

Testimony For Senate Finance Committee Hearing:  
Wednesday March 25th

**HB1112**  
**Health Insurance Coverage Protection Commission - Study on Individual  
and Group Health Insurance Market Stability**

**FAV**

Madam Chair and Members of the Committee:

My name is Jacqueline MacMillan. I am a member of Progressive Maryland's Healthcare Taskforce, and I live in Baltimore.

HB1112 provides that the Health Insurance Coverage Protection Commission consider whether to adopt a direct payment, fee-for-service model for the Maryland Medical Assistance Program, or Medicaid. Under Maryland's current Medicaid system, 85% of patients receive healthcare coverage through Managed Care Organization (MCOs).

Medicaid MCOs, like other private insurers, restrict the providers that patients can see. And it is well documented that provider directories are often outdated and inaccurate. This causes a variety of problems, from difficulty finding specialists, and harmful delays in needed care, to surprise bills that result when a patient sees a provider who was incorrectly identified as "in network."

Restrictive networks are particularly problematic for Medicaid patients enrolled in MCOs because provider participation rates are already so low. Only 75% of providers take Medicaid patients, compared to 88% for Medicare, and 94% for private insurance.

In 2023, Qlarant, Maryland's external Medicaid quality review organization, evaluated the [network adequacy](#) of Maryland's nine Medicaid MCOs to ensure they could provide enrollees with timely access to necessary care and a sufficient

number of in-network providers. The telephone surveyors were unable to *even reach* 40% of the MCOs' network providers.

Qlarant's surveyors' task was to verify: the accuracy of online provider directories; provider acceptance of the listed MCO; acceptance of new Medicaid patients; and first availability for routine and urgent appointments. Based on the 2023 assessment, six of the nine MCOs were required to submit Corrective Action Plans to Qlarant to improve compliance.

Transitioning from Managed Care to a direct, fee-for-service mode of payment would benefit Medicaid patients by eliminating restrictive provider networks. All qualified Medicaid providers would be available to all Medicaid enrollees, affording patients a much larger pool from which to find appropriate specialists.

The state of Connecticut moved from managed care to a fee-for-service model in 2012, and saw a significant increase in the number of providers taking Medicaid patients. The reduction in paperwork from the nine MCOs in Maryland to a single payer would attract providers by making the administration of Medicaid simpler and less expensive, as it did in Connecticut.

There are many good reasons for Maryland to transition to a direct fee-for-service payment system for Medicaid, which should be thoroughly explored by state officials. These include significant cost savings to the state and greater transparency, as demonstrated by Connecticut's experience, better access to care for Medicaid patients—fewer care and claim denials, more providers taking Medicaid, the elimination of restrictive networks—and better health outcomes.

I urge you to give favorable consideration to HB1112.

Thank you,  
Jacqueline MacMillan