THEME 02

HEALTHCARE IS A HUMAN RIGHT

Healthcare is a human right. It should be affordable, it should be close by, and it should treat you with care. This is the foundation of how we care for each other in this country. In MD-01, too many of our neighbors live an hour from a specialist and a month from a mental health appointment. The fight is to make that right real in every household.

IN THIS THEME

BRIEF 2.1

Mothers Shouldn't Die Having Babies

WHAT'S HAPPENING

The United States has the highest maternal mortality rate of any wealthy country in the world. The rate for Black mothers is roughly three times the rate for white mothers. The CDC has consistently estimated that more than 80 percent of these deaths are preventable. We are losing mothers in the United States that we should not be losing.

Most of those deaths come down to access and follow-up. Pregnant patients should not have to drive an hour to see an obstetrician, and the 60-day postpartum Medicaid window leaves new mothers uninsured during the most medically dangerous part of recovery. Doulas and midwives, who have decades of evidence behind them as life-saving for high-risk pregnancies, should be paid through Medicaid the same way other providers are.

The Black Maternal Health Momnibus Act is the legislative answer. It is a package of bills (originally led by Representatives Lauren Underwood and Alma Adams, and Senator Cory Booker) that together cover the things that actually drive mothers' deaths: the social drivers of health, the workforce shortage in obstetrics, maternal mental health, postpartum insurance coverage, doula and midwife integration, environmental hazards, and care for incarcerated and veteran mothers. The package was reintroduced in the 119th Congress.

Members of the Black Maternal Health Caucus have already secured more than $200 million in maternal health appropriations over the past several cycles. The substance is well-developed. The block is making it law.

WHAT THIS MEANS AT HOME

MD-01 has its own maternal health story. The data ranks the Eastern Shore among the worst regions in Maryland for maternal outcomes.

Rural counties on the Eastern Shore have lost obstetric services. Pregnant patients in the lower Shore, especially Crisfield, Smith Island, and the southernmost reaches of Worcester and Somerset counties, often drive an hour or more to deliver a baby. UM Shore Easton serves Dorchester, and TidalHealth in Salisbury serves the central Lower Shore, but distances grow with each closure of a labor and delivery unit. The Eastern Shore consistently ranks among the worst regions in Maryland for prenatal access, low birthweight outcomes, and maternal morbidity.

Consider a new mother in Pocomoke. She gave birth at the only hospital that still does deliveries within an hour of her home. Sixty days after she leaves the hospital, her Medicaid coverage drops, right when postpartum depression most often hits. The first signs of preeclampsia and other postpartum complications also commonly show up in those weeks. Without a 12-month postpartum Medicaid extension, she is uninsured during the most medically dangerous window after giving birth.

Mothers in MD-01 are dying or coming close because the closest care is too far away or the coverage runs out too soon.

MY TAKE

A wealthy country in 2026 should not be losing mothers in childbirth at the rate the United States loses them. There is nothing partisan about saying every pregnant person in MD-01 deserves a doctor within driving distance, insurance that lasts past their first checkup, and a birth attendant trained for their pregnancy.

OUR PLAN

In Congress

Cosponsor the full Black Maternal Health Momnibus Act, including every component bill rather than a curated subset.

Join the Black Maternal Health Caucus. Use the Caucus's appropriations work to direct federal maternal health funding toward Eastern Shore community-based maternal health organizations. The grant flow has historically gone to urban centers. The Shore deserves its share.

Cosponsor legislation to make 12-month postpartum Medicaid coverage permanent and federally required. Maryland adopted the option already; federal law should require it nationwide and protect it from rollback.

Cosponsor legislation to make doulas and midwives Medicaid-reimbursable providers. The evidence on doula support and birth outcomes is overwhelming. Federal Medicaid policy should accelerate state adoption.

In the District

A district office liaison for healthcare access issues, including maternal and prenatal care. The liaison helps constituents navigate Medicaid, find prenatal providers, and access the workforce-shortage solutions the Momnibus would fund.

The Eastern Shore Maternal Health Initiative, organized through Community Project Funding (the modern name for federal earmarks). Three priorities: mobile prenatal care for the lower Shore counties that have lost OB services; workforce pipeline grants for OB nurses, midwives, and lactation consultants based on Delmarva; and a perinatal mental health pilot at the Wicomico-Worcester level.

Maternal health convenings on the Eastern Shore, bringing together TidalHealth, Delmarva community health centers, the Maryland Maternal Health Innovation Program, doulas, midwives, and the Black Mamas Matter Alliance. The point is to keep the conversation open and the funding flowing.

Through Oversight

Public report from the district office on prenatal access by county in MD-01. Posted online. Updated annually.

Demand committee hearings on hospital closures of labor and delivery units in rural America. The Eastern Shore is a use case.

Coordinate with the Maryland Attorney General and the Maryland Department of Health on enforcement of pregnancy discrimination and maternal care quality standards.

THE HONEST PART

The full Momnibus has not passed in three Congresses. The package is bipartisan in substance but partisan in passage. Without filibuster reform or a 60-vote bipartisan coalition, the omnibus version is unlikely to clear the Senate. The strategy is moving individual component bills, attaching pieces to appropriations bills, and using Caucus oversight to make sure the pieces that pass actually get implemented and funded.

The 12-month postpartum Medicaid extension is the most viable single piece in the near term. Most states have already adopted the option. Codifying it federally is the next step.

Federal Medicaid policy depends on state implementation. Even when federal law changes, states have to adopt and fund the changes. Maryland is in good shape; the broader fight is about the states that are not.

The hospital closure problem on the Eastern Shore cannot be fixed by federal legislation alone. It is a federal-state-local fight that needs investment in workforce, infrastructure, and reimbursement rates. Federal funding helps. It does not solve.

