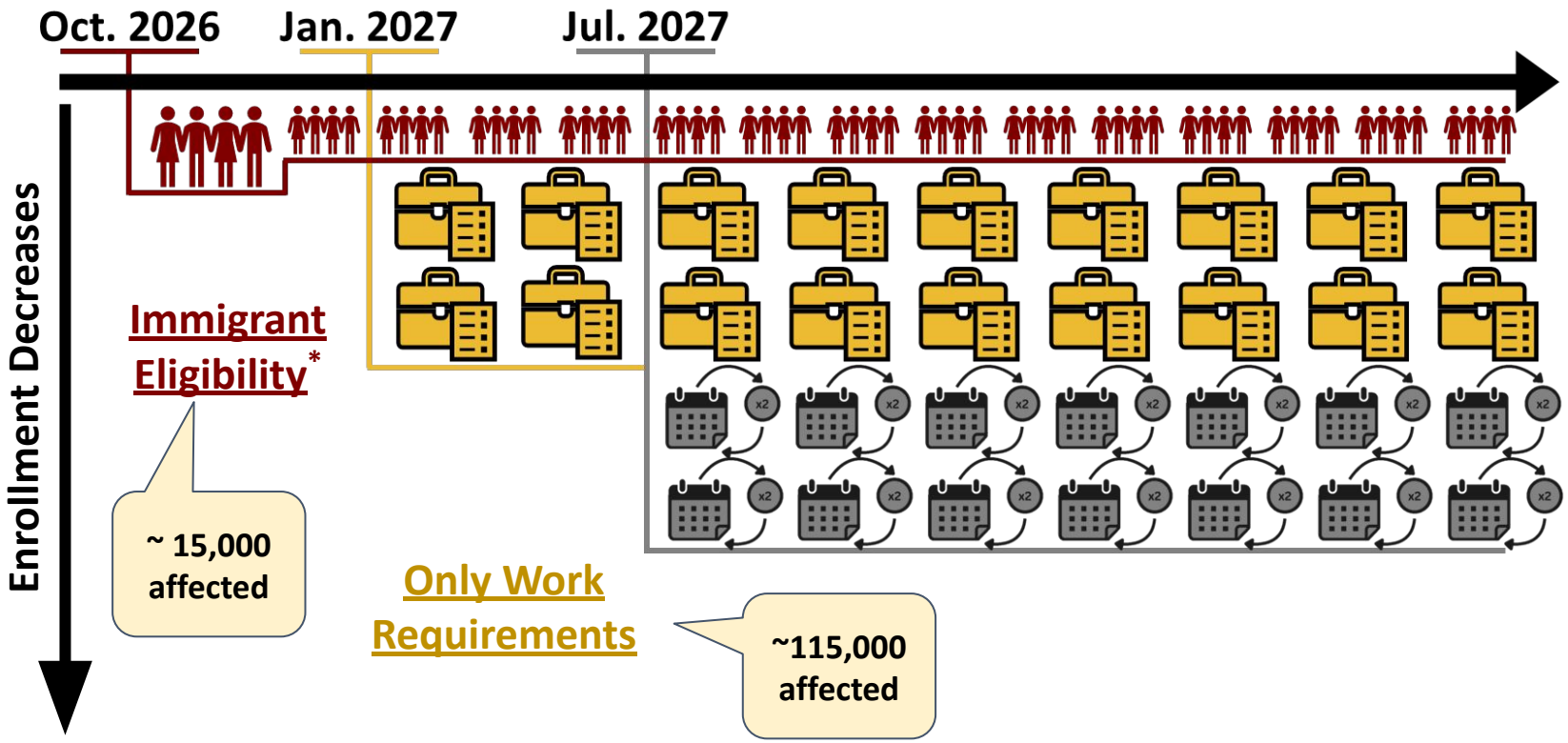
H.R. 1: Big Picture of Enrollment Impacts



*Pending CMS guidance, the Department assumes that all immigrants who no longer qualify for coverage will lose eligibility effective October 1, 2026.

