

Bill Title: HB 971 - Maryland Medical Advisory Committee - Duties and Workgroup to Study the Adoption of a Fee-For Service Model for All Medicaid Services

Hearing Date: 02/24/2026

Position: Support (FAV)

To: House Health Committee

From: Donna Ticknor, MD; Anne Arundel County, District 33B

Date: 02/20/2026

Madam Chair Bagnall and Members of the Health Committee:

My name is Dr. Donna Ticknor. I have been a Maryland resident for 28 years. I practice medicine throughout the State of Maryland and have been a practicing physician for over 25 years. I am also a member of the American Psychiatric Association, Maryland Psychiatric Society, Physicians for National Health Plan- MD/DC Chapter and the Progressive Maryland Healthcare Taskforce and other healthcare advocacy organizations.

PROBLEM

The 2025 Budget Reconciliation Act reduces federal Medicaid funding by \$1 trillion over the next decade. The cuts will be particularly deep in 2027 and 2028. Medicaid is a lifeline for one out of four Marylanders, including children and low-income families, people with disabilities, the elderly and working adults who don't have affordable insurance options.

CURRENT SITUATION

We appreciate all that our state health officials have been doing to understand the implications of HR 1 and the ways in which Medicaid enrollees will need help to comprehend and meet the new work requirements.

But Maryland also needs to identify new sources of significant revenue to offset the federal cuts and avoid cuts in services.

SOLUTION

HB 971 offers a way to do that. It empowers the Maryland Medicaid Advisory Committee to create a workgroup dedicated to studying the benefits of transitioning away from our use of middlemen Managed Care Organizations (MCOs) in favor of a direct payment system or fee-for-service model. Connecticut adopted such a system in 2012 and has saved \$4 billion over the intervening years. Their state has also seen increased participation from clinicians.

A recent white paper published by Physicians for a National Health program estimates that Maryland could save up to \$521 million annually by taking a similar step.

Why? MCOs on average take about 13 cents of every Medicaid dollar for overhead and profits. The state would only need 3 to 4 cents on a dollar to administer and run our publicly funded Medicaid program. By removing the “middle man” the state retains more of each Medicaid dollar which can then be directed towards patients, doctors and caregivers.

In addition to the extraordinary cost savings, transitioning away from an MCO model would also simplify the lives of Medicaid enrollees and the clinicians who care for them. Instead of worrying about whether a specialist is part of their particular MCO’s network, Medicaid enrollees would have a unified statewide network of Medicaid providers to choose from. Instead of worrying about whether a medication or procedure is covered by their patient’s specific MCO, clinicians would have a unified statewide Medicaid system to deal with.

Connecticut has found that a simplified, unified Medicaid system has helped draw physicians into the program. After Connecticut’s transition in 2012, the number of primary care physicians who participate in Medicaid rose by 14.6 percent. When there is less paperwork and bureaucratic complexity to deal with, clinicians are more likely to choose to serve Medicaid patients.

Some of Maryland’s MCOs are owned and operated by for-profit insurance companies with terrible records of care denials. Others are owned by nonprofit health systems. The health systems who operate MCOs might object that scrapping the MCO model would destroy valuable opportunities for improving care coordination. But this is not correct. Connecticut has continued to effectively promote care coordination by providing dedicated funds for primary care practices that operate as “patient-centered medical homes” (PCMHs). Some of Connecticut’s largest health systems participate in the PCMH model, and they have been able to use that model to streamline care and to minimize unnecessary emergency-room visits.

CONCLUSION

We owe it to our kids, our seniors, healthcare workers, and our vulnerable communities to move expeditiously to explore this option. The nine or ten cents from each Medicaid dollar that isn’t going to MCOs can be used for the services and support people rely on to meet their healthcare needs.

At least four other states are actively working on similar legislation - Minnesota, Hawaii, Illinois, and West Virginia.

Currently, Maryland Medicaid programs struggle to enroll an adequate number of clinicians, especially psychiatrists and specialized mental health clinicians. By simplifying the process of using one state-run Medicaid program, it will reduce the cost and the administrative burden to solo mental health clinicians and small mental health clinics and encourage more participation. It will also reduce the number of unnecessary prior authorizations and profit-driven mental health care denials. This improves the care and choice of Medicaid recipients. It also reduces the Moral Injury that drives clinicians away from participating in Medicaid programs and also leaving the healthcare profession.

<https://pnhp.org/understanding-moral-injury-in-health-care/>

<https://pnhp.org/removing-the-middlemen-from-medicaid/>

As mental health care advocate, I pledge that if this bill is passed, I will do all that is within my power to help increase the enrollment of needed psychiatrists and specialized mental health clinicians into an improved Medicaid program for Maryland patients that also supports the Maryland healthcare clinicians who care for them.

I urge you to give favorable consideration to this measure which will give Maryland a powerful way to respond to the harm of federal budget cuts and improve the lives of its citizens.

Thank you.

Respectfully submitted,

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