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

Adverse Decisions in Behavioral Health

July 30, 2026

National Perspective

D. Brian Hufford, Esq. | The Hufford Law Firm, PLLC | Senior Legal Advisor to The Patient's Union

Beth Ann Middlebrook, Esq. | B. Middlebrook Consulting, LLC | Advisor to The Bowman Family Foundation

Maryland Perspective

Paul C. Berman, Ph.D. | Licensed Psychologist | Professional Affairs Officer, Maryland Psychological Association

Dan Martin, J.D. | Chief Public Policy Officer, Mental Health Association of Maryland

Overly Restrictive Criteria and Parity Non-Compliance Concerns

- On a national level, commercial payers often utilize medical necessity criteria, standards and guidelines for behavioral health treatment services that are more restrictive than: generally accepted standards of care; independent best practice guidelines; criteria and guidelines utilized for medical/surgical treatment services.
- This includes independent national criteria and guidelines, such as MCG Care Guidelines and InterQual Criteria, as well as internally developed criteria, such as UBH (Optum) Level of Care Guidelines, Aetna Behavioral Health Clinical Policies, Cigna's Behavioral Health Medical Necessity Criteria, etc. Several class actions challenging guidelines as overly restrictive and violating parity have been brought.
- Payers often represent that they rely on generally accepted standards of care (e.g., ASAM, LOCUS, CALOCUS), however, do not interpret or apply such guidelines with fidelity.
- Less than 1% of denials are ever appealed. A substantial % of appeals are successful. Health Insurers Deny 850 Million Claims a Year, The Wall Street Journal, Feb. 12, 2025.

Overly Restrictive Criteria and Parity Non-Compliance Concerns

Payers also often apply medical necessity criteria without consideration or deference to independent clinical judgment or the individualized needs of the patient. It is important to note common disclaimers and clarifications set forth in independent generally recognized behavioral health medical standards & criteria:

- "The ASAM criteria are designed to serve as a resource for general, mental health, and addiction treatment clinicians and counselors, but are **not intended to substitute for their independent clinical judgment based on the particular facts and circumstances presented by individual patients. (***ASAM Criteria Fourth Edition, "Cautionary Statement for Use of The ASAM Criteria)*
- "Within each Service Intensity Level, or Level of Care, there should be an **array of different services that can be selected and combined according to individual needs to help the person achieve recovery. In this way, the care team can create a treatment plan that is uniquely suited to the child or adolescent and their family."** *(CALOCUS)*
- "APA Practice Guidelines are assessments of current scientific and clinical information provided as an educational service. The guidelines **do not set a standard of care and are not inclusive of all proper treatments or methods of care.** The **ultimate recommendation** regarding a particular assessment, clinical procedure, or treatment plan **must be made by the clinician directly involved in the patient's care** in light of the psychiatric evaluation, other clinical data, and the diagnostic and treatment options available." *(APA Practice Guidelines)*

Overly Restrictive Criteria and Parity Non-Compliance Concerns | What Other States Are Doing

WA state enacted HB1432 (effective July 2025, certain substantive requirements apply to plans issued or renewed on or after Jan. 1, 2027), which includes the following:

- Requires health plans' utilization review and clinical review criteria for mental health and substance use disorder (MH/SUD) services to be consistent with generally accepted standards of care, rather than proprietary internal guidelines.
- Prohibits prior authorization before admission for withdrawal management (detoxification) and inpatient or residential substance use disorder treatment in licensed behavioral health agencies. Instead, the insurer must initially cover at least 3 days of withdrawal management, and at least 2 days of inpatient/residential SUD treatment before conducting a medical necessity review. This shifts the burden away from patients and providers and prevents delays in treatment during crises.
- Requires that if a carrier fails to respond within statutory time limits to a prior authorization request, a grievance, an appeal, or certain prescription drug exception requests, the request is deemed approved. This creates a meaningful incentive for timely decisions rather than allowing delays
- Incorporates the 2024 MHPAEA Final rule in WA law.

