



MHA ANALYSIS OF DENIALS DATA



Denials Through FY 2024



MULTIFACETED CHALLENGES OF DENIALS



Denials on the Rise

- Payer denials have grown substantially since 2013
- Growth in denials has accelerated in recent years
- Denied dollars have increased steeply in the emergency department and outpatient settings
- AI is contributing to increased denials



Harmful Impact to Patients & Providers

- Denials can cause delays for patients in receiving necessary care
- Higher out-of-pocket costs resulting from denials can cause patients to defer care
- Denied and delayed payment of claims is contributing to financial pressures on hospitals and operational uncertainty
- Valuable staff and clinical resources diverted to fight inappropriate claim denials



The Need for More Payer Accountability

- Maryland needs a system for reviewing payer denials that
- Refines data disclosures and ensures data integrity
 - Enhances payer denial transparency
 - Reduces denial rates while examining factors that contribute to excessive denial rates, such as the use of AI in claims review and prior-authorization requirements

DATA TERM DEFINITIONS

- **Denial** – a healthcare claim (IP, OP, ED) for which a payer denies payment in part or whole
- Denial reasons
 - **Medical necessity** - Denial of payment for services deemed not reasonable or necessary based on the payer's evidence-based clinical criteria
 - **No pre-authorization** - Failure to obtain required payer approval before services are rendered
 - **Untimely filing** - Submission of a claim after the payer's required filing deadline
 - **Registration/eligibility**: incorrect or unverified patient or insurance information that prevents the payer from confirming active coverage at the time of service
 - **EMTALA** – Emergency Medical Treatment and Labor Act designed to prevent the practice of refusing treatment or transferring patients who cannot pay.
 - EMTALA was reported as its own standalone category through FY24

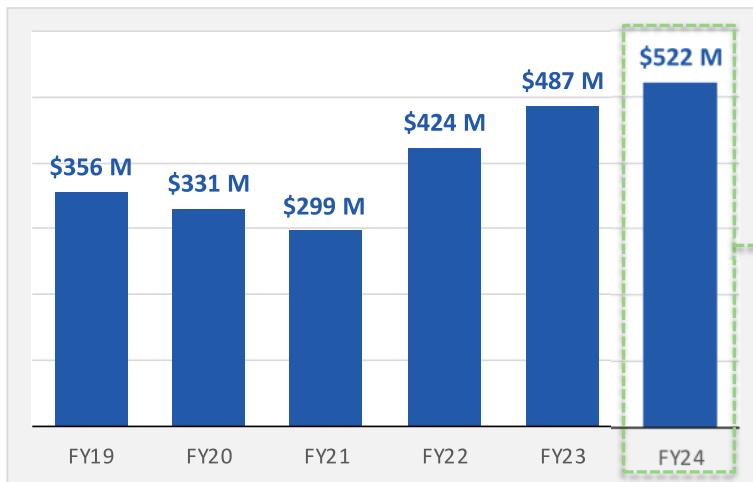
LEGAL DEFINITIONS

- **Adverse decision** - a decision "by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and may result in noncoverage of the health care service"

DENIAL DOLLARS UP 47% FROM FY19

MD Denials Dollars

FY19 to FY24



47% increase from FY19 to FY24

Breakout of \$522M Denials in FY24

By Payer

- 39% Medicaid MCO (\$202 M)
- 20% Commercial (\$106 M)
- 15% Medicare Advantage (\$77 M)
- 10% Medicare FFS (\$50 M)
- 17% All Other (\$87 M)

By Patient Setting

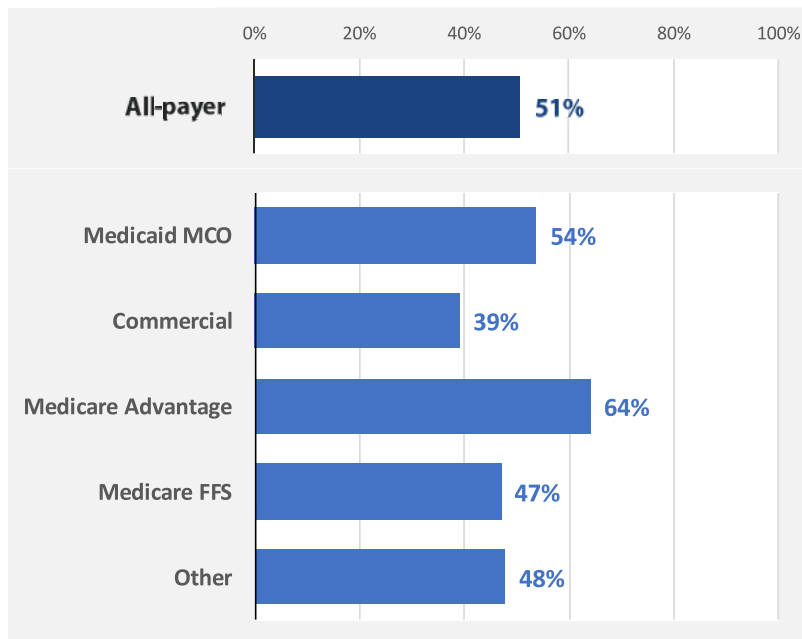
- 53% Inpatient Services (\$276 M)
- 32% Outpatient Services (\$168 M)
- 15% ED Services (\$77 M)