RECEIPTS

BILLS

- Black Maternal Health Momnibus Act (H.R. 7973, reintroduced March 18, 2026). Lead sponsors: Rep. Lauren Underwood (D-IL), Rep. Alma Adams (D-NC), Sen. Cory Booker (D-NJ).
- Healthy MOM Act (H.R. 6242). 12-month postpartum Medicaid coverage. Sponsor: Rep. Bonnie Watson Coleman (D-NJ).
- Doula and midwife Medicaid coverage legislation. Multiple bills across recent Congresses.
- Healthy Moms and Babies Act (S. 2289). The closest 119th Congress vehicle for several maternal health reforms.

SOURCES

- CDC maternal mortality data: cdc.gov/reproductivehealth/maternal-infant-health/maternal-mortality
- Maryland Maternal Health Innovation Program: health.maryland.gov/phpa/mch
- Black Mamas Matter Alliance: blackmamasmatter.org
- March of Dimes Maryland Report Card: marchofdimes.org/peristats/data/state-summary/Maryland
- Black Maternal Health Caucus: blackmaternalhealthcaucus-underwood.house.gov

PARTNERS

Maryland Maternal Health Innovation Program. Black Mamas Matter Alliance. March of Dimes Maryland. TidalHealth (Salisbury). Delmarva community health centers. National Birth Equity Collaborative.

BRIEF 2.2

Doctors When You Need Them

WHAT'S HAPPENING

Healthcare access in MD-01 is being squeezed on three fronts at once: doctors, hospitals, and nurses.

The specialist shortage.

The Eastern Shore has documented gaps in specialist care, particularly pediatric subspecialties (cardiology, neurology, behavioral health, developmental pediatrics). Families with sick kids drive to Baltimore, Wilmington, or Hopkins for care that should be available within an hour. The drivers are well-known. Medicare reimburses rural specialists less than urban peers under a formula called the Geographic Practice Cost Index (GPCI). The federal visa program for international physicians (Conrad 30) is over-subscribed in Maryland. Residency slots are concentrated in cities, and most physicians practice within 100 miles of where they trained. Telehealth flexibilities expanded during COVID and are now at risk of expiring.

The hospital closures.

UM Harford Memorial Hospital in Havre de Grace closed February 6, 2024, after 112 years. UM Upper Chesapeake opened a Medical Center in Aberdeen with a full emergency department, observation beds, and a Behavioral Health Pavilion. It does not have medical-surgical inpatient beds, an ICU, or inpatient surgery. The full-service hospital for Harford County is now in Bel Air. Residents in Havre de Grace, Perryville (just over the Susquehanna in Cecil), and the northern part of the county now face longer ambulance rides for inpatient and surgical care, walk-in access gaps, and continuity-of-care problems.

The Franklin Square emergency department.

MedStar Franklin Square Medical Center in eastern Baltimore County has some of the longest ED wait times in the state. Behavioral health patients board there for days waiting for psychiatric placement. Primary-care shortages in Essex, Middle River, Rosedale, and Dundalk push more people to the ED who should be in a clinic.

The nursing fight.

The administration has, in twelve months, made three federal moves that hit the nursing workforce hard. The One Big Beautiful Bill Act, signed July 4, 2025, eliminated Grad PLUS loans and capped graduate student federal borrowing at $20,500 per year and $100,000 lifetime, unless a degree is classified as "professional," in which case the cap is $50,000 per year and $200,000 lifetime. In November 2025, the Department of Education proposed a rule excluding nursing from the "professional degree" definition. Master's, DNP, and PhD nursing programs would be reclassified at the lower cap. The rule takes effect July 1, 2026 unless Congress or HHS intervenes.

At the same time, Title VIII (the federal Nursing Workforce Development Program, the primary federal funding stream for nursing education for more than half a century) had its authorization expire on October 1, 2025 during the federal shutdown. Funding is hanging on a continuing resolution at $305 million annually. For comparison, Congress provides $17.8 billion annually for graduate medical education for physicians.

In the middle of a documented nursing shortage, with hospital RN vacancy rates near 10 percent and 200,000 nurse openings projected per year, the federal government is cutting nursing funding, capping nursing loans below the cost of advanced practice degrees, and proposing a rule that says nursing is not a profession.

WHAT THIS MEANS AT HOME

Consider a senior in Havre de Grace who has a stroke at 2 AM. Before February 2024, the ambulance went to UM Harford Memorial, ten minutes away. Now it drives forty-five minutes to UM Upper Chesapeake in Bel Air for the kind of inpatient stroke care she needs. In stroke care, "time is brain." Forty-five minutes versus ten can be the difference between recovery and permanent disability.

The local nursing pipeline runs through Wor-Wic Community College, Salisbury University, UMES, Chesapeake College, Cecil College, and Harford Community College. Every one of those schools is now operating in a worse federal funding environment than they were a year ago. A nursing student at UMES who wanted to become a nurse practitioner is one Department of Education rule away from a $30,000-a-year loan cap drop.

MY TAKE

Healthcare as a right means a child in Crisfield reaches a pediatric specialist, a senior in Havre de Grace gets an ambulance in time, and a nursing student at UMES can afford her degree. The federal levers exist for all three. The political will to use them is the question.

OUR PLAN

In Congress

On specialists:

- Cosponsor the Resident Physician Shortage Reduction Act to expand residency slots in or rotating through the Eastern Shore.
- Cosponsor legislation to expand Conrad 30 / J-1 visa waiver slots and make the rural-specialty pathway more flexible.
- Push for fixing the Medicare GPCI and work-RVU floor for shortage areas. The current formula systematically underpays rural specialists.
- Make permanent the COVID-era Medicare telehealth flexibilities so tele-pediatric subspecialty care from Hopkins or University of Maryland Children's into Salisbury, Cambridge, and Easton can keep operating.

On hospitals:

- Cosponsor legislation supporting Rural Emergency Hospital designation pathways and reimbursement.
- Defend Maryland's Total Cost of Care Model at CMS. Maryland's unique Medicare waiver lets hospitals invest in upstream interventions, which is part of why safety-net facilities like Franklin Square stay financially viable.

- Support permanent authorization of the CMS Acute Hospital Care at Home program.