Overly Restrictive Criteria and Parity Non-Compliance Concerns | What Other States Are Doing

California enacted SB 855 (effective Jan. 2021), which includes the following:

- Requires coverage for all medically necessary treatment of MH/SUDs and defines "medical necessity" broadly to include services needed to prevent illness, diagnose, treat, minimize progression of disease, and improve functioning.
- Utilization review must be based on the most recent generally accepted standards of mental health and substance use disorder care; requires use of LOCUS, CALOCUS, ECSII and ASAM Criteria.
- Regulations implementing SB 855 :
  - Require insurers to incorporate the most recent evidence-based clinical standards, minimize delays in updating their criteria, avoid variation caused by outdated internal guidelines, ensure reviewers possess appropriate behavioral health expertise.
  - Create a formal complaint process for consumers, allow the Department of Insurance to investigate patterns of improper denials, increase insurer accountability for parity violations and utilization review practice
  - Require insurers to authorize out-of-network behavioral health treatment when medically necessary services are unavailable in-network, or the network fails timely access or geographic access standards

Overly Restrictive Criteria and Parity Non-Compliance Concerns | What Other States Are Doing

Oregon has enacted ORS 743A.168 which includes the following:

- **Any medical necessity, utilization review, or other clinical review** for behavioral health services must be based solely on:
  - current generally accepted standards of care;
  - for level-of-care placement decisions, the most recent placement criteria developed by the nonprofit professional association for the relevant clinical specialty (e.g., ASAM Criteria for substance use disorder treatment or LOCUS/CALOCUS where applicable); and
  - any other clinical criteria used must themselves be evidence-based and derived from generally accepted standards of care.
- Codifies the parity principle that MH/SUD treatment may not be subjected to medical necessity requirements or treatment limitations that are **more stringent** than those applied to M/S conditions.
- For behavioral health UR, providers may request the criteria that will be used to make authorization decisions and reviews must be conducted according to **criteria made available in advance** upon request. This transparency makes it easier for providers and regulators to challenge denials.

Workgroup Tasks

From Chapters 671 and 672 of 2025 (Senate Bill 776/HB 995):
f) The Workgroup shall…:
2) make recommendations to improve State reporting on adverse decisions, including recommendations
regarding:
i) Standardized definitions of:
1. medical service categories;
2. health settings;
3. adverse decisions; and
4. medical necessity
ii) a standardized method for categorizing adverse decisions and prior authorization denials; and
iii) a standardized process for reporting grievances or filing complaints and appealing adverse
decisions;
3) develop strategies for, and make recommendations to reduce, the number of adverse decisions; and
4) develop recommendations for legislation to address the rise in adverse decisions and standardize State
reporting requirements regarding adverse decisions across all payers.

Workgroup Inquiries

01	Which service categories and data elements are missing?
02	How should clinical, administrative, and prior-authorization denials be categorized?
03	What standardized forms and electronic submission processes should Maryland require?
04	How can reporting and consumer protections be aligned across all payers and regulators?

A treatment interruption is not merely a delayed transaction

Behavioral health depends on continuity, therapeutic momentum, and trust.

- When psychotherapy or substance-use treatment is stopped pending appeal, the patient cannot be made whole simply by authorizing visits later.
- The pause can worsen symptoms, disrupt engagement, increase crisis risk, and force clinicians to choose between uncompensated care and abandonment of an active course of treatment.
- Denial, if overturned on appeal, is not simply a delay:
    - The treatment process has been disrupted, often with significant consequences including resumption of severe pathology like depression, substance use, etc. – all with an impact on functioning
    - An active treatment relationship is disrupted which can negatively impact the treatment
    - Lost stability and momentum cannot be restored retroactively.
    - The denial itself may change the clinical outcome.

Where are we seeing denials?

No identified pattern

- Pre-Authorization requirements
- CPT code
- Diagnosis
- Treatment Frequency/Intensity
- Type of Treatment
- Concurrent
- Retrospective
- Approval of reduced # of services

Unpredictable denials of coverage and treatment with no advance explanation

Coverage Denials

- Diagnosis: Post Traumatic Stress Disorder
- Method of treatment: Dialectical Behavior Therapy (DBT) which requires individual, group, and coaching services
- Individual therapy and medication management on same day

Medical Necessity Denials

- CPT code: 90847
- Substance Use Treatment when abstinent for a period of time
- Group and Individual Treatment on same day

Question 1: Which service categories and data elements are missing?

Service type

For both MH and SUD and in-network and out-of-network separately, report outpatient psychotherapy, neuropsychological and psychological testing, medication management, IOP, PHP, residential treatment, inpatient rehabilitation, acute inpatient psychiatry, tele-behavioral health, prescription drugs, separately.

Clinical request

Capture CPT/HCPCS code, diagnosis, units and duration requested vs. approved, level of care

Denominator and impact

Report total requests and covered lives, provider geography, and network access (in-network vs. out-of-network).