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Across the Country

National Trends in Adverse Determinations

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Denials | National and State Concern

- Nationally, denials have increased almost 25% between 2016 and 2020. (Source: Optum)
- A July 2023 report highlights that overall MCOs denied one out of every eight (12.5%) prior authorization requests in 2019. (Source: OIG)
- NY is seeing higher denial rates from commercial market segments (14.12% for full denial rates vs. 11.90% for managed care) when looking at denial rates in full, but it appears Medicaid Managed Care has a higher denial rate when looking at claims denied in part (28.09% for managed care vs. 24.81% for commercial). (Source: People's Action Institute)

Denials |Other States with FFS

Maryland - The Medicaid FFS denial rate is 11.7% (CY 2025). There were a total of 13.1M processed claims totaling $3.2B in provider payments. (Source: Senate Finance Committee)

- **Alabama** - The state with the highest average in-network denial rate for HealthCare.gov insurers was 34%. (Source: KFF, 2023)
- **South Dakota** - The state with the lowest average in-network denial rate for HealthCare.gov insurers was 6%. (Source: KFF, 2023)
  - The ranking of states by average ACA claim denials rates provides more detail. (Source: Becker's Payer Issues)

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Denials | Maryland Medicaid Trends

In-patient denial dollars increased alongside an increase in total claims dollars (FY 2021 - 2024)

- FY 2023 showed an increase in denial dollars with slight stabilization in FY 2024.
  - The annual volume of denied dollars remains 42% higher than in FY 2021. The total amount of denied dollars in FY 2024 is $210.8M.
  - In-patient denials represent the largest proportion of denial dollars. Growing from $65.8M in FY 2021 to over $116M in FY 2024
- Total overall claims increased from ~$835 million in FY 2021 to almost $2 billion in FY 2024
  - Denied claims ~ $47 million (~6%) in FY 2021 to $72 million (~4%) in FY 2024

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Denials | Maryland MCO Trends

FY 2021	FY 2024
Average total claims dollars: **~$93 million** Average denial dollars: **~$5 million** (high variability)	Average total claims dollars: **~$206 million** Average denial dollars: **~$8 million** (high variability)

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Regulations and Oversight

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Medicaid Oversight of MCO Denials

- **Requires high-level reporting** on pre-service and post-service activities for federal and state monitoring
  - EQRO Grievances, Appeals, and Denials (GAD) Quarterly and Annual Reports
  - Independent Review Organization (IRO) Case Reviews
- **Operates complaint processes for members and providers** to ask questions, seek assistance, or report anomalies in denial processes for investigation and follow-up
- **Conducts limited scope audits** to ensure MCO rules and regulations are applied accurately and consistently
- **Imposes sanctions** by ordering MCOs to provide or reimburse for services when improperly denied
  - *Ad hoc* CTU review of complaints received by Complaints Resolution Unit (CRU)

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COMAR Definition of Adverse Determination

COMAR 10.67.01.01B(3): Definition of "Action" aligns with the federal definition of adverse benefit determination.

"Action" means:

(a) Denial or limited authorization of a requested service, including: (i) The type or level of service; (ii) Requirements for medical necessity; (iii) Appropriateness; (iv) Setting; or (v) Effectiveness of a covered benefit.

(b) Reduction, suspension, or termination of a previously authorized service;

(c) Denial, in whole or part, of payment for a service, except for administrative denials of unclean claims;

(d) Failure to provide services in a timely manner;

(e) Failure of an MCO to act within the required time frames; or

(f) The denial of an enrollee's request to dispute a financial liability, including: (i) Cost sharing; (ii) Copayments; (iii) Premiums; (iv) Deductibles; (v) Coinsurance; or (vi) Other enrollee financial liabilities.