On Franklin Square specifically:

- Direct SAMHSA Crisis Stabilization Unit funding and 988 mobile crisis funding to eastern Baltimore County so EDs are not the default destination for psychiatric emergencies.
- Expand Federally Qualified Health Center capacity in the Essex / Middle River / Rosedale / Dundalk corridor through HRSA Section 330 grants.

On nurses:

- Cosponsor the Loan Equity for Advanced Professionals Act, the Professional Degree Restoration Act, and the Professional Student Degree Act. All three would explicitly include MSN, DNP, PhD, and other advanced nursing degrees in the federal "professional degree" definition.
- Cosponsor the Title VIII Nursing Workforce Reauthorization Act of 2025 (H.R. 3593 / S. 1874). Push for funding above the $305 million baseline.
- Defend the Nurse Faculty Loan Program and the Nursing Workforce Diversity Program against further cuts.
- Cosponsor the Workplace Violence Prevention for Health Care and Social Service Workers Act, requiring OSHA to issue an enforceable standard.
- Use the Congressional Review Act if necessary to block the November 2025 Department of Education rule before it takes effect July 1, 2026.

In the District

A district office liaison for healthcare access issues, paired with the maternal health liaison from Brief 2.1. Helps constituents navigate Medicare appeals, Medicaid coverage, FQHC referrals, and rural health resources.

A constituent-services review of whether parts of northeastern Harford County would benefit from a federally designated Rural Emergency Hospital, and whether existing UM Aberdeen meets the underlying access need or whether a supplemental facility is warranted.

Constituent-service oversight on UM Upper Chesapeake's promised shuttle service, behavioral-health bed expansion, and outpatient buildout in Harford County. The promises were made when Harford Memorial closed. My office tracks and publishes performance against them.

A specific outreach to the MD-01 nursing programs (Wor-Wic, Salisbury University, UMES, Chesapeake College, Cecil College, Harford Community College). Help them apply for Title VIII grants, HRSA Advanced Nursing Education grants, and Nurse Faculty Loan Program funding, with priority on clinical preceptor support, the bottleneck that turns away qualified nursing applicants nationally each year.

Through Oversight

Public letters to CMS demanding renewal of the Maryland Total Cost of Care Model on terms that protect Franklin Square and other safety-net facilities.

Demand committee hearings on the Department of Education's "professional degree" rulemaking and the Title VIII funding shortfall.

Coordinate with Maryland's Attorney General on Medicare and Medicaid reimbursement enforcement.

Annual public report on emergency department wait times, ambulance response times, and nursing workforce vacancy rates by MD-01 county. Posted online.

THE HONEST PART

The specialist shortage cannot be solved by federal legislation alone. It requires medical education investment, residency placement, reimbursement reform, and visa policy working together. Federal levers are real but slow. The Conrad 30 expansion is the most viable single piece in the near term.

Reopening Harford Memorial is not feasible. The hospital is gone. The fight is making sure UM Aberdeen and the Bel Air full-service hospital actually meet the access need, and that Northern Harford has the EMS, telehealth, and outpatient capacity to fill the gap.

The Maryland Total Cost of Care Model renewal is up to CMS. Maryland's congressional delegation has to make the case. Federal majority composition matters less than CMS leadership for this fight.

The nursing fights are time-sensitive. The Department of Education rule takes effect July 1, 2026 unless intervened. The Title VIII reauthorization needs a vehicle (probably an end-of-year omnibus or appropriations bill). Both are within reach if the political pressure stays on.

RECEIPTS

BILLS

- Resident Physician Shortage Reduction Act (H.R. 4731 / S. 2439). Bipartisan.
- Loan Equity for Advanced Professionals Act (H.R. 6574). Restores nursing professional-degree status for federal student aid purposes.
- Professional Degree Access Restoration Act (H.R. 6677 / S. 4039). Restores nursing professional-degree status for federal student aid purposes.
- Professional Student Degree Act (H.R. 6718). Restores nursing professional-degree status for federal student aid purposes.
- Title VIII Nursing Workforce Reauthorization Act of 2025 (H.R. 3593 / S. 1874).
- Workplace Violence Prevention for Health Care and Social Service Workers Act.

ADMINISTRATIVE ACTIONS

- One Big Beautiful Bill Act, signed July 4, 2025. Eliminated Grad PLUS loans and capped graduate student federal borrowing.
- Department of Education proposed rule, November 2025 (RISE negotiated rulemaking). Excludes nursing from the "professional degree" definition. Effective July 1, 2026 unless intervened.
- Title VIII Nursing Workforce Development Program authorization expiration, October 1, 2025.

SOURCES

- Bureau of Labor Statistics, registered nurses occupational outlook

- HRSA Health Professional Shortage Areas
- CMS Maryland Total Cost of Care Model
- American Nurses Association on the professional degree rule

PARTNERS

TidalHealth (Salisbury). University of Maryland Shore Regional Health. MedStar Health. UM Upper Chesapeake Health. Maryland Hospital Association. Maryland Health Care Commission. American Nurses Association. American Association of Colleges of Nursing. National Black Nurses Association. Maryland Nurses Association. MD-01 nursing programs (Wor-Wic, Salisbury University, UMES, Chesapeake College, Cecil College, Harford Community College).

BRIEF 2.3

Care That Treats You Right

WHAT'S HAPPENING

There are two separate fights inside this one. Both come down to whether the healthcare system treats patients like people.

Kennedy Krieger on the Eastern Shore.

In 2026, the Maryland Capital Budget appropriated $5 million ($2.5 million Senate, $2.5 million House) to launch a new Kennedy Krieger Institute facility in Wicomico County. The facility is a special education school for students with developmental and behavioral disabilities whose needs cannot be met in the local public school system. It is the result of a three-year advocacy effort led by Healthy Minds for Shore, the Greater Salisbury Committee, and Wicomico County Public Schools.

