

March 25, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

House Bill 1112 - Health Insurance Coverage Protection Commission: Study on Individual and Group Health Insurance Market Stability – **UNFAVORABLE**

Dear Senator Beidle,

Thank you for the opportunity to submit testimony in opposition to House Bill 1112. I am the President and Chief Executive Officer for Jai Medical Systems Managed Care Organization, Inc. (Jai Medical Systems), one of the nine managed care organizations serving 1.3 million Marylanders enrolled in the Medicaid HealthChoice Program. Jai Medical Systems has participated in the HealthChoice Program since its inception in 1997. During our nearly 30 years of commitment to the people of Maryland, we have become known for our high quality. In fact, we are the only MCO in history to receive a 5 out of 5 rating from the National Committee for Quality Assurance for six years in a row. In addition, our health plan, as well as all managed care organizations (MCOs) in Maryland's Medicaid HealthChoice Program, have achieved *Health Plan Accreditation* and *Health Equity Accreditation from the National Committee for Quality Assurance*.

I would like to share why the current Medicaid HealthChoice Managed Care model represents a stronger, more effective delivery system than Medicaid Fee For Service (FFS) or standalone Administrative Services Organization (ASO) models and why weakening or displacing managed care would be detrimental to both beneficiaries and the State.

Maryland's Medicaid Managed Care program, as designed by the legislature, is intentionally designed to deliver coordinated, accountable, and cost-effective care to low income and medically complex populations. By placing both financial and clinical responsibility with MCOs, the State aligns incentives toward prevention, quality improvement, care coordination, and efficient use of resources. In contrast, FFS and ASO models focus primarily on paying for or administering individual services, with limited accountability for outcomes, coordination, or the total cost of care. For these reasons, Maryland relies on managed care for the vast majority of Medicaid beneficiaries while using FFS and ASO models only in targeted and complementary roles. House Bill 1112 would undermine this proven structure.

Managed Care Provides Clear Accountability for Cost and Quality

Under Maryland Medicaid Managed Care, MCOs are paid a fixed per member per month rate and are responsible for managing the full continuum of covered services. This capitated structure makes health plans directly accountable for cost control, access to care, and quality performance. By contrast, FFS reimburses providers for each service delivered, regardless of outcomes or overall value, and ASOs administer benefits *without assuming financial risk*. These models diffuse accountability and limit the State's ability to drive performance improvement.

In addition, Managed care allows the State to set clear expectations through contracts, enforce performance standards, and require corrective action when plans fail to meet quality or access requirements; tools that are far more effective than retrospective oversight alone.

Further, MCOs are held accountable to their spending and must ensure that at least 85% of the dollars they receive are spent on direct member care. This medical loss ratio rule ensures that care is provided by MCOs and that in the event that an MCO spends less than 85% of its dollars on care, the State of Maryland and the federal government receive a refund from the MCO for the percentage below 85%. It is our understanding the Maryland Medicaid Managed Care program is the only program within the Maryland government that has such protection as part of its contract process.

Managed Care Enables Stronger Care Coordination

Managed care is built around primary care, prevention, and coordination across providers and care settings. MCOs are contractually required to manage referrals, transitions of care, chronic conditions, and high-risk populations. FFS lacks built-in incentives for coordination, often resulting in fragmented care and duplicative services. ASO models focus primarily on utilization management and administrative functions rather than whole person care. Effective care coordination under managed care reduces avoidable emergency department visits, unnecessary hospitalizations, and preventable complications; improving outcomes while controlling costs.

Further, the benefits of Medicaid managed care extend beyond what can be easily measured in short-term cost analyses. The most meaningful savings produced by the Program are realized in the lives of Marylanders who receive timely preventive care that identifies and treats serious conditions before they become catastrophic. Under managed care, routine screenings occur, chronic conditions are managed early, and diseases such as hepatitis C are identified and treated before they progress to irreversible harm. These are not abstract savings; they represent people who avoid advanced illness, invasive procedures, and life-altering outcomes. By preventing avoidable suffering and preserving health, managed care not only improves lives today, but also spares the State the far greater costs associated with late-stage disease and complex interventions in the future.

Managed Care Supports Predictable and Sustainable State Spending

Capitated payments under managed care provide budget predictability and shift utilization risk away from the State. This allows Maryland to manage Medicaid expenditures responsibly while maintaining comprehensive benefits. Under FFS, increased utilization directly translates into higher State spending, regardless of whether services are appropriate or effective. ASO models retain this utilization risk while adding another layer of administrative cost. Managed care is therefore essential to Maryland's long term fiscal sustainability and its ability to invest in quality improvement and innovation.