By Denial Reason

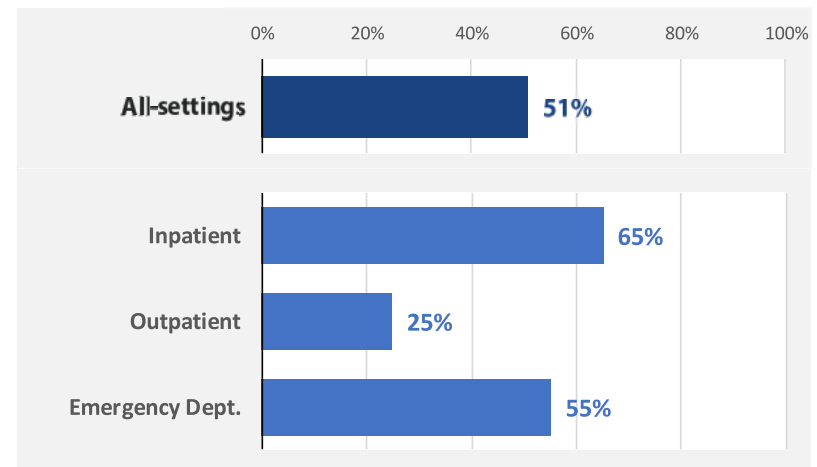
- 51% Medical Necessity (\$264 M)
- 23% No Pre-Authorization (\$122 M)
- 9% Untimely Filing (\$45 M)
- 17% Other (\$90 M)

MEDICAL NECESSITY DENIALS AS % OF TOTAL | FY24

What percent of denial \$ are **medical necessity denials**... **by payer?**



What percent of denial \$ are **medical necessity denials**... **by patient setting?**



Source: HSCRC Denials Data

Note: Behavioral health plans grouped in "Other"