The facility is a school, not a hospital. It is not a general healthcare access expansion. Families on the Shore who need pediatric specialty care, complex inpatient care, or rehabilitation services still need separate pathways (see Brief 2.2). Anyone in Annapolis or Washington who claims this single facility solves the Shore's pediatric healthcare problem is overselling it.

Discrimination and mistreatment in healthcare.

The other half of treatment-with-respect is what happens when a patient is dismissed, racially profiled, denied appropriate pain management, or discriminated against. The federal mechanisms that should catch and punish this are real, but they are systematically under-staffed and, since January 2025, actively narrowed.

Section 1557 of the Affordable Care Act prohibits discrimination in any health program or activity receiving federal financial assistance. That covers essentially every hospital, every nursing home, and every Medicare or Medicaid provider in MD-01. The protected categories include race, color, national origin, sex (including pregnancy, sexual orientation, and gender identity under the 2024 final rule), age, and disability. Enforcement runs through the HHS Office for Civil Rights (OCR). The 2024 final rule, after eight years of litigation and rulemaking, included strong language access requirements, prohibitions on discriminatory use of clinical algorithms, and explicit Bostock-aligned protections for LGBTQIA+ patients. The current administration has narrowed enforcement, particularly the gender identity and pregnancy termination provisions, and OCR staffing has been cut substantially.

The federal government has additional levers beyond Section 1557: Title VI of the Civil Rights Act (race, color, national origin in federally-funded programs), the Americans with Disabilities Act (Title III for hospitals as public accommodations), the Age Discrimination Act, the Emergency Medical Treatment and Labor Act (EMTALA, which requires emergency departments to screen and stabilize every patient regardless of ability to pay), the CMS Conditions of Participation (the rules every Medicare-participating hospital must follow), and HIPAA privacy enforcement. These are powerful tools when enforced. They have been spotty in practice, particularly for Black patients.

The evidence on racial disparities in healthcare is no longer in dispute. Black patients receive less pain medication for the same conditions, are misdiagnosed and dismissed at higher rates than white patients, and are discharged earlier than is clinically appropriate. Black women die in childbirth at three times the rate of white women (see Brief 2.1). The Institute of Medicine documented all of this in its 2003 report "Unequal Treatment," and the patterns have not meaningfully changed in the 23 years since.

WHAT THIS MEANS AT HOME

A family in Salisbury whose child has autism gains a new educational pathway through Kennedy Krieger. That family still needs a developmental-behavioral pediatrician, a speech therapist, and an occupational therapist within driving distance. The school does not replace the rest of the care.

The accountability piece shows up differently. Consider a Black mother in Pocomoke who arrives at an emergency department in active labor and is dismissed without a proper screening. Under EMTALA, that hospital had a federal obligation to screen and stabilize her. Under Section 1557, racial discrimination in her treatment is illegal. Without an HHS Office for Civil Rights staffed to investigate, without a Joint Commission citation that has consequences, and without a CMS condition of participation that the hospital actually fears losing, those federal protections live only on paper. The MD-01 patient population also includes growing Spanish-speaking and Haitian Creole-speaking communities, especially in Salisbury, Cambridge, and parts of Baltimore County. "We did not have an interpreter" should not be how a hospital's deposition starts.

MY TAKE

Care happens when nurses are supported, patients are heard, discrimination is documented, and institutions face consequences for failure. A federal representative who says they care about healthcare access has to work on all four.

OUR PLAN

In Congress

On Kennedy Krieger and pediatric specialty care:

- Pursue federal grant alignment for the Kennedy Krieger Eastern Shore facility through HHS, HRSA, and Department of Education funding streams (Autism CARES Act, IDEA Part B, HRSA developmental-behavioral pediatrics).
- Coordinate with TidalHealth and University of Maryland Shore Regional Health on building out the broader pediatric specialty network around the Salisbury hub.

On Section 1557 and OCR:

- Vote against further cuts to HHS Office for Civil Rights (OCR) staffing and budget.
- Defend the 2024 Section 1557 final rule against rollback, including the gender identity, pregnancy termination, language access, and clinical algorithm provisions.

- Cosponsor legislation to strengthen Section 1557 enforcement: a private right of action for compensatory damages, clarification that disparate-impact claims are available, and authorization for the Attorney General to bring federal civil actions in patterns-and-practices cases.

On EMTALA, ADA, and CMS:

- Defend EMTALA against administrative narrowing of emergency abortion care obligations under HHS. A patient in a medical emergency, including a pregnancy emergency, must be screened and stabilized.
- Push CMS to use Conditions of Participation more vigorously, including patterns of discrimination as a basis for survey citation. Decertification from Medicare is the strongest accountability tool the federal government has over hospitals.

On transparency and data:

- Defend and expand the Patient Safety and Quality Improvement Act framework. Hospitals should report publicly, disaggregated by race, ethnicity, sex, language, and disability status, on patient safety events, hospital-acquired conditions, readmissions, mortality, and patient complaints.
- Defend the AHRQ National Healthcare Quality and Disparities Report, which has been a target. It is the federal government's only systematic public accounting of healthcare disparities.

On training and language access:

- Make implicit bias and cultural competence training a condition of federal grant funding for clinical training programs (HRSA, AHRQ, HHS workforce programs). Maryland already requires this for license renewal in several health professions; federal programs should align.
- Defend the 2024 Section 1557 language access requirements.

In the District

An MD-01 patient ombudsman function in the district office. When a constituent believes they have been mistreated or discriminated against in a healthcare setting, the office helps them file with HHS OCR, with CMS, with the Joint Commission, and with the Maryland Department of Health. The office tracks the patterns. This is constituent service that has not historically been provided in this district.

Help Kennedy Krieger and partner organizations apply for federal grants that complement the state capital funding.

A district office liaison for Spanish-speaking and Haitian Creole-speaking constituents on healthcare access issues, including language access complaints under Section 1557.

Through Oversight

Use congressional inquiry power to push CMS, AHRQ, and the Maryland Health Care Commission to publish patient-experience and outcome data for MD-01 hospitals broken out by race, ethnicity, language, and insurance status.

