Tinna Damaso Quigley
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224-5744
Tel. 410-528-5773

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HB 971 – Maryland Medical Advisory Committee – Duties and Workgroup to Study the Adoptionof a Fee-for-Service Model for All Medicaid Services – UNFAVORABLE – House Health Committee

Thank you for the opportunity to submit testimony regarding House Bill 971. This legislation requires the Maryland Medical Advisory Committee to form subcommittees and workgroups, as necessary, to carry out the duties of the Committee; establishes the Workgroup to Study the Adoption of a Fee-for-Service Model for all Medicaid Services to study the feasibility of implementing a direct care payment model throughout the State's Medicaid program; and requires the workgroup to report its findings and recommendations to the Advisory Committee and certain members of the General Assembly by January 1, 2027.

Since 1997, HealthChoice has focused on improving health outcomes, managed care efficiencies, and fiscal sustainability, resulting in increased access to quality healthcare and reduced overall spending for the Maryland community.

Nearly one in four, or roughly 1.4 million, Maryland residents are enrolled in Medicaid. Approximately 86% of those enrolled participate in HealthChoice. As one of the nine HealthChoice Managed Care Organizations (MCOs) proudly serving over 171,000 Marylanders, CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) remains committed to providing accessible and affordable healthcare to the communities we serve in all jurisdictions in Maryland. HealthChoice MCOs are routinely evaluated by the National Committee for Quality Assurance and are audited annually to ensure each MCO meets quality, access, and timeliness standards. On a broad level, a study conducted by Health Management Associates found that MCOs outperform fee-for-service on Child and Adult Core Set measures, and this can be attributed to several core tenets of managed care such as structured care coordination and programs to address social drivers of health.[1]

Medicaid is a critical safety net program and is at an inflection point in its history. Due to federal legislation passed last July, states who expanded Medicaid are preparing to implement complex new federal requirements such as work or community engagement requirements and redetermining certain members' eligibility more frequently – from annually to every six months. House Bill 971 indicates that the findings are to be presented by January 1, 2027, which is when the aforementioned changes are to start, as mandated by federal statute. The state, as well as other stakeholder partners such as the MCOs and providers, are working diligently ahead of that date to develop comprehensive communication materials for members, optimize IT system capability, and maintain sufficient staffing to carry out these new time-intensive requirements. These efforts are to ensure that every eligible Medicaid enrollee retains their coverage with as few barriers as possible. Given the significant planning and implementation required by all stakeholders – and the fact that the Centers for Medicare & Medicaid Services (CMS) has yet to issue comprehensive guidance on community engagement requirements – initiating this workgroup would divert critical focus away from those efforts. Our Medicaid enrollees are among the most vulnerable in our communities and evaluating the feasibility to overhaul a current delivery system that consistently provides quality care to enrollees at this critical time would take away the diligent attention our enrollees deserve.

[1] https://www.healthmanagement.com/wp-content/uploads/HMA-Value-of-Managed-Care.pdf

House Bill 971 also charges the workgroup to study Connecticut, a state that moved away from managed care in 2012, and how its fee-for-service model improved access, provider participation, and cost of care. While reviewing the experiences of other states can be informative, extrapolating such findings does not account for the fact that each state operates within different contexts. For example, Connecticut cites a managed fee-for-service model as helping to increase provider participation in Medicaid, it does not have the same levers in place that Maryland does to support primary care delivery such as the Maryland Primary Care Program. Additionally, an independent analysis of Connecticut's managed fee-for-service model found that Connecticut Medicaid primary care provider slightly decreased between 2021-2022.[2] In 2022, Connecticut Medicaid underperformed compared to the median state score on over half of the quality measures focused on acute and chronic conditions for both children and adults.[3] Moreover, Connecticut's Medicaid program had higher spending on individuals with disabilities and older adults than other states in the Northeast, and beneficiary satisfaction scores broadly have declined over time. [4]It is also worth noting that, in 2024, Connecticut explored the feasibility of a return to Medicaid managed care. Like many states, Connecticut continues to face affordability challenges, which were not eliminated by moving away from managed care.

HealthChoice MCOs are a critical feature of Maryland's healthcare landscape and consistently provide accessible, equitable care that enable consumer choice while upholding quality. **For these reasons, CareFirst CHPMD respectfully requests an unfavorable report on House Bill 971.**

Sincerely,

Vice President
State Government Affairs, Maryland

[2] https://portal.ct.gov/dsshome/-/media/dss/ct_dss_medicaid-landscape-analysis_final-report_1252024_v2.pdf?rev=d863a052048b462db8aff2e4b89024aa&hash=C97D47644B5EE807766A98C6E644F6AE
[3] Ibid.
[4] Ibid.