Updated 01 30 2026



PATIENT SETTING DENIALS AT A GLANCE | FY24

Inpatient Services

1 in every 8

inpatient claims has a denial

67K

inpatient denials

\$276 M

inpatient denials dollars

\$4,110

average per inpatient denial

Outpatient Services

1 in every 10

outpatient claims has a denial

255K

outpatient denials

\$168 M

outpatient denials dollars

\$659

average per outpatient denial

Emergency Dept. Services

1 in every 7

ED claims has a denial

245K

ED denials

\$77 M

ED denials dollars

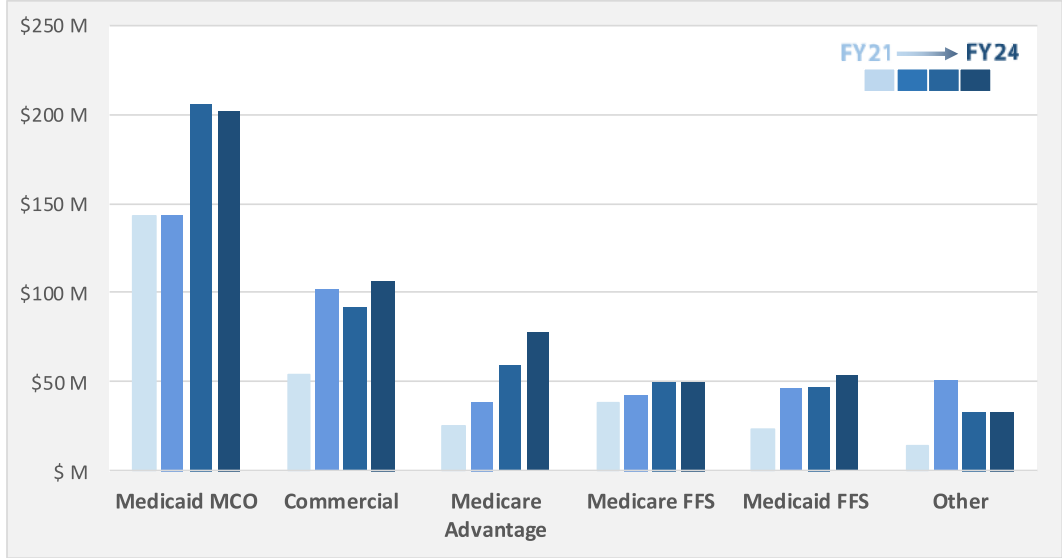
\$315

average per ED denial

DENIALS DOLLARS BY PAYER

Denials Dollars by Payer

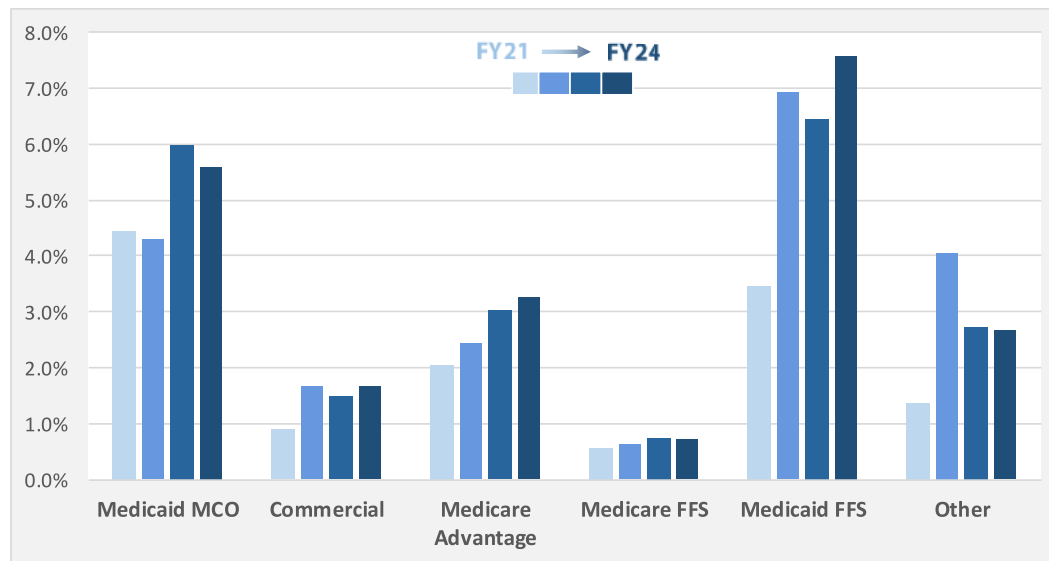
FY21 to FY24



- **Medicaid MCOs** consistently comprise the **most denials \$**
- **Medicare Advantage** experienced a **204% increase** from FY21 to FY24
 - 38% increase on a denials \$per claim basis
- **Commercial** denials \$ saw an **111% spike** in FY22 and have maintained high totals thereafter

DENIALS DOLLARS AS % OF CHARGES BY PAYER

Denials Dollars as % of Charges by Payer
FY21 to FY24



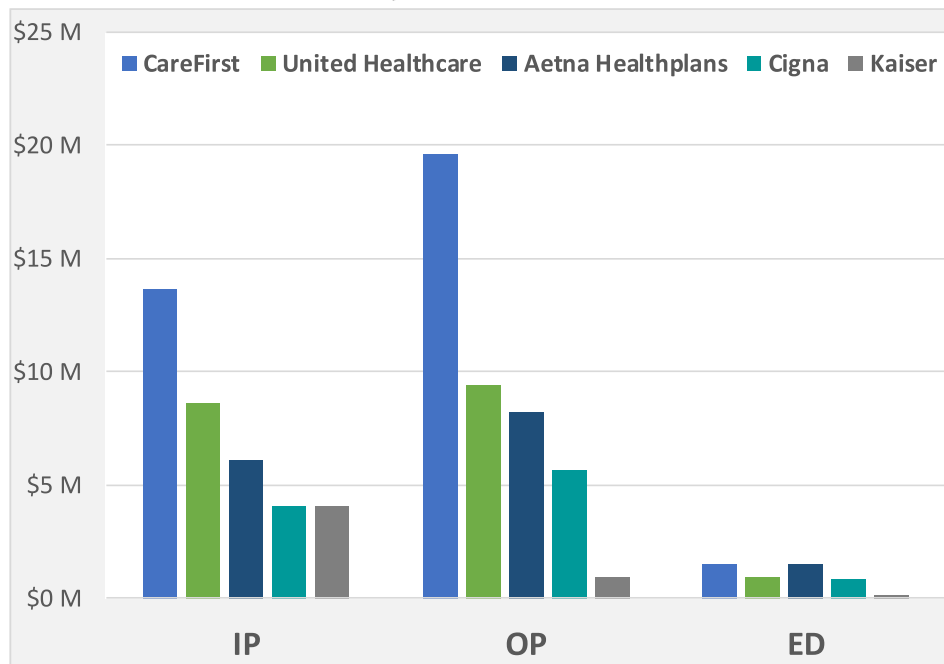
- The two payer groups with the highest denials as % of charges were **Medicaid FFS (7.6% in FY24)** and **Medicaid MCO (5.6%)**
- Even when taking the growth of **Medicare Advantage** charges into account, denials still **increased 60% from FY21**
- **Commercial** denials as a % of charges were 51% higher in FY24 than FY19 - the largest increase of any payer