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Applicable Regulations about Denials

42 CFR 438.210(a): Establishes coverage parameters that factor in medical necessity as defined by the State, permits MCOs to place "appropriate limits" according to criteria or for purposes of utilization control

42 CFR 438.210(b): Sets parameters on who can make authorization decisions and requires MCOs to ensure consistency in decision-making

COMAR 10.67.09.03: Outlines HealthChoice MCO provider complaint and appeal processes

COMAR 10.67.09.04: Establishes timeframes and parameters for preauthorization decisions

COMAR 10.67.09.05: Describes enrollee appeal process

COMAR 10.01.04: Describes state fair hearing process for members

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Applicable Regulations about Denials

42 CFR 447.253(e): Medicaid agency must provide an appeal procedure for providers

COMAR 10.09.92.06: Outlines the utilization review process and requirements. Payment is made based on the determination of the retrospective review

COMAR 10.09.92.13 and 10.09.36.09: Outlines appeal procedures

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Medicaid Oversight of FFS Denials

- **Operates complaint processes for providers** to ask questions, seek assistance, or report anomalies in denial processes for investigation and follow-up
- **Conducts Quality Assurance audits and trainings** to ensure the Utilization Review Agent (UCA) is making determinations in alignment with MDH guidance
- **Offer multiple appeal avenues** including asking for a reconsideration review by the UCA, administrative review by the Department, or appeal to the Office of Administrative Hearings

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Medicaid and CHIP Payment and Access Commission (MACPAC)

2024 Review of Medicaid Denials and Appeals:

- Federal Policy Review
- State Policy Scan
- State and Stakeholder Interviews
- Beneficiary Focus Groups

MACPAC 2024 Recommendations	MD Medicaid Implementation		
States should issue guidance to improve clarity and content of denial notices.	**Active**		
MCOs should provide beneficiaries with option to receive electronic denial notice.	**Active**		
Collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. CMS should update the MCPAR template and issue guidance to states regarding implementation of this data reporting requirement.	**Active**		
States should conduct routine clinical appropriateness audits of managed care denials and use findings to ensure access to medically necessary care.		**In Progress**	
CMS should publicly post all state MCPARs. States must include denials and appeals data on their quality rating system websites.		**In Progress**	
Establish an independent, external medical review process accessible by beneficiary.			**Pending**
Extend timeline for requesting continuation of benefits. CMS should issue guidance, including model notice language for beneficiary awareness of their rights to keep receiving services while under appeal.			**Pending**

Maryland Medicaid

Next Steps

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Suggested Workgroup Actions | Infrastructure

Establish Necessary Infrastructure and Foundation for Improvement

- Establish best practices for accountability across payor oversight agencies
- Develop state regulations on the application of AI to utilization management

Suggested Workgroup Actions | Data Analysis

Apply data to policy and decision making

- Standardize data definitions on what is collected and Identify common denial reasons.
  - Establish comparability between commercial and Medicaid denials
  - Compare by geography and by payor
- Understand drivers of denial trends and associated costs
  - Identify outliers and reasons for variability in denial rates
- Study the impact of denials on health outcomes
- Establish expectations for achieving balance between cost containment and provision of the standard of care

Suggested Workgroup Actions | Collaboration

Leverage existing relationships

- Consult with other states on oversight processes and data reporting
- Share resources between Medicaid and stakeholder groups

Action Steps for Hospitals

- Send concrete examples of cases with concerns to MDH Provider Network Services: mdh.healthchoiceprovider@maryland.gov
  - Inappropriate definitions/interpretation of clinical criteria for medical necessity
  - Downcoding
  - Audit requests

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Thank You!

Questions??