Managed Care Improves Member Navigation and Access

MCOs are responsible for helping members navigate the healthcare system, including selecting providers, understanding benefits, obtaining referrals, and resolving access issues. This creates a clear point of accountability for beneficiaries who need assistance. In contrast, FFS provides little to no support for care navigation, and ASOs generally do not offer member-facing services. As a result, beneficiaries, particularly those with complex medical or social needs are often left to navigate an already complex system on their own. In addition, managed care improves access

to appropriate care through extensive provider networks which are superior to Medicaid FFS. These MCO networks reduce access barriers for vulnerable populations while meeting or exceeding state network adequacy requirements that do not exist within the FFS model.

Managed Care is a Resilient Model

The current managed care model protects the State and beneficiaries from the risks inherent in a single-point-of-failure system, such as is the case with a FFS model. Maryland's own experience underscores this risk. In December 2021, the Maryland Department of Health experienced a cybersecurity incident that required certain State systems to be taken offline as a precaution, resulting in widespread disruptions to FFS Medicaid claims processing, eligibility verification, and other administrative functions. During this period, many FFS recipients experienced service difficulties while providers experienced payment delays because claims could not be accepted or processed through State systems.

In contrast, recipients enrolled in MCOs did not experience any service disruption while payments from HealthChoice managed care organizations to providers continued uninterrupted. This incident illustrates how a centralized FFS infrastructure concentrates operational risk at the State level, allowing system failures whether due to cyber incidents, technology outages, or administrative disruptions to have immediate and statewide consequences. By contrast, Maryland's Managed Care model distributes operational responsibility across multiple accountable organizations, creating resilience, continuity of payments, and stability of access for beneficiaries even when State systems experience disruptions.

Appropriate but Limited Role of Fee for Service and ASO Models

Maryland appropriately continues to use FFS and ASO arrangements for specific purposes, such as certain carved out services, long term services and support, and federally required populations. These models serve targeted needs but were never intended to function as the primary Medicaid delivery system. Expanding or substituting these models for comprehensive managed care would weaken accountability, fragment care, and expose the State to unnecessary financial risk.

Managed Care Oversight and Fraud Detection

The current Medicaid managed care model helps safeguard the Program from fraud, waste, and abuse. One of the core functions of managed care is the prevention, identification, and reporting of potential fraud and/or abuse. MCOs conduct ongoing claims review and member utilization review to identify fraud in real-time. In addition, as part of the provider credentialing process, MCOs conduct pre-contractual site visits to verify the legitimacy and operational capacity of the entity. When potential fraud, waste, and abuse is identified, MCOs are required to report such findings to the Maryland Department of Health and the Office of Inspector General in accordance with applicable federal and state requirements.

Maryland Medicaid Managed Care 1115 Waiver and Budget Neutrality

The Medicaid Managed Care program in Maryland is externally validated by the Centers for Medicare and Medicaid Services (CMS). The HealthChoice Program exists under an 1115 waiver that has been approved by CMS and is reviewed and validated every five (5) years. CMS approves Section 1115 waivers based on their capacity to advance Medicaid objectives, specifically improving care, health equity, access, and quality while remaining *budget neutral*. Budget neutrality requires that the waiver must not increase federal spending; rather *costs must be equal to or lower than what they would have been without the waiver*.

Conclusion

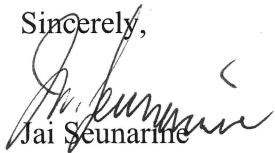
Jai Medical Systems is proud to serve in the Maryland HealthChoice Program as the only Minority Business MCO, and we are proud of the local jobs that we have provided to the people of our community. Medicaid managed care is a stronger and more effective delivery system because it aligns incentives with outcomes, establishes clear accountability for cost and quality, enhances care coordination, and supports predictable and responsible state budgeting. These core features are essential to serving complex, high-need populations while maintaining fiscal discipline.

In closing, the HealthChoice Program has been evaluated, refined, and overseen for decades through CMS waiver approvals, actuarial certifications, quality audits, network adequacy reviews, and performance reporting. As a result, the value of managed care in Medicaid is well established and not speculative.

Maryland's own experience demonstrates that managed care is best positioned to meet the clinical, operational, and fiscal demands of a modern Medicaid program. Undermining this proven structure would weaken accountability, fragment care, and expose the State to unnecessary financial and operational risk. House Bill 1112 would move Maryland in the wrong direction by calling into question a system that is working as intended. For these reasons, I respectfully urge the Committee to issue an unfavorable report on House Bill 1112.

Thank you for your consideration.

Sincerely,



Jai Seunarine
President and Chief Executive Officer

cc: Members, Senate Finance Committee