FY24 DENIALS DOLLARS

TOP 5 COMMERCIAL PAYERS¹

FY24 Denials Dollars by Commercial Payer

Inpatient, Outpatient, Emergency Department



- **CareFirst** has the largest commercial market share in Maryland and expectedly has the most dollars of denials
- Most Commercial denials are in the IP or OP setting

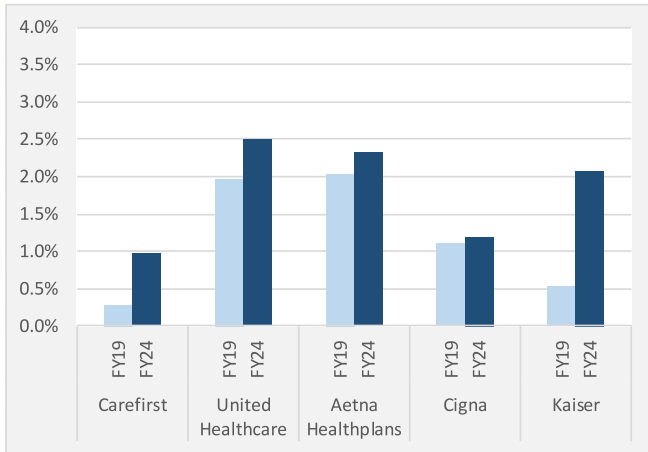
¹ Five largest Commercial Payers in Maryland by total charges
Source: HSCRC Denials Data

INCREASES IN DENIAL DOLLARS AS PERCENT OF CHARGES

TOP 5 COMMERCIAL PAYERS¹

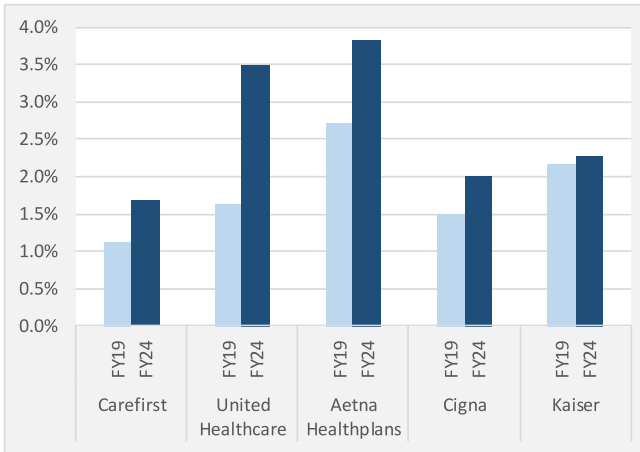
Denials Dollars as % of Charges

Inpatient | FY19 v FY24



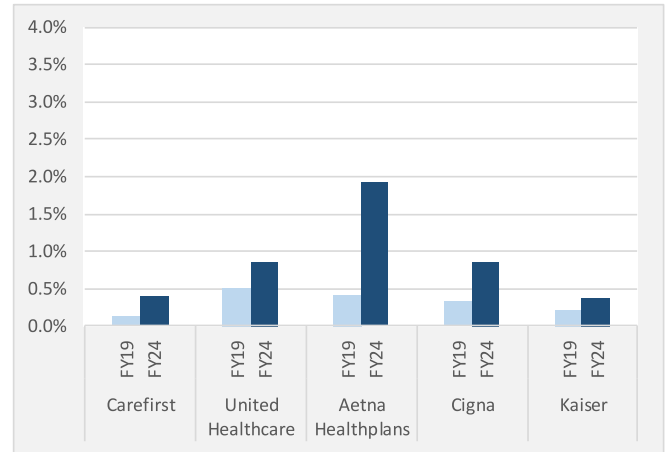
Denials Dollars as % of Charges

Outpatient | FY19 v FY24



Denials Dollars as % of Charges

Emergency Department | FY19 v FY24



Denial dollars as a % of charges increased for each of the five largest payers and for every patient setting

