

Testimony
February 24, 2026
HB1112

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

FAV With Sponsor Amendment

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.

The sponsor amendment to HB1112 will empower the Maryland Medicaid Advisory Committee to create a workgroup dedicated to studying the benefits of transitioning Maryland Medicaid from a system of provider payments by Managed Care Organizations (MCOs), to a direct, fee-for-service payment model.

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 And it is well documented that provider directories are often outdated and inaccurate.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.

(<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, affording them a much larger pool from which to find appropriate specialists. This transition would also streamline the Medicaid application process. New enrollees in Maryland now have to sift through information about nine different MCOs to try determine which would provide better access to the care they need.

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 Medicaid administration simpler and less expensive, as it did in Connecticut.

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, greater transparency, fewer care and claim denials, better access to care—more providers and no more networks—and better health outcomes.

I urge you to give favorable consideration to this amendment.

Thank you,
Jacqueline MacMillan