



Potential Workgroup Recommendations - Update October 5, 2026

Marie Grant, Insurance Commissioner

Agenda

- Discussion of Potential Workgroup Recommendations
- Comments from Public Stakeholders, as time allows



Workgroup Charges

The Workgroup shall*:

- Make recommendations to improve State reporting on adverse decisions, including recommendations regarding:
 - Standardized definitions of:
 - medical service categories;
 - health settings;
 - adverse decisions; and
 - medical necessity
 - A standardized method for categorizing adverse decisions and prior authorization denials; and
 - A standardized process for reporting grievances or filing complaints and appealing adverse decisions;
- Develop strategies for, and make recommendations to reduce, the number of adverse decisions; and
- Develop recommendations for legislation to address the rise in adverse decisions and standardize State reporting requirements regarding adverse decisions across all payers.

*Chapters 671 and 672 of 2025 ([Senate Bill 776/HB 995](#))

Definitions - Medical Service Categories

- The Maryland Insurance Administration (MIA), in their 2025 report (due December 2026) is requiring commercial carriers to submit the following categories in their appeals and grievance report:
 - Adverse Decisions regarding Prior Authorization or Step Therapy Protocol; Adverse Decisions Overturned after a Reconsideration Request;
 - Non-formulary Prescription Drugs - Number of Requests made and granted;
 - Adverse Decisions Aggregated by ZIP Code;
 - Grievance Decisions Aggregated by ZIP Code; and
 - Whether an Artificial Intelligence, Algorithm, or other software tool was used in making an Adverse Decision.
- The workgroup expressed support for the MIA to expand medical service categories that commercial carriers are required to submit in future appeals and grievance reports to include:
 - Post-acute service categories, including skilled nursing facilities;
 - Inpatient rehabilitation facilities;
 - Inpatient mental and behavioral health; and
 - Inpatient substance use treatment services.

Recommendations Related to State Reporting on Adverse Decisions

- The Maryland Health Care Commission (MHCC) has adopted regulations that will allow the State to gather more complete information on how claims are processed, adjudicated, denied or paid, and to enable state agencies and partners to aggregate and analyze data to answer specific policy questions. Data collection requirements will include:
 - Reporting on all adjudicated claims, including claims that have been denied or rejected for any reason.
 - Quarterly submission of adjudicated claims beginning in calendar year (CY) 2027.
 - A one-time submission of historical data for claims adjudicated in CY 2026.
- These changes will be included in the 2027 Medical Care Data Base (MCDB) Data Submission Manual.
- The updated regulations will apply to all commercial payers and market segments, including Medicare Advantage (MA).
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Recommendations Related to State Reporting on Adverse Decisions (con't)

- The following national standardized reason codes will also be included in the 2027 Medical Care Database (MCDB) Data Submission Manual.
 - Claims Adjustment Reason Code (CARC) and Remittance Advice Code (RARC) fields for medical and dental claims
 - CARCs describe why a claim/service line was paid differently than billed;
 - RARCs provide additional context or instructions explaining the adjustment.
 - National Council for Prescription Drug Programs (NCPDP) reject reason code field for pharmacy claims
 - NCPDPs are sent by pharmacy benefit managers (PBMs) and health insurers when an electronic claim is denied at the point of sale.
 - MHCC will coordinate with Maryland Medicaid regarding denied claims reporting.
- MHCC will publish periodic reports on types of services denied and reasons for denial, as well as context and legal implications for denials.

Recommendations for Updates in Prior Authorization and Reducing Adverse Decisions

- Require public posting for clinical criteria for private review agents that are Commercial Insurers, PBMs, and Managed Care Organizations (MCOs). This requirement would not apply to Medicaid Fee-for-Service but its clinical criteria for commonly requested medications are currently posted.
 - The MIA should conduct periodic sample audits of clinical criteria used for prior authorizations for compliance. Maryland Medical Assistance Program will continue to provide oversight for the MCO prior authorizations process and is currently working to implement routine clinical appropriateness audits of pre-service managed care denials and use findings to remove overly restrictive clinical criteria. Maryland Medical Assistance Program requires MCOs to ensure clinical criteria and medical necessity determinations are not overly restrictive compared to that of Fee-for-Service.

Recommendations for Updates in Prior Authorization and Reducing Adverse Decisions

- Require Application Programming Interface (API) requirements under the Centers for Medicare and Medicaid Services (CMS) interoperability and prior authorization rule in Maryland Commercial market on or before July 1, 2028.
 - Currently applicable to Medicare, Medicaid, and federal Exchange plans.
- The Health Services Cost Review Commission (HSCRC) and MIA should explore conditioning the MA stabilization program eligibility process for 2028 to include standards for prior authorization requirements for Post-Acute care and compliance with federal regulations on prior authorization.

Recommendations for Improved Process for State Appeals of Adverse Decisions and Other Denials

- MIA should update and simplify the complaints process for consumers and providers, working with the new Health Insurance Advisory Board.
- MIA will work on a uniform, plain language appeal form and/or electronic process. The Maryland Medical Assistance Program will collaborate with the MIA to determine reasonable modifications to its appeal process that would remain in compliance with state and federal regulations, improve plain language on forms, and allow closer alignment.
- MHCC, MIA, and the Maryland Medical Assistance Program should work together to identify payer outliers and reasons for variability in denial rates, and enforce where appropriate for the agency.

Additional Workgroup Meeting

Friday, October 30, 2026

10:00 am - 12:00 pm

Written Comments

Written Comments will be accepted through
EOD Monday, October 19, 2026 on the topics
covered in today's meeting.

Those can be submitted via email to:

jamie.sexton@maryland.gov and janice.lepore1@maryland.gov.

Public Questions or Comments?



Thank
you