¹ Five largest Commercial Payers in Maryland by total charges

Source: HSCRC Denials Data

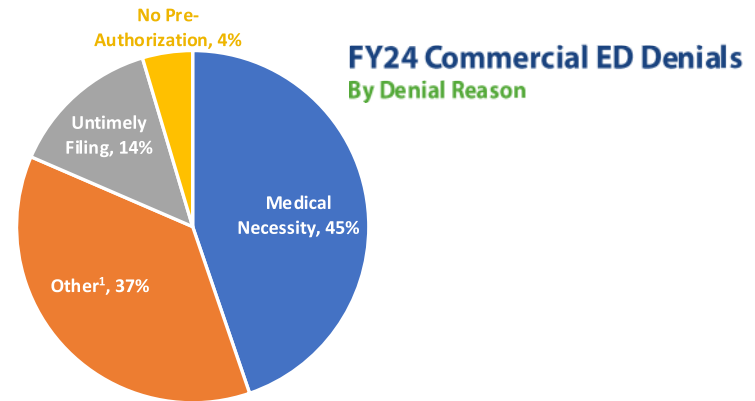


COMMERCIAL DENIALS IN THE EMERGENCY DEPT.

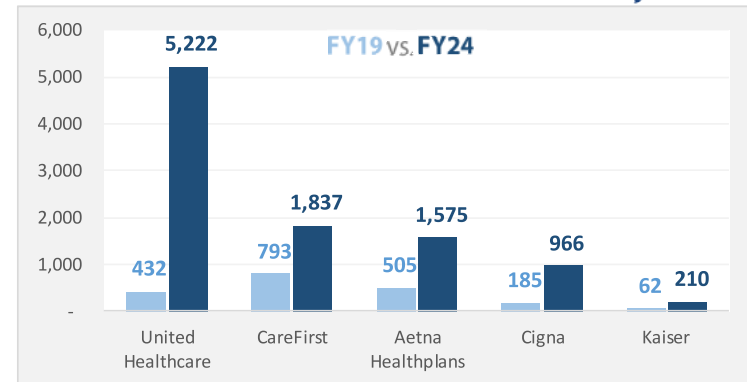
- In FY24, Commercial ED denials represent:
 - **5.0%** of all denials
 - **1.5%** of all denials dollars

- 45% of Commercial ED denials are for **medical necessity**

- Medical necessity denials in the ED saw large increases across all of MD's 5 largest commercial payers
- United Healthcare saw the largest increase: **12 times** more medical necessity denials **in FY24** compared **to FY19**



Commercial ED Claims with Medical Necessity Denial



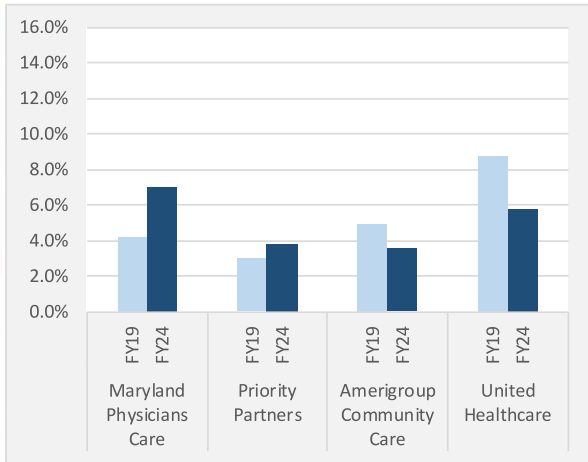
¹ "Other" denial reasons include missing information, out-of-network, eligibility issues, duplicate claims, and more