Public letters to HHS OCR on individual MD-01 complaints. The threat of public attention is part of how compliance happens.

Annual report from the district office on civil rights complaints filed against MD-01 hospitals and their resolution.

THE HONEST PART

The Kennedy Krieger Eastern Shore facility is a state-funded school. Federal funding can complement it but not replace the state capital investment. Federal alignment work is real but bounded.

OCR enforcement depends on the administration in power. Defending the 2024 Section 1557 rule is a defensive fight as long as the current administration runs HHS. The work is keeping the rule alive in court and in regulation, and limiting damage from rollback.

A private right of action for Section 1557 has been introduced in prior Congresses and not passed. It needs a Senate path that does not currently exist. Until then, the work is OCR oversight and CMS Conditions of Participation enforcement.

The patient ombudsman function does not require federal legislation. It requires staff and intent. It is one of the most concrete things a member of Congress can do that almost nobody actually does.

RECEIPTS

BILLS

- Section 1557 enforcement strengthening legislation (private right of action, disparate impact, AG civil actions). Multiple bills introduced in recent Congresses.
- Workplace Violence Prevention for Health Care and Social Service Workers Act (cross-reference Brief 2.2).

FEDERAL AUTHORITIES

- Section 1557 of the Affordable Care Act (42 U.S.C. § 18116). 2024 final rule.
- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d).
- Americans with Disabilities Act, Title III (42 U.S.C. § 12181 et seq.).
- Age Discrimination Act of 1975.
- Emergency Medical Treatment and Labor Act, EMTALA (42 U.S.C. § 1395dd).
- CMS Conditions of Participation (42 C.F.R. § 482).
- HIPAA Privacy Rule.

COURT CASES

- Idaho v. United States (2024). The U.S. Supreme Court dismissed the case as improvidently granted (DIG), declining to resolve the EMTALA emergency-abortion question on the merits. The current narrowing of emergency abortion care under EMTALA is happening administratively under HHS, not by Supreme Court ruling.

STATE FUNDING

- 2026 Maryland Capital Budget appropriation for Kennedy Krieger Eastern Shore: $5 million ($2.5M Senate, $2.5M House).

SOURCES

- HHS Office for Civil Rights: hhs.gov/ocr
- AHRQ National Healthcare Quality and Disparities Report
- Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (2003)
- Kennedy Krieger Institute: kennedykrieger.org

PARTNERS

HHS Office for Civil Rights. Maryland Department of Health. Maryland Health Care Commission. NAACP Maryland State Conference. Maryland Legal Aid (health justice unit). Disability Rights Maryland. Healthy Minds for Shore. Greater Salisbury Committee. Wicomico County Public Schools. Kennedy Krieger Institute. TidalHealth. University of Maryland Shore Regional Health.

BRIEF 2.4

Coverage You Can Count On

WHAT'S HAPPENING

Federal healthcare coverage in MD-01 runs through four programs: Medicaid, the ACA marketplace, Medicare, and Medicaid HCBS waivers (which fund Maryland's Developmental Disabilities Administration, DDA). All four have been damaged in the past year. The damage is layered.

The One Big Beautiful Bill Act and Medicaid.

The OBBBA, signed July 4, 2025, imposed work requirements on Medicaid and tightened eligibility through faster redetermination cycles. The Congressional Budget Office and independent analyses confirm coverage losses on a scale not seen since the ACA passed in 2010. Millions of Americans have been pushed off Medicaid rolls. The harm is concentrated in rural areas (much of MD-01) and among the working poor who lose coverage between paperwork cycles even when they remain eligible.

ACA premium subsidies.

The Inflation Reduction Act's enhanced ACA premium tax credits dramatically lowered marketplace premiums and brought enrollment to record highs. The OBBBA narrowed those subsidies and made them less generous. Restoring them is the single fastest way to lower healthcare costs for working families in this district.

Medicare.

Medicare's drug-price negotiation authority, won under the Inflation Reduction Act (IRA Title I, Subtitle B, Part 2), is being challenged by the pharmaceutical industry and at risk of administrative rollback. Medicare Advantage plans, which now cover more than half of all Medicare beneficiaries, have well-documented problems with prior-authorization abuses, upcoding, and network narrowing. Traditional Medicare still does not cover dental, vision, or hearing.

Maryland's DDA cuts.

Governor Moore proposed $150 million in cuts to the Maryland Developmental Disabilities Administration in his FY2027 budget, on top of $164 million in cuts the year before. After advocacy from families and the Developmental Disabilities Coalition, the General Assembly reduced this year's cut to $126 million and blocked a proposed individual-budget cap. The cuts include reductions to wages for self-directed care providers, the parents, siblings, and personal-care assistants who keep people with developmental disabilities out of institutions. These are state decisions, but most DDA services run through Medicaid HCBS waivers, where the federal government supplies the larger half of the funding through Medicaid match dollars.

The pattern across all four is the same. Coverage that used to work is being squeezed. The cumulative effect on a household in MD-01 is fewer people insured, higher premiums for those who are, and fewer support services for families who depend on them.

WHAT THIS MEANS AT HOME

Consider a Worcester County small business owner who buys health insurance through the Maryland Health Connection marketplace. Under the Inflation Reduction Act's enhanced premium tax credits, his monthly premium dropped to a level he could budget around. After the OBBBA narrowed those credits, his premium went up roughly $300 a month. That is $3,600 a year out of a small business owner's pocket for the same coverage he had before. Multiply that by the small business owners and self-employed workers across the Lower Shore, and you have one specific corner of the federal coverage squeeze hitting MD-01.

The pediatric specialist drive (Brief 2.2), the maternal mortality rate (Brief 2.1), and the Eastern Shore VA wait (Brief 1.4) all get worse when the underlying insurance coverage is also being squeezed.

MY TAKE

A country that has Medicare, Medicaid, the ACA, and HCBS waivers already has the architecture of universal coverage. The fight in this Congress is to stop the cuts, restore what has been taken, and expand the parts that work. That is the substance of defending healthcare as a right.