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League of Life &
Health Insurers of Maryland

Maryland's Fragmented & Complex Health Insurance Landscape

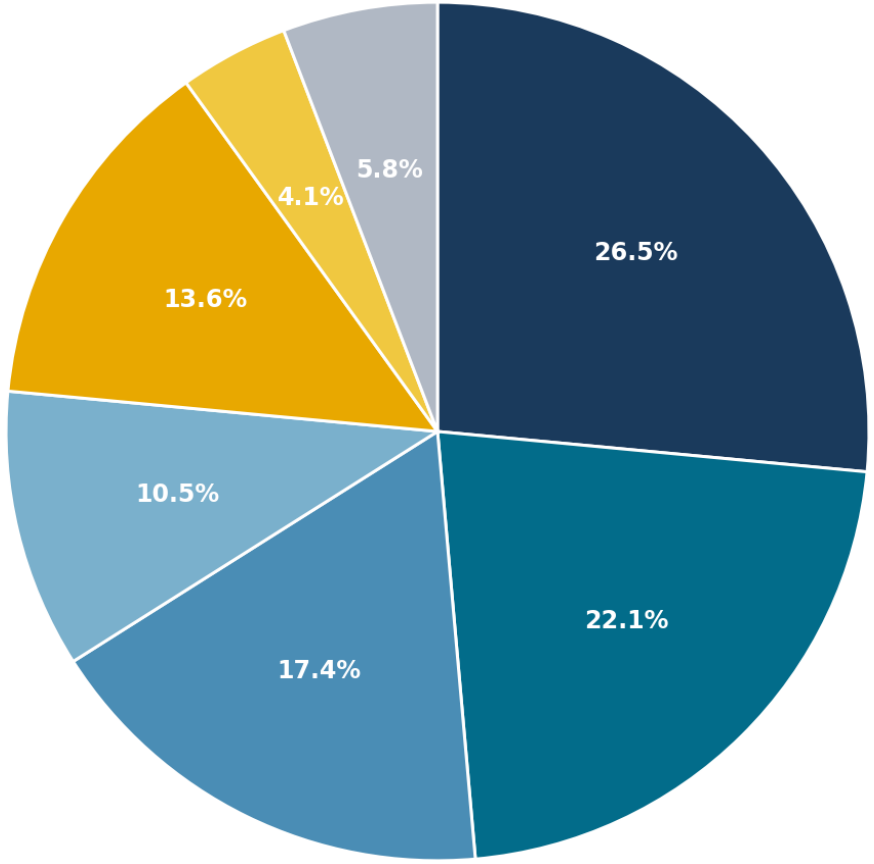
Context for Understanding Adverse Decisions

Workgroup to Study the Rise in Adverse Decisions in the State Health Care System

Maryland Insurance Administration · 2025–2026

Maryland's Health Insurance Landscape

League of Life & Health Insurers of Maryland



Coverage by Segment

MIA-Regulated (Fully Insured)	
Fully-Insured Group	13.6%
Fully-Insured Individual	4.1%
MIA-Regulated Subtotal	17.7%
Outside MIA Jurisdiction	
Self-Insured Market	26.5%
Medicaid	22.1%
Medicare	17.4%
FEHBP & Military	10.5%
Uninsured	5.8%

The General Assembly and MIA have legislative and regulatory authority over approximately 17% of commercially insured covered lives in Maryland.

Why Fragmentation Matters

The regulatory scope of the MIA covers only a shrinking slice of the market

League of Life & Health Insurers of Maryland

What the MIA's Data CAN Tell Us

- Fully insured group plans (540,532 lives in 2025)
- Individual non-Medigap plans (300,991 lives)
- Adverse decisions, grievances & external complaints from regulated carriers
- Quarterly carrier reporting with claims and enrollment data
- Grievance outcomes and IRO external review results

What the MIA's Data CANNOT Tell Us (the majority)

- 1.33M+ lives in large group self-insured plans — NO MIA oversight
- 456K FEHBP lives governed by federal law (ERISA)
- Denial rates or PA policies of self-insured employers
- Self-insured plan grievance & appeals outcomes
- Adverse trends among the 68% of commercially insured Marylanders outside MIA jurisdiction

Data showing "rising adverse decisions" comes exclusively from the ~32% of the market MIA regulates. Any statewide conclusion must account for the data gap in the remaining 68%.