INCREASES IN DENIAL DOLLARS AS PERCENT OF CHARGES

TOP 4 MEDICAID MCO PAYERS¹

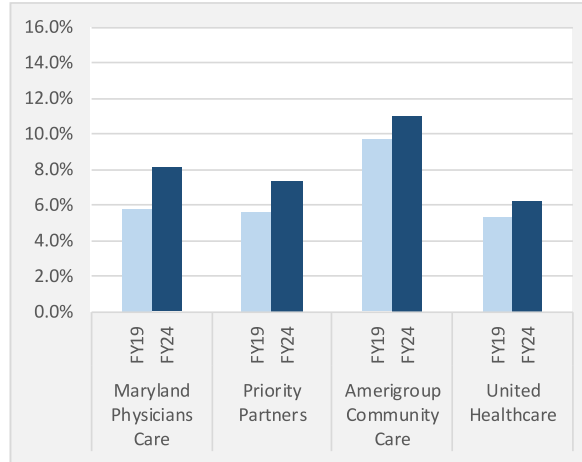
Denials Dollars as % of Charges

Inpatient | FY19 v FY24



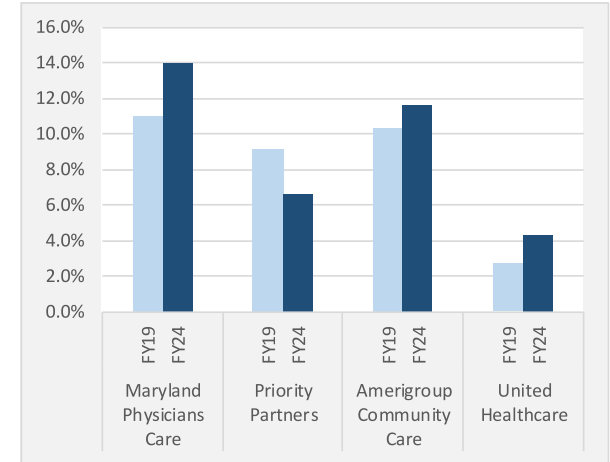
Denials Dollars as % of Charges

Outpatient | FY19 v FY24



Denials Dollars as % of Charges

Emergency Department | FY19 v FY24



Denial dollars as a % of charges increased for each of the four largest Medicaid MCOs in the Outpatient setting

¹ Five largest Commercial Payers in Maryland by total charges

Source: HSCRC Denials Data



WORKFORCE IMPACT OF DENIALS

“Denials don’t just delay revenue—they eat into it”

- OS-Healthcare, Denial Rates Are Climbing: What Healthcare Revenue Cycle Leaders Should Be Watching in 2025



Rework Expenses: Each denied claim costs providers between \$25 and \$181 to correct and resubmit

If the average denial costs providers \$100 to correct and resubmit, MD hospitals spent **over \$56M on rework expenses** in FY24



Revenue Leakage: Unresolved denials can lead to substantial write-offs, particularly in hospital settings



Staff Time: Managing denials consumes valuable time and resources that could be better spent on patient-focused operations

In just 4 years, one MD Health System has seen a **36% increase** in staffing costs related to denials and a **17% increase** in purchased services related to denials

PATIENT IMPACT OF DENIALS



DENIED

- Lymphoma patient completed chemotherapy and was preparing for radiation treatment
- Radiologist suggested proton therapy treatment due to its precision, the sensitive target area (neck), and long-term benefits
- **Prior Authorization Denied** - Commercial payer will not cover proton radiation, only traditional radiation, due to high cost and relatively low acuity diagnosis
- After unsuccessful peer-to-peer call, radiologist and patient forced to decide whether to keep fighting for proton therapy, further delaying treatment (already 2 weeks past planned start date). They decided to start traditional radiation



DENIED

- Patient presented with active suicidal ideation and intent
- Failed to meet medical clearance for admission to a locked behavioral unit due to the essential use of CPAP for Obstructive Sleep Apnea
- **Denied for Medical Necessity** - MCO claims care should have been administered in a behavioral unit
- Clinical staff say the acute medical unit was not only clinically appropriate, but was also the only safe environment capable of managing the dual behavioral and medical complexity of this case

FACTORS IMPACTING RISING DENIAL RATES

- **Tougher Prior Authorization Rules**
 - Payers continue to tighten their requirements for prior authorizations, especially for expensive treatments, diagnostic imaging, and elective procedures.
- **More Denials Based on Medical Necessity**
 - Claims are facing increased scrutiny, with AI being used to flag cases that may not meet the payer's definition of medical necessity.
- **Out-of-Network (OON) Services Face Extra Scrutiny**
 - The No Surprises Act is tightening rules around out-of-network billing, and many providers are seeing increased denials for emergency or specialist services that lack pre-approval.



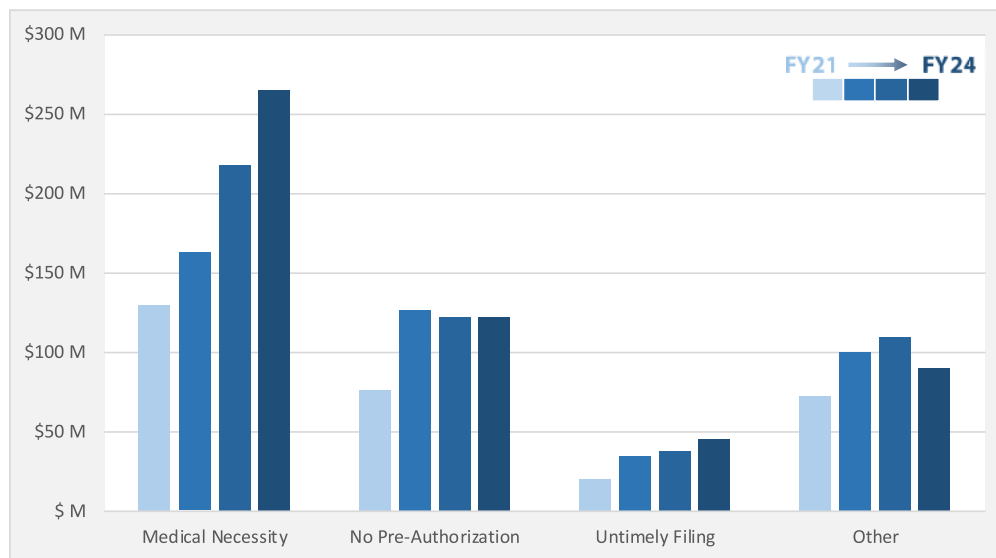
APPENDIX



DENIALS DOLLARS BY DENIALS REASON

Denials Dollars by Reason

FY21 to FY24



- **Medical necessity** denials increased **104%** from FY21
- **No pre-authorizations** denials rose **61%**
- **Untimely filing** denials saw the largest percent increase (**114%**)