OUR PLAN

In Congress

On Medicaid (reverse the OBBBA damage):

- Cosponsor legislation to repeal the OBBBA Medicaid work requirements, redetermination acceleration, and eligibility narrowing.
- Restore the enhanced Medicaid match for expansion states and protect Maryland's expansion population.
- Cosponsor legislation to broaden categorical Medicaid eligibility for postpartum, behavioral health, and dental coverage.

On the ACA marketplace:

- Cosponsor legislation to make the IRA-era enhanced ACA premium tax credits permanent and extend them above 400 percent of the federal poverty line.
- Close the family glitch permanently. The 2022 administrative fix is good but should be statutory.
- Cosponsor a Medicare-pegged public option through the Maryland Health Connection marketplace.

On Medicare:

- Defend Medicare's drug-price negotiation authority (IRA Title I, Subtitle B, Part 2) against industry challenges and rollback efforts.
- Cosponsor legislation to lower the Medicare eligibility age to 60.
- Expand traditional Medicare to include dental, vision, and hearing (see Brief 2.5).

- Cosponsor legislation to tighten Medicare Advantage oversight, including prior-authorization limits, upcoding penalties, and network adequacy enforcement. Bring Medicare Advantage into closer alignment with traditional Medicare on access and appeals.

On HCBS and DDA:

- Cosponsor the HCBS Access Act and any successor legislation to fund waiver waitlists and stabilize direct support professional wages.
- Cosponsor legislation to permanently raise the federal Medicaid match rate for Home and Community-Based Services. A higher federal share reduces pressure on state budgets to cut services like Maryland's Community Pathways waiver.
- Push for a federal direct support professional wage floor through Medicaid reimbursement policy.

In the District

A district office case manager dedicated to coverage issues: Medicaid redeterminations, ACA marketplace navigation, Medicare appeals, Medicare Advantage prior-authorization disputes, and HCBS waiver waitlists. Most coverage problems show up at the kitchen-table level. The district office has to be ready to help.

A public roundtable with DDA-impacted families from MD-01 in the first term, working with The Arc Maryland and the Self-Directed Advocacy Network. The point is to listen and to bring federal pressure where state pressure has fallen short.

Coverage clinics across MD-01 counties. Open hours where constituents can bring insurance paperwork and get help.

Specific outreach to Maryland Medicaid (Maryland Medical Assistance) and the Maryland Health Connection navigator program to coordinate enrollment and re-enrollment work.

Through Oversight

Annual report from the district office on coverage losses by program and county in MD-01. Posted online.

Public letters to CMS on Medicare Advantage prior-authorization patterns affecting MD-01 beneficiaries. Use congressional inquiry power to surface aggregate denial rates by plan and condition.

Coordination with the Maryland Attorney General on insurance market enforcement, including ACA marketplace consumer protection.

Demand committee hearings on the OBBBA's Medicaid coverage losses. Get HHS, CMS, and OMB on the record.

THE HONEST PART

Repealing the OBBBA Medicaid provisions requires a House majority that wants to do it. Until that exists, the work is preventing further erosion, defending Medicaid expansion in Maryland, and making sure the redetermination process is administered as gently as possible at the state level.

The IRA-era ACA subsidies and the Medicare drug negotiation authority are policy gains that have to be defended every appropriations cycle. They are not safe. The work is keeping them.

The Maryland DDA cuts are state decisions. A federal representative cannot reverse them by fiat. What the federal government can do is increase the HCBS match rate, fund waiver waitlists, and set a federal floor for direct support professional wages. Those changes reduce the budget pressure that pushed Maryland to cut DDA in the first place.

A federal public option through the Maryland Health Connection has been proposed before. It does not pass without a Senate path. The work is keeping the legislation alive and ready.

RECEIPTS

BILLS

- Legislation to repeal the OBBBA Medicaid provisions. Multiple bills in current Congress.
- IRA ACA subsidy permanence legislation. Multiple bills.
- Family glitch statutory fix legislation.
- Medicare eligibility age reduction. Standalone bills exist; Medicare for All variations also include this.
- HCBS Relief Act of 2025 (S. 2076). The closest 119th Congress vehicle for HCBS Access Act priorities.
- Federal HCBS match rate increase legislation.

FEDERAL AUTHORITIES

- Inflation Reduction Act of 2022 (Title I, Subtitle B, Part 2, Medicare drug negotiation; ACA enhanced premium tax credits).
- One Big Beautiful Bill Act of 2025 (P.L. 119-21). Medicaid work requirements and eligibility changes; ACA subsidy narrowing.
- Medicaid Home and Community-Based Services (HCBS) waivers under Section 1915(c) and Section 1115 of the Social Security Act.

SOURCES

- Congressional Budget Office analysis of OBBBA coverage effects
- Center on Budget and Policy Priorities (CBPP) analysis of Medicaid changes
- Kaiser Family Foundation (KFF) on ACA subsidies and Medicare Advantage
- Maryland Department of Health, Medicaid
- Maryland Health Connection
- Maryland Developmental Disabilities Administration
- The Arc Maryland

PARTNERS

The Arc Maryland. Self-Directed Advocacy Network. Maryland Developmental Disabilities Coalition. AARP Maryland. AFSCME Council 67 (Maryland public employees). Maryland Medicaid Matters Coalition. Maryland Health Connection navigators. NCPSSM Maryland.

BRIEF 2.5

Mental Health, Dental, and Vision for Everyone

WHAT'S HAPPENING

Mental health care, dental care, and vision care are still treated as optional extras in the federal healthcare system, even though every one of them affects whether people can work, live independently, and stay healthy.

Mental health.

The Mental Health Parity and Addiction Equity Act has been federal law since 2008. It says insurance plans cannot put more restrictive limits on mental health care than they do on physical health care. In practice, enforcement has been weak. Networks for mental health providers are inadequate. Prior authorization is heavier on mental health than on physical health. Reimbursement rates push mental health providers out of insurance networks entirely, so even insured patients pay out of pocket or do without.