Source: MIA § 15-133 Report (Dec. 2025); MIA § 15-10A-06(b)(3) Report (2024)

Adverse Decisions: What the Data Actually Shows

MIA-regulated carriers only — 2024 report data

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9.9M

Clean claims processed (Q3–Q4 2024, partial year)

~2M

Total enrolled members (Q3–Q4 2024 snapshot)

93%

of medical claims approved after final PA review (AHIP 2024)

~3%

Final denial rate for medical services nationally

The Regulatory Scope Problem

The MIA's 2024 report tracks adverse decisions only from carriers subject to Insurance Article § 15-10A. As the fully insured market has contracted from 42.8% (1998) to 16.3% (2025) of under-65 Marylanders, absolute denial numbers within the regulated segment reflect a smaller pool — not necessarily a deterioration in carrier behavior. Rising raw counts may reflect market composition shifts rather than insurer conduct changes.

The MIA began collecting new claims data (clean claims + enrollment) only in Q3 2024, providing a denominator for the first time. Full-year data will be available in the 2025 report.

Key Definitional Note

"Adverse decision" = determination that a service is not medically necessary, appropriate, or efficient.

NOT all denials = PA denials. Includes: coding errors, eligibility issues, duplicate claims, and network issues.

Grievances filed ≠ overturned decisions. Most grievances are resolved in the member's favor at the internal stage.

Source: MIA § 15-10A-06(b)(3) 2024 Report; AHIP Prior Authorization Survey June 2025

Engaging the Concerns About Denial Trends

Acknowledging the concerns without dismissing them — and providing proper context

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Concerns Raised About Denials Data

- Data shows absolute adverse decision counts have increased in recent years
- Hospital-based care and mental/behavioral health represent high denial concentration
- Patients may face financial hardship, delayed care, or care abandonment after denials
- Critics argue that high denial rates reflect profit-motivated, not medically-driven, decisions
- Concerns about consistency of clinical criteria applied across carriers

Context the Data Requires

- Raw adverse decision counts are not normalized to claims volume or enrollment size
- A growing individual market (+8.2% in 2024) naturally produces more initial denials
- Most denials are overturned on internal grievance review — a working safeguard
- Many initial denials stem from incomplete provider submissions, not medical judgment
- The market's ERISA-governed self-insured majority operates without comparable data reporting

Where Agreement Exists

All stakeholders agree: prior authorization should be used only when clinically justified; the process should be fast, transparent, and not burdensome to providers or patients. The industry is actively moving in this direction — nationally and in Maryland.

Source: MIA § 15-10A-06(b)(3) 2024 Report; Workgroup Meeting 2 Materials (March 2026)

National Reform: Insurers Are Already Acting

Voluntary industry commitments signal the direction of travel

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96% / 93%

Rx & Medical Claims NOT Subject to PA in Commercial Market

AHIP 2024 Survey (32 health plans, 109M lives)

97%

of medical PA requests ultimately approved (commercial)

AHIP 2024 Survey

30%

reduction in PA requirements announced by major national insurer

Industry announcement May 2026; only 2% of services now require PA

100%

of surveyed health plans: AI is NOT used alone to deny PA requests

AHIP 2024 Survey

AHIP Voluntary Commitments (Effective 2025–2027)

- ✓ Standardize electronic prior authorization (FHIR® API-based) — target: January 1, 2027
- ✓ Reduce in-network medical PA volume — demonstrated reductions by January 1, 2026
- ✓ Honor prior PA for 90-day continuity when patients change plans mid-treatment
- ✓ Improve plain-language denial communications and expand real-time electronic approvals (~20% of PAs today)

Policy Considerations for the Workgroup

Framing recommendations that reflect the full market picture

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Data & Transparency

- Consider whether full-year enrollment and claims denominators would provide helpful context before drawing trend conclusions
- Explore whether voluntary data-sharing from self-insured administrators could supplement MIA reporting
- Examine how PA denials relate to other adverse decision categories to support more nuanced analysis
- Assess whether additional carrier-level context would help regulators and the public interpret reported figures

