HB 1445

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1445 (Delegate Wolek, *et al.*)
Health

Maryland Medical Assistance Program and Developmental Disabilities Administration - Home- and Community-Based Services Eligibility Determinations (Maryland Protecting People With Disabilities Act)

This bill establishes additional requirements for waivers administered by the Developmental Disabilities Administration (DDA) and codifies existing federal mandates related to the waivers. The Maryland Department of Health (MDH) is prohibited from procedurally disenrolling individuals from Medicaid or home- and community-based services (HCBS) based on missing documentation, except under certain circumstances. MDH must retroactively reinstate certain recipients who were procedurally disenrolled. MDH, subject to federal approval, must reserve certain HCBS waiver slots for recipients who lost eligibility under certain circumstances. Beginning January 1, 2027, MDH must submit quarterly reports to the General Assembly regarding Medicaid recipients who receive HCBS and post the reports on the MDH website.

Fiscal Summary

State Effect: MDH expenditures increase by an estimated $670,500 in FY 2027 for personnel plus a *significant* additional amount (not shown) for waiver services and administrative changes, as discussed below. Future years reflect annualization and ongoing costs. Federal fund revenues increase for personnel only. **This bill increases the cost of an entitlement program beginning in FY 2027.**

(in dollars)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
FF Revenue	$335,200	$386,700	$405,100	$423,600	$442,100
GF/FF Exp.	$670,500	$773,300	$810,100	$847,100	$884,200
Net Effect	($335,200)	($386,700)	($405,100)	($423,600)	($442,100)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary/Current Law:

Existing Federal Mandates

The bill makes the following changes that codify existing federal mandates and are consistent with current practice for DDA waivers.

Appealing a Loss of Eligibility: The bill repeals the current requirement that an individual receiving DDA services who loses Medicaid eligibility must have 90 days to appeal the determination. Instead, an individual *may* appeal the determination. Per federal regulations (42 CFR § 431.231), an individual may request a hearing within 10 days and the reinstated services must continue until a decision is rendered.

Timely Determinations: MDH must comply with specified federal regulations (42 C.F.R. § 435.912) related to the timely determination and redetermination of Medicaid eligibility, including processing an application (1) within 45 days if a determination of disability is not required and (2) within 90 days if a determination of disability is required.

Ex Parte Redeterminations: MDH must conduct *ex parte* redeterminations (a process to determine eligibility using existing data without requiring the recipient to submit additional information) and use all procedures authorized under specified federal regulations (42 C.F.R. § 435.916) to prevent procedural disenrollment (termination of eligibility for services based on reasons related to the renewal process and not on a determination of ineligibility) of individuals receiving HCBS.

Provision of Information: MDH must provide, in electronic and paper formats, and orally as appropriate, the following information to all applicants and other individuals on request: (1) requirements for Medicaid eligibility; (2) available Medicaid services; and (3) the rights and responsibilities of applicants and Medicaid recipients. MDH must provide this information in plain language and in a manner that is timely and accessible to individuals who are limited English proficient or living with disabilities, as specified.

Continuous Eligibility

Under current practice, waiver participants have a 30-day period from the notice of eligibility renewal to respond with the necessary redetermination information. Those with incomplete redetermination information are not eligible to continue receiving services.

The bill specifies that if MDH determines that the information necessary to confirm a recipient's eligibility to continue to receive services is incomplete, MDH must continue to provide HCBS and other Medicaid services until the recipient has exhausted all due process rights and a final determination is issued.

Reinstatement Due to Procedural Termination

Under current practice, an individual may be disenrolled from the waiver due to being found ineligible or due to a procedural reason. The individual may appeal the decision and continue to receive services while the appeal is pending. If an individual does not file a timely appeal, the individual will lose services.

The bill specifies that, if a recipient is procedurally disenrolled due to a failure by MDH to redetermine eligibility in a timely manner and the delay was no fault of the recipient, MDH must reinstate the recipient's eligibility and the provision of HCBS and authorize enrollment retroactively to the date of disenrollment, pending completion of the redetermination process.

Reinstatement of Coverage and Waitlist Modifications

Subject to federal approval, MDH must reserve a portion of the participant capacity in the HCBS waiver for services needed by recipients with developmental disabilities who (1) were disenrolled from the waiver program on or after January 1, 2024; (2) have had Medicaid eligibility reinstated; and (3) have requested the reinstatement of waiver services. MDH may not place an individual on a waiting list or require a new waiver application if their disenrollment resulted from a delay or an error by MDH.

Prohibitions on Procedural Disenrollment

MDH may not procedurally disenroll an individual from Medicaid or HCBS solely based on missing documentation, a missing signature, or incomplete information unless MDH has (1) exhausted all *ex parte* verification processes, as specified; (2) provided a clear, specific, and accessible written notice identifying the exact information required; (3) provided the recipient with a reasonable opportunity to supply the information; and (4) verified that the individual received the notice and documented the verification. If MDH violates these requirements, a recipient's HCBS must continue without interruption.

If MDH disenrolls a Medicaid recipient in violation of these requirements, MDH must (1) automatically reinstate Medicaid and HCBS retroactive to the date of disenrollment and (2) treat the recipient as continuously enrolled.

Reporting Requirements

By January 1, 2027, and quarterly thereafter, MDH must submit to the General Assembly a report on Medicaid recipients who receive HCBS and post each report on the MDH website. The reports must include:

- the total number of Medicaid recipients for whom a redetermination of eligibility was initiated;
- the total number of Medicaid recipients for whom coverage is renewed;
- of the recipients whose eligibility is renewed, the total number whose coverage was renewed based on an *ex parte* redetermination;
- the total number of recipients whose eligibility was terminated;
- the total number of recipients whose eligibility was terminated for procedural reasons; and
- the mean and median processing times for redeterminations of eligibility.

