REFUGE
BY LOTUS PSYCHOTHERAPY

Date: February 20, 2026
HB 971
Maryland Medical Advisory Committee – Duties and Workgroup to Study the Adoption of a Fee-For-Service Model for All Medicaid Services

FAVORABLE

Dear Madam Chair and Members of the Committee:

My name is Allison M. Scarinzi and I live in the Annapolis, Maryland area. I am the sole owner of Lotus Psychotherapy, LLC, a mental health and substance use practice providing outpatient therapy for adults, children, adolescents, and families. We also provide psychiatric medication management and Intensive Outpatient Programming (IOP).

Our IOP programs are accredited for adolescent mental health and substance use, adult substance use, and adult mental health. We are licensed by the Maryland Behavioral Health Administration as a Level 2.1 provider, delivering nine hours of clinical group therapy per week. To date, we are the only adolescent IOP program within a 50-mile radius and the only Adult Mental Health IOP in Anne Arundel County that accepts Medicaid.

I am here to urge a favorable report on HB 971.

THE PROBLEM

The 2025 Budget Reconciliation Act reduces federal Medicaid funding by $1 trillion over the next decade, with particularly deep cuts in 2027 and 2028. Medicaid is a lifeline for one in four Marylanders — including children, low-income working families, people with disabilities, seniors, and five out of eight nursing home residents.

In my practice, Medicaid is not an abstract policy issue. It represents real children in crisis, adults in recovery, and families fighting to stay intact.

We are already seeing the consequences of instability. As of today, we have **681 unprocessed, denied, or rejected claims from Maryland Medicaid**. These are not hypothetical numbers —

they represent services already delivered to vulnerable patients. Providers are being asked to carry the financial burden of system inefficiencies while continuing to serve patients in crisis.

It is already an arduous process to enroll as a Medicaid provider in Maryland. Ongoing administrative issues, including Carelon system disruptions, have resulted in annual financial losses for our practice. Despite this, after CareFirst, Maryland Medicaid is our next highest payer because the community need is so great.

We remain committed to serving Medicaid recipients. But we cannot keep our doors open if we are not paid for services rendered or if our patients lose their coverage entirely.

THE CURRENT SITUATION

We appreciate the efforts of Maryland health officials to understand the implications of federal changes and the added complexity of new work requirements for Medicaid enrollees.

However, Maryland must also identify substantial, sustainable sources of revenue to offset federal cuts and prevent devastating service reductions — particularly in behavioral health, where demand continues to rise.

We are already seeing coverage instability. As of February 20th, we have implemented financial hardship applications and are providing pro bono care to **12 active patients who have lost their Medicaid eligibility this year alone**. These individuals do not have the financial means to secure private insurance. Without our intervention, they would have no access to care.

And it is only February.

THE SOLUTION: HB 971

HB 971 empowers the Maryland Medicaid Advisory Committee to create a workgroup to study transitioning from Managed Care Organizations (MCOs) to a direct payment, fee-for-service model.

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Connecticut adopted such a model in 2012 and has saved approximately $4 billion since implementation. Importantly, clinician participation increased.

A recent white paper from Physicians for a National Health Program estimates that Maryland could save up to **$521 million annually** by making a similar transition.

Why? Because MCOs retain approximately **13 cents of every Medicaid dollar** for administrative overhead and profit. The state could administer Medicaid for roughly **3 cents per dollar**. That 10-cent difference could be redirected to:

- Patient care
- Provider reimbursement
- Eligibility infrastructure
- Behavioral health expansion
- Workforce stabilization
- Navigators to assist with new work requirements

As a provider, I can tell you that administrative complexity is one of the greatest deterrents to accepting Medicaid. A unified, statewide fee-for-service model would reduce bureaucratic duplication, simplify prior authorizations, standardize formularies, and eliminate the need to navigate multiple MCO networks.

For patients, this means a single, unified network of providers. For clinicians, it means clarity and predictability.

After Connecticut transitioned to a unified model, participation by primary care physicians increased by 14.6%. When the administrative burden decreases, provider participation increases.

That is exactly what Maryland needs.

WHY THIS MATTERS FOR BEHAVIORAL HEALTH

Behavioral health providers operate on narrow margins. We cannot sustain months of denied or unprocessed claims. We cannot expand access if reimbursement remains unpredictable. And we cannot continue to absorb coverage losses indefinitely.

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If Medicaid destabilizes, behavioral health providers — especially those serving adolescents and substance use populations — will close or reduce services. When that happens:

- Emergency rooms fill
- Hospitalizations increase
- Families destabilize
- Substance use relapses rise
- Juvenile justice involvement increases

The cost of inaction will far exceed the cost of reform.

CONCLUSION

We owe it to our children, our seniors, our healthcare workforce, and our most vulnerable communities to seriously evaluate how to preserve and strengthen Medicaid in Maryland.

HB 971 does not mandate immediate change. It authorizes a thoughtful, data-driven study of a model that has already proven successful in another state and could generate significant savings here.

The ten cents of every Medicaid dollar currently diverted to MCO overhead could instead fund direct care, stabilize providers, and protect access during a time of federal retrenchment.

At least five other states — including Minnesota, Hawaii, Illinois, Wisconsin, and West Virginia — are actively exploring similar legislation.

Maryland should not fall behind.

I respectfully urge you to give HB 971 a favorable report and allow Maryland to explore a sustainable path forward that protects both patients and providers.

Thank you for your time and consideration.

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