% OF CLAIMS WITH A DENIAL

BY PAYER & PATIENT SETTING

% of Claims with a Denial

By Payer | By Patient Setting | FY24

	IP	OP	ED	Total
Medicaid FFS	42.5%	31.5%	11.7%	23.9%
Medicaid MCO	19.7%	17.1%	30.7%	24.0%
Medicare Advantage	22.5%	11.5%	9.3%	12.4%
Medicare FFS	6.5%	8.8%	9.7%	8.7%
Commercial	7.7%	5.7%	5.5%	5.8%
Total	12.8%	9.4%	14.5%	11.5%

42.5% of all Medicaid FFS claims from the IP have a denial

Change in % of Claims with a Denial

FY19 to FY24 | Increases/Decreases

	IP	OP	ED	Total
Medicaid FFS	+15.1%	+7.7%	+2.3%	+6.1%
Medicaid MCO	-0.1%	+1.8%	+1.8%	+1.4%
Medicare Advantage	+4.9%	+3.2%	-1.0%	+2.3%
Medicare FFS	+0.4%	-1.0%	-1.5%	-1.0%
Commercial	+2.1%	+1.6%	+3.2%	+2.1%
Total	+2.2%	+0.4%	+1.6%	+1.0%

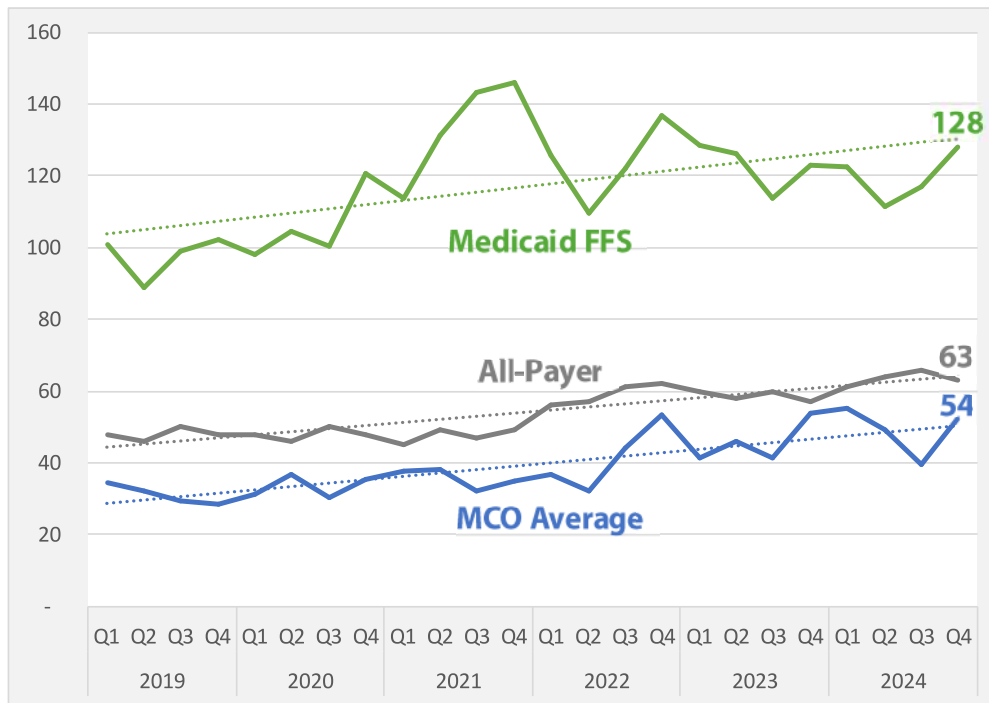
Commercial denials %s increased across all 3 patient settings

Source: HSCRC Denials Data
 Note: "Other" payer category not shown

DAYS IN RECEIVABLE ARE INCREASING

Avg. Days in Accounts Receivable | 2019 - 2024

Medicaid FFS, All-Payer, MCO Average



Average Days in Accounts Receivable has been **generally increasing** for the past six years

Average Days in AR increasing by:

- **4.60 per year for Medicaid FFS**
- **3.45 per year for All-Payer total**
- **3.77 per year for MCOs (averaged)**

Source: MHA AR Report (data sent directly from hospitals)

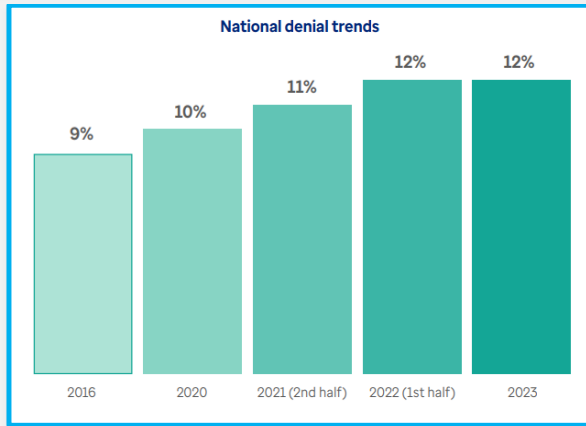
Accounts Receivable consist of billed and unbilled charges that have been adjudicated or are pending adjudication by payers, including contractual adjustments and denials under appeal

Updated 01 30 2026



NATIONAL DENIALS REPORTS

The Optum 2024 Revenue Cycle Denials Index

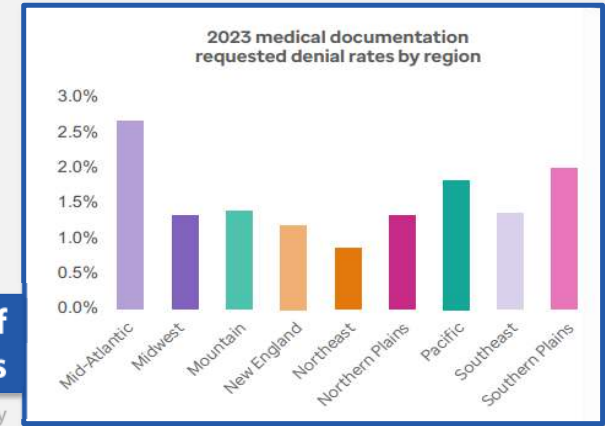


“Denial rates remain staggeringly high”

National denial rate up 3% since 2016

MD’s region (Mid-Atlantic) has highest rate of “medical documentation requested”* denials

*Medical documentation requested not equivalent to medical necessity



Other National Denials Reporting

- Denials on the rise FY 2024:
 - 1 in 5 of all healthcare Healthcare.gov issuer claims were denied in 2023²
 - 19% of in-network, 37% of out-of-network claims
- MCOs in MD have worsening PCP satisfaction results⁵ in:
 - Accuracy of claims processing
 - Timeliness of initial claims processing
 - Timeliness of adjustment/appeal claims processing
- Largest Initial Denial Private Payor Groups³:
 - Medicare Advantage: 15.7%, Commercial payers: 13.9%
- Primary Drivers of Denials⁴:
 - Medical necessity-related denials
 - Incomplete or inaccurate patient registration data at intake
 - No pre-authorization and eligibility issues
 - Coding inaccuracies

*National data sourced from hospital based Optum Health Revenue Cycle Denials Index, based on internal analysis of 124 million inpatient and outpatient all-payer hospital claims remits valued at \$500 billion in total charges across over 1,400 hospitals.

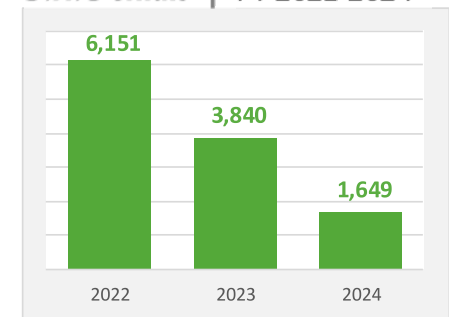
Source: OS, Inc¹, KFF², AHA³, Experian⁴ MDH.CS⁵

LIMITED DATA ON BEHAVIORAL HEALTH DENIALS

It is unclear if the available data is capturing all denials from behavioral health payers

- Denials for Behavioral Health payers first show in the HSCRC's denials data in FY 2022 and have **decreased since** ►
- For the most recent year (FY 2024), denials from Behavioral Health payers comprise:
 - 0.29% of all denials (1,649 denials)
 - 0.35% of all denials dollars (\$1.84 M)
- The majority of behavior health denials are attributed to Optum Behavioral Health. In FY 2024, Optum comprised:
 - 84% of all B.H. denials
 - 78% of all B.H. denials dollars
- In FY 2024, denials for **no pre-authorization dropped substantially** ►

B.H. Denials | FY 2022-2024



% of B.H. Denials for No Pre-Auth.