State Fiscal Effect: While many of the bill's provisions codify existing federal regulatory requirements and reflect current waiver practice, MDH advises that several provisions (continuous eligibility during redetermination, reinstatement due to procedural termination, reinstatement of coverage and waitlist modifications, and prohibitions on procedural disenrollments) have a *significant* fiscal impact on waiver operations and expenditures, as discussed below. MDH further advises that implementation of the bill requires additional staff in the Office of Eligibility Services.

Continuous Eligibility

The bill requires MDH, if the information necessary to confirm a recipient's eligibility to continue to receive services is incomplete, to continue to provide HCBS and other Medicaid services until the recipient has exhausted all due process rights and a final determination is issued. Currently, waiver participants have a 30-day period to respond with the necessary redetermination information, after which they are ineligible to continue receiving services.

Medicaid advises that requiring MDH to continue to provide services beyond the 30-day period has an indeterminate but significant impact on expenditures.

Reinstatement Due to Procedural Termination

The bill requires MDH to reinstate a recipient's eligibility and provision of HCBS and authorize enrollment retroactive to the date of disenrollment, pending completion of the redetermination process, if a participant is procedurally disenrolled due to an MDH administrative error. MDH advises that retroactively reinstating services for individuals has a significant fiscal impact.

MDH advises that, between January 1, 2024, and December 31, 2025, a total of 19,387 individuals were enrolled in a DDA wavier. Over these two years, 1,747 individuals (9% of total enrollees) were disenrolled, 107 of which (6.1% of all disenrollments) were for a procedural reason. In calendar 2024, the average annual cost of DDA waiver services was $154,006 per participant. If DDA were to reinstate services for *all 107* of these individuals, expenditures would increase by up to $16.4 million annually (100% general funds), or $12.4 million in fiscal 2027 to reflect the bill's October 1, 2026 effective date. MDH assumes that these individuals have not appealed the decision and are, thus, not eligible for federal matching funds for reinstated services. Reinstatement of services for these individuals also requires updates to the Eligibility and Enrollment system at an additional but indeterminate cost.

Reinstatement of Coverage and Waitlist Modifications

The bill requires MDH (subject to federal approval) to reserve slots in the HCBS waiver for services needed by recipients disenrolled from the waiver program on or after January 1, 2024, who have had Medicaid eligibility reinstated and requested reinstatement.

MDH advises that it will need to submit amendments for each of the six HCBS waiver programs to reserve capacity for those who were disenrolled and ensure that those disenrolled are not required to submit a new waiver application or join a waitlist. The number of individuals who were disenrolled from a waiver, had their Medicaid eligibility reinstated, and have requested reinstatement cannot be reliably estimated. MDH advises that, to the extent it must reinstate *all 1,747* individuals disenrolled since January 1, 2024, expenditures increase by as much as $269.0 million annually, or $201.8 million in fiscal 2027 to reflect the bill's October 1, 2026 effective date. Reinstatement of these individuals also requires system enhancements to Maryland Benefits (an online portal that allows residents to apply for government programs through a single application) at an additional indeterminate cost.

Prohibitions on Procedural Disenrollment

The bill prohibits MDH from procedurally disenrolling an individual solely based on missing documentation or information unless MDH completes specified steps. If MDH violates these requirements, a recipient's HCBS must continue without interruption. If MDH disenrolls a recipient in violation of these requirements, MDH must automatically reinstate Medicaid and HCBS retroactive to the date of disenrollment and treat the recipient as continuously enrolled.

MDH advises that verification and documentation of individuals' receipt of notice requesting additional information requires significant additional funds. This includes an indeterminate amount for system enhancements to Maryland Benefits to track when an

electronic notice is viewed via the consumer portal and expenditures associated with sending correspondence via certified mail (at an estimated cost of $5.30 per letter).

Personnel

MDH advises that implementation of the bill requires additional personnel to support continuous eligibility, reinstate individuals who are disenrolled due to procedural reasons, reinstate individuals disenrolled who have regained Medicaid coverage and request reinstatement, make modifications to current waiver waitlists, and verify and document specified communications during the reinstatement process. Thus, MDH expenditures increase by $670,480 (50% general funds, 50% federal funds) in fiscal 2027, which accounts for the bill's October 1, 2026 effective date. This estimate reflects the cost of hiring 10 medical care program administrators in the Medicaid Office of Eligibility Services. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	10.0
Salaries and Fringe Benefits	$579,072
Operating Expenses	91,408
Total FY 2027 Personnel Expenditures	**$670,480**

Future year expenditures reflect full salaries with annual increases and employee turnover as well as annual increases in ongoing operating expenses.

Reporting Requirements

The bill requires MDH to submit quarterly reports on HCBS participants. MDH notes that it is currently subject to a quarterly reporting requirement regarding Medicaid enrollment change and application processing established by the 2025 *Joint Chairmen's Report*. These reports include data on the number of eligibility renewals completed; the number of new individuals enrolled; measures of churn that reflect the number of individuals enrolled who previously received coverage and the timeframe of when they were last enrolled; and the number of individuals disenrolled, shown by reason for disenrollment, identifying procedural disenrollments and disenrollments due to overscale income, aging out, and other common reasons for disenrollment. The reports also include specified administrative data, including measures of application processing times. The most recent report was submitted in October 2025.

The Department of Legislative Services notes that the current reporting requirement ends April 15, 2026. This analysis assumes that MDH can submit any required reports using existing budgeted resources.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: SB 742 (Senators Guzzone and Zucker) - Finance.

Information Source(s): Maryland Department of Health; Department of Human Services; Department of Legislative Services

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js/ljm

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