SB 791 (Ch. 848, 2024) Reforms Already in Law

- Electronic PA portal required by July 1, 2026 — linked to EHR/e-prescribing systems with real-time auto-approval for qualifying requests
- Chronic condition PA: no reauthorization for up to 1 year; no adverse decision on reauth if treatment ongoing and prescriber attests continued need
- New enrollees: carriers may not disrupt an active course of treatment without reauthorization
- PA continuity: prior authorizations honored for up to 90 days when patients change plans
- 60-day advance notice required before any new PA requirement takes effect

Regulatory Scope

- Acknowledge ERISA preemption limits on self-insured plan regulation
- Explore DBM/State employee plan as model for voluntary MIA external review
- Coordinate with federal CMS on Medicare Advantage PA oversight
- Build legislative record documenting the 68% data gap before mandating carrier-only changes

Source: MIA § 15-133 (2025); MIA § 15-10A-06 (2024); AHIP (June 2025); UHC Newsroom (May 2026); Ch. 848 (SB 791), 2024 Laws of Maryland

Key Takeaways

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1. The regulated market is a minority.	MIA oversees only 32% of commercial lives. Any data-driven conclusion must acknowledge the 68% gap.
2. Context matters for denial numbers.	Absolute counts without enrollment/claims denominators are incomplete. The new reporting requirement (Q3 2024+) is a step forward.
3. Industry is moving — voluntarily.	National insurers have committed to cutting PA requirements, improving electronic processing, and boosting transparency.
4. Agreement on goals; debate on methods.	All parties want accessible, timely, affordable care. Workgroup recommendations should build on shared principles.
5. Regulatory coordination is essential.	Effective reform in Maryland requires federal coordination (ERISA, CMS) and cooperation from self-insured administrators.

Contact

League of Life &
Health Insurers of Maryland

Matthew Celentano

Executive Director

League of Life & Health Insurers of Maryland

leaguemaryland.com

410-269-1554

mcelentano@fblaw.com

MMCOA

MARYLAND MCO ASSOCIATION

Workgroup to Study the Rise in Adverse Decisions in the State Health Care System

June 11, 2026

About MMCOA

- Overview of Association & Members serving 1.2 million Marylanders

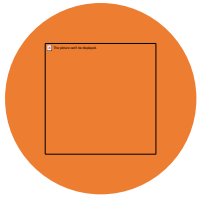
Overview of HealthChoice

Brief HealthChoice History

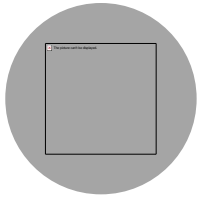
Program growth from 1997 to 2026

AHEAD and focus on Primary Care & Health Related Social Needs

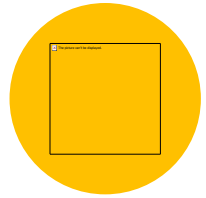
Workgroup MCO Perspectives



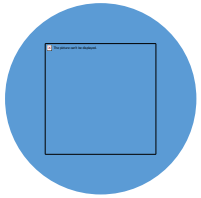
Obligations as stewards of state resources



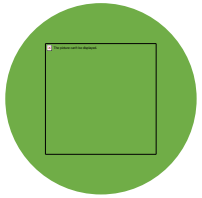
Fraud, Waste and Abuse Detection; even more important given the focus from CMS



Quality – Contractual obligations to meet and exceed national benchmarks



Artificial Intelligence Use prohibited for PA or UR decisions



Reduce inappropriate utilization – making sure care is delivered in cost effective manner

Adverse Decisions

- Adverse Decision defined - COMAR 10.67.13.02(B)(1)
  - An "Adverse decision" means a review determination by a managed care organization that a health care service for which a provider seeks reimbursement is not medically necessary.