The 988 Suicide and Crisis Lifeline has handled millions of calls since launch. Federal funding for 988 and for the Press 1 veterans-specific line is at risk in every appropriations cycle.

The Bipartisan Safer Communities Act (signed 2022) funded school-based mental health services that have built capacity in MD-01 schools. That funding needs reauthorization.

Dental.

Traditional Medicare does not cover most dental care. The ACA marketplace requires pediatric dental coverage but not adult coverage. Roughly one in four American adults has gone without needed dental care in the past year because they could not afford it. The Eastern Shore has documented dental deserts, especially in Worcester, Somerset, and Dorchester counties.

Vision and hearing.

Traditional Medicare does not cover routine eye exams, glasses, or hearing tests, and only covers limited hearing aid services. The 2022 OTC hearing aid rule was a start but did not solve access for the people who most need it. Untreated hearing loss is now well-documented as a contributor to cognitive decline in older adults, an issue that hits a retirement-heavy district like MD-01 hard.

WHAT THIS MEANS AT HOME

Consider a retiree in Easton with progressive hearing loss. His doctor recommended hearing aids that would cost him $2,000 out of pocket. Traditional Medicare does not cover them. He has been hearing thirty percent less for three years because he cannot afford to spend $2,000 on the recommendation. The longer he waits, the higher his cognitive risk goes. Federal Medicare policy is the difference between him hearing his grandkids and not.

The 988 line in Maryland has been a lifeline for veterans, for LGBTQIA+ youth, and for anyone in crisis. The federal funding behind it is what keeps it on.

MY TAKE

Your teeth, your eyes, your ears, and your mental health are not optional. Treating them as if they were is one of the most expensive lies the federal healthcare system tells. Cheap preventive care now costs less than the disability and crisis care that comes later when problems go untreated.

OUR PLAN

In Congress

On mental health:

- Cosponsor legislation giving the Department of Labor, HHS, and state insurance regulators clear authority and resources to audit and penalize parity violations under the Mental Health Parity and Addiction Equity Act. The Consolidated Appropriations Act of 2021 (enacted December 27, 2020) reporting requirements need teeth.
- Cosponsor legislation expanding Medicare and Medicaid coverage to include licensed marriage and family therapists, licensed mental health counselors, peer support specialists, and community health workers. Maryland and many other states have moved on this; federal Medicare needs to catch up.
- Defend 988 Suicide and Crisis Lifeline funding and the Press 1 veterans line in every appropriations cycle.
- Defend and expand the Bipartisan Safer Communities Act's school-based mental health funding when it comes up for reauthorization.

On dental:

- Cosponsor the Medicare Dental Benefit Act when introduced, with full coverage of routine and preventive dental care, not the watered-down option that limits coverage to dental services tied to other medical procedures.
- Cosponsor legislation expanding the federal definition of essential health benefits under the ACA to require adult dental coverage in marketplace plans.
- Push federal funding for dental therapy training programs and Federally Qualified Health Center (FQHC) dental clinics. The Shore has documented dental deserts.

On vision and hearing:

- Cosponsor legislation adding comprehensive vision and hearing coverage to traditional Medicare. Routine eye exams, glasses, hearing tests, and hearing aids should be covered.
- Push Medicare expansion of diabetic eye disease screening in rural areas. Low cost, high payoff for an aging Shore population.

In the District

A district office liaison for mental health, dental, and vision access. The liaison helps constituents navigate parity complaints, find in-network therapists, locate FQHC dental capacity, and access Medicare Advantage dental and vision riders where available.

Coverage clinics across MD-01 counties (paired with Brief 2.4 clinics) include mental health, dental, and vision navigation help.

A specific outreach to MD-01 schools using Bipartisan Safer Communities Act funding to make sure the funding reaches the schools that need it.

A specific outreach to senior centers across the district on Medicare Advantage dental, vision, and hearing benefits, including how to compare plans and what is actually covered.

Through Oversight

Public letters to the Department of Labor and HHS on mental health parity enforcement. Use congressional inquiry power to surface aggregate data on parity violations by insurance plan.

Annual report from the district office on mental health provider availability, dental clinic capacity, and vision and hearing service access in MD-01.

Push the Maryland Insurance Administration and the Maryland Attorney General on parity enforcement at the state level.

THE HONEST PART

The Mental Health Parity Act is on the books. Enforcement is the work. Neither full statutory amendment nor regulatory enforcement happens without administration cooperation. The work is keeping pressure on Department of Labor and HHS regulators and supporting state-level enforcement.

A Medicare dental benefit has been proposed for years. The political block is the cost score and the dental industry. The work is keeping the legislation alive and ready.

A Medicare vision and hearing benefit is in similar territory. The OTC hearing aid rule was a partial win. The full benefit needs legislation that has not yet passed.

The 988 funding fight is annual. School-based mental health funding is on a multi-year reauthorization cycle. Both need defenders every cycle, not just every Congress.

RECEIPTS

BILLS

- Mental Health Parity Act enforcement legislation (multiple bills strengthening 2008 MHPAEA and 2020 CAA reporting requirements).
- Medicare Dental Benefit Act (H.R. 2045 / S. 939 / S. 2084). Multiple introductions in 119th Congress.

- Medicare vision and hearing coverage legislation.
- ACA essential health benefits expansion (adult dental coverage requirement).
- Bipartisan Safer Communities Act reauthorization.

FEDERAL AUTHORITIES

- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Consolidated Appropriations Act of 2021 (parity reporting requirements).
- Bipartisan Safer Communities Act of 2022 (school mental health funding).
- ACA essential health benefits framework.
- OTC Hearing Aid Rule (2022, FDA).

SOURCES

- 988 Suicide and Crisis Lifeline: 988lifeline.org
- Department of Labor parity enforcement
- Maryland Insurance Administration
- KFF on Medicare dental, vision, and hearing

PARTNERS

National Alliance on Mental Illness (NAMI) Maryland. Mental Health Association of Maryland. Maryland Dental Action Coalition. AARP Maryland. Maryland Insurance Administration. SAMHSA-funded community mental health centers. MD-01 school districts.