Process and outcome

Define and count requests, approvals, modified approval, partial denial, preauthorization, concurrent, and retrospective denials, appeal levels, time to decision, time to appeal, internal reversals, MIA outcomes, and denials never appealed.

"Mental health services" is too broad to reveal where care is denied

Question 2: How should clinical, administrative, and prior authorization denials be categorized?

Clinical / utilization management

Medical necessity; prior authorization, concurrent, and retrospective review, including post-claim payment claw backs/setoffs; step therapy; experimental and investigational treatment; and medical necessity standards and criteria.

Administrative / procedural

Benefit exclusions, coding, incomplete information, untimely filing, referral requirements, out-of-network status, and other nonclinical bases.

Disposition

Track upheld, modified, reversed internally and at what level of appeal, and reversed or modified by MIA.

Include and categorize clinical and administrative denials separately

Question 3: What standardized forms and electronic submission processes should Maryland require?

One standard form

MIA should lead development of one plain-language Appeal Form and a Legal Informational Sheet informing consumers/providers of legal rights, time-frames, and available remedies.

Multiple submission methods

Require secure web upload or portal submission, with secure email, fax, and mail alternatives. Every submission should receive a timestamp, confirmation, case number, and status tracking.

Available at every entry point

MIA should require payers to include with every denial notice the Appeal Form and Legal Informational Sheet and make them available on payer, provider, and MIA websites; offer accessible, multilingual, printable, and paper-on-request versions.

Note: Enforcement of current and future regulations

For example, Maryland has the Uniform Treatment Plan (UTP) Form. But some insurers do not recognize it, others say they need more information, others say pre-auth is not a treatment review and UTP is not appropriate.

Maryland should require one appeal form, legal informational sheet and a traceable electronic process

Question 4: How can reporting and consumer protections be aligned across all payers and regulators?

Common data dictionary

Use common definitions and required data elements for MIA-regulated plans, Medicaid managed care, the State employee plan, and other public payers to the greatest extend permitted, and available remedies.

Audit and publish

Identify payer outliers.

Aggregated statewide totals should supplement payer-specific data.

Separate plan/product types

Separate fully insured group, individual/market-based plans (ACA), Medicaid, Medicare, and State and local government plans.

Report the number of lives and denials that remain outside State data collection.

Comparable appeal protections

Map differences in appeal levels, filing periods, decision deadlines, continuation-of-benefits rules, and external review. (Note: included as Legal Information Sheet.)

Align data across all payers and regulators

A fair system must make the right decision easier than the denial

One appeal form for every denial

Require one uniform, plain-language appeal form across payers and denial types, accepted electronically with confirmation, status tracking, and one complete record through every review level. Legal informational sheet developed by the MIA to educate and inform consumers and providers of their rights to be included with every appeal form.

Consistent treatment-need standards

Use transparent, standardized level-of-care frameworks—such as LOCUS and CALOCUS—while preserving individualized clinical judgment of reviewers with relevant behavioral-health expertise.

Remove the incentive to deny

The current structure rewards denials – denials save money without consequence. Denials are most often not appealed because of lack of consumer and provider knowledge, provider time demands, and lack of confidence that appeals will be fairly adjudicated by the insurance company. Track non-appealed denials, overturn rates, delays, and payer outliers; use audits, corrective action, and meaningful consequences.

Protect care during a timely appeal

For an established behavioral-health treatment plan, preserve treatment and payment while a timely appeal is pending when interruption poses clinical risk, with appropriate safeguards and prompt review.

Utilize data to inform parity compliance

Examine comparative data for MH/SUD compared to M/S for disparities and indications of parity non-compliance to be cross-referenced with data provided via parity reporting.

Mental Health Association of Maryland (MHAMD) | Preliminary Survey Data

Payer Practices that Delay Provision of Care

49% of respondents experienced authorization barriers including prior authorization, concurrent review or other insurance requirements that impeded delivery of care to their patients.

Out-of-Network Patients Forced to Drop Out of Care

68% of out-of-network providers reported their patients have been forced to drop out of care because the cost to them was too expensive.

In-Network Patients Forced to Drop Out of Care

43% of in-network providers reported their patients have been forced to drop out of care due to high out of pocket costs.

Selected preliminary data from MHAMD survey of Maryland behavioral health providers about the impact of insurance or health plan networks on their delivery of mental health and substance use care. Based on nearly 300 responses as of 7/22/26.