- Medically necessary defined - COMAR 10.67.01.01 (B.112) "Medically necessary" means that the service or benefit is:
  - (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
  - (b) Consistent with current accepted standards of good medical practice;
  - (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
  - d) Not primarily for the convenience of the consumer, the consumer's family, or the provider.

Adverse Decisions

Claims Denials

Prior Authorizations

Prior Authorizations

COMAR 10.67.09.04 – Governs MCO actions and decisions on service authorizations

- **Standard PA decisions**: Within 2 business days of necessary clinical info
- **Expedited:** No later than 72 hours
- **Pharmacy (outpatient drugs):** Notice within 24 hours.

Denials (or lesser authorization) must be made by a healthcare professional with appropriate clinical expertise in the enrollee's condition and cannot be arbitrary/solely diagnosis-based.

Notices: Timely written adverse action notices to enrollee and provider, including reasons, criteria, appeal rights

MCO contracts (e.g., CY 2026 HealthChoice MCO Agreement) require written UM policies/procedures for consistent application of criteria (including specialist consultation), practice guidelines, and limits only for utilization control that achieve the service's purpose without arbitrary reductions. Compensation for UM staff cannot incentivize denials of medically necessary care.

MCOs must follow 42 CFR 438.210 (service authorization) and provide services no less in amount, duration, scope than FFS Medicaid.

Common Reasons for PA Denials

- Medical Necessity / Does not meet criteria
- Incomplete Submission
  - In MY2024, MCOs reported a range of receiving PA requests with complete information from 80% to 96%
- Out of Network Provider
- Not a covered Benefit or Service

Emergency Department Claims

Emergency Department Claims

MCOs have obligations to ensure care is delivered in the most appropriate site/setting as part of medical necessity and UM (e.g., via PA criteria, discharge planning, care coordination).

MCOs must cover medically necessary emergency services 24/7 without PA (COMAR 10.67.05.08 and federal rules).
Post-stabilization follows 42 CFR 438.114. ED claims are reviewed against EMTALA (screening/stabilization) + Maryland medical necessity.

ED claim denials: MCOs review for whether services meet emergency criteria (prudent layperson standard) and medical necessity.

MCOs reimburse hospitals per HSCRC rates for qualifying services; out-of-network emergency care has specific rules (COMAR 10.67.04.20)

MCO contracts emphasize coordination between settings, discharge planning, and avoiding unnecessary higher-acuity care. UM programs must address both over/under-utilization and appropriate level of care (COMAR 10.67.03.06)

MCOs can deny ED claims based on site/setting if not medically necessary/most cost-efficient, but must follow clinical criteria, provide determination notice, and allow appeals.

Common Reasons for Claims Denials

- Top reasons for denials other than Medical Necessity
  - Member not eligible on date of service (not eligible for Medicaid)
  - Requested service is not a covered benefit
  - Service not authorized
  - Duplicate claim
  - Incorrect provider number/registration issue (NPI, ePREP, MPRIME)
  - Fraud, Waste, and Abuse detection (NCCI edit enforcement)
  - Payor of last resort/COB activities

Recommendations & Next Steps

- Review existing reports from the MIA and MDH regarding Adverse Decisions and Pre-Service Denials
  - Health Care Appeals and Grievabnce Law 2024 Report Insurance Article 15-10A-06(b)(3)
  - Measurement Year 2024 Grievance Appeals Denials Annual Report
- Standardize definition and reporting of Adverse Decisions
- Promote consistent billing practices amongst Maryland hospitals
- Promote Hospital charges consistency and stabilization
- Ensure the system is promoting cost savings across all sectors
- Survey of MHA on data collection
  - Survey of its members related to AI usage and other billing tech practices
  - Improve concurrent review process and planning between hospitals and MCOs

Questions and Contact Information

- Questions?
- Contact info for MMCOA

Joe Winn, Executive Director
Maryland MCO Association
301-873-2150
jwinn@marylandmco.org