

Testimony
Date February 20, 2026
HB971
Maryland Medical Advisory Committee -
Duties and Workgroup to Study the Adoption of a Fee-For Service Model for All
Medicaid Services

FAV

Madam Chair Bagnall 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.

I am testifying in favor of HB971, which empowers the Maryland Medicaid Advisory Committee to create a workgroup dedicated to studying the benefits of transitioning from Medicaid Managed Care Organizations (MCOs) as middlemen payers of healthcare providers to a direct payment, fee-for-service model of payment.

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 And it is well documented that provider directories are often outdated and inaccurate.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 surveyors were unable to *even reach* 40% of the MCO's 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.

(<https://health.maryland.gov/mmcp/healthchoice/Documents/MY2023%20Grievance%20Appeals%20Denials%20Annual%20Report.pdf>)

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, providing a much larger pool from which to find appropriate specialists. This transition would also simplify the process of signing up for Medicaid. New enrollees now have to sift through information about nine different MCOs to try determine which one would be best for them.

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 nine MCOs to a single payer can save medical offices money, and make Medicaid simpler and more attractive to providers.

There are many good reasons for Maryland to transition to a fee-for-service payment system for Medicaid, which should be thoroughly explored by state officials. These include significant cost savings to the state, which should be shifted to direct care, fewer care and claim denials, more providers accepting Medicaid, improved, more timely access to providers by patients, and better health outcomes.

I urge a favorable report on HB971.

Thank you,
Jacqueline MacMillan