SOURCES

Theme 2: Healthcare is a Human Right

Sources for every claim made in the briefs of this theme. Bills cite the 119th Congress sponsor and bill number unless otherwise noted; "*see Brief X.Y*" indicates a citation that recurs across briefs and is fully detailed in the named brief.

THEME 02: HEALTHCARE IS A HUMAN RIGHT

Brief 2.1: Mothers Shouldn't Die Having Babies

BILLS

- Black Maternal Health Momnibus Act (H.R. 7973, reintroduced March 18, 2026). Lead sponsors: Underwood (D-IL), Adams (D-NC), Booker (D-NJ).
- Healthy MOM Act (H.R. 6242). 12-month postpartum Medicaid. Watson Coleman (D-NJ).
- Healthy Moms and Babies Act (S. 2289).

SOURCES

- CDC maternal mortality data.
- Maryland Maternal Health Innovation Program.
- Black Mamas Matter Alliance.
- March of Dimes Maryland Report Card.
- Black Maternal Health Caucus.

Brief 2.2: Doctors When You Need Them

BILLS

- Resident Physician Shortage Reduction Act (H.R. 4731 / S. 2439). Bipartisan.
- Loan Equity for Advanced Professionals Act (H.R. 6574). Restores nursing professional-degree status.
- Professional Degree Access Restoration Act (H.R. 6677 / S. 4039).
- Professional Student Degree Act (H.R. 6718).
- Title VIII Nursing Workforce Reauthorization Act of 2025 (H.R. 3593 / S. 1874).
- Workplace Violence Prevention for Health Care and Social Service Workers Act.

ADMINISTRATIVE ACTIONS

- One Big Beautiful Bill Act, July 4, 2025. Eliminated Grad PLUS loans.
- Department of Education proposed rule, November 2025 (RISE rulemaking). Excludes nursing from "professional degree." Effective July 1, 2026 unless intervened.
- Title VIII authorization expiration, October 1, 2025.

SOURCES

- Bureau of Labor Statistics, registered nurses occupational outlook.

- HRSA Health Professional Shortage Areas.
- CMS Maryland Total Cost of Care Model.
- American Nurses Association on the professional degree rule.

Brief 2.3: Care That Treats You Right

BILLS

- Section 1557 enforcement strengthening legislation (private right of action, disparate impact, AG civil actions). Multiple bills introduced in recent Congresses.

FEDERAL AUTHORITIES

- Section 1557 of the Affordable Care Act (42 U.S.C. § 18116). 2024 final rule.
- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d).
- Americans with Disabilities Act, Title III (42 U.S.C. § 12181 et seq.).
- Age Discrimination Act of 1975.
- Emergency Medical Treatment and Labor Act, EMTALA (42 U.S.C. § 1395dd).
- CMS Conditions of Participation (42 C.F.R. § 482).
- HIPAA Privacy Rule.

COURT CASES

- Idaho v. United States (2024). Dismissed as improvidently granted; current EMTALA narrowing is administrative under HHS.

STATE FUNDING

- 2026 Maryland Capital Budget appropriation for Kennedy Krieger Eastern Shore: $5 million ($2.5M Senate, $2.5M House).

SOURCES

- HHS Office for Civil Rights.
- AHRQ National Healthcare Quality and Disparities Report.
- Institute of Medicine, "Unequal Treatment" (2003).
- Kennedy Krieger Institute.

Brief 2.4: Coverage You Can Count On

BILLS

- Legislation to repeal OBBBA Medicaid provisions. Multiple bills in current Congress.
- IRA ACA subsidy permanence legislation. Multiple bills.
- Family glitch statutory fix legislation.
- Medicare eligibility age reduction (standalone bills; Medicare for All variations also include this).
- HCBS Relief Act of 2025 (S. 2076). Closest 119th Congress vehicle for HCBS Access Act priorities.
- Federal HCBS match rate increase legislation.

FEDERAL AUTHORITIES

- Inflation Reduction Act of 2022 (Title I, Subtitle B, Part 2; ACA enhanced premium tax credits).
- One Big Beautiful Bill Act of 2025 (P.L. 119-21). Medicaid work requirements; ACA subsidy narrowing.
- Medicaid HCBS waivers under Section 1915(c) and Section 1115 of the Social Security Act.

SOURCES

- Congressional Budget Office analysis of OBBBA coverage effects.

- Center on Budget and Policy Priorities (CBPP).
- Kaiser Family Foundation (KFF) on ACA subsidies and Medicare Advantage.
- Maryland Department of Health, Medicaid.
- Maryland Health Connection.
- Maryland Developmental Disabilities Administration.
- The Arc Maryland.

Brief 2.5: Mental Health, Dental, and Vision for Everyone

BILLS

- Mental Health Parity Act enforcement legislation (multiple bills strengthening 2008 MHPAEA and 2020 CAA reporting requirements).
- Medicare Dental Benefit Act (H.R. 2045 / S. 939 / S. 2084).
- Medicare vision and hearing coverage legislation.
- ACA essential health benefits expansion (adult dental coverage requirement).
- Bipartisan Safer Communities Act reauthorization.

FEDERAL AUTHORITIES

- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Consolidated Appropriations Act of 2021 (parity reporting requirements).
- Bipartisan Safer Communities Act of 2022.
- ACA essential health benefits framework.
- OTC Hearing Aid Rule (2022, FDA).

SOURCES

- 988 Suicide and Crisis Lifeline.
- Department of Labor parity enforcement.
- Maryland Insurance Administration.
- KFF on Medicare dental, vision, and hearing.

WANT MORE

Read the full plan.

This is one of five themes from **The New Plan**, Randi White's plan for MD-01. Read all 27 briefs, every citation, and the full pay-for plan in one place.

READ EVERYTHING AT

randiformd.com/plan

Or write me. The plan is a working document and I read what comes in.
info@randiformd.com