SB 561

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 561 (Senator Sydnor)
Finance

Maryland Medical Assistance Program - Community Violence Prevention Services - Reimbursement and Provision of Services

This bill requires Medicaid to reimburse for community violence prevention (CVP) services that are provided in any setting, including services provided through telehealth. The Maryland Department of Health (MDH) must approve at least three training and certification programs for certified violence prevention professionals. The bill removes the requirement that a training and certification program be accredited. An entity that employs or contracts with a certified violence prevention professional to provide CVP services may not be required to maintain an affiliation with a hospital or trauma center.

Fiscal Summary

State Effect: Medicaid expenditures increase by $2.7 million (60% federal funds, 40% general funds) in FY 2027 to expand CVP services, as discussed below. Federal fund revenues increase accordingly. Future years reflect annualization. **This bill increases the cost of an entitlement program beginning in FY 2027.**

($ in millions)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
FF Revenue	$1.6	$2.1	$2.1	$2.1	$2.1
GF/FF Exp.	$2.7	$3.5	$3.5	$3.5	$3.5
Net Effect	($1.1)	($1.4)	($1.4)	($1.4)	($1.4)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: Medicaid must reimburse for CVP services that are provided in person, regardless of the location at which the services were provided, as well as such services appropriately delivered through telehealth.

"Telehealth" means the delivery of CVP services to a Medicaid recipient at an originating site by a certified violence prevention professional through the use of technology-assisted communication. "Telehealth" includes synchronous and asynchronous interactions and an audio-only telephone conversation between a certified violence prevention professional and a Medicaid recipient that results in the delivery of billable, covered CVP services. "Telehealth" does not include an email message or facsimile transmission.

Medicaid must allow a distant site provider (the certified violence prevention specialist who provides services to a Medicaid recipient at an originating site from a different physical location than the location of the recipient) to provide CVP services from any location and may not exclude from coverage a CVP service (1) solely because it is provided through telehealth and not through an in-person consultation or contact between a certified violence prevention professional and a Medicaid recipient or (2) provided in person solely because the service may also be provided through telehealth.

Current Law: "Community violence" means intentional acts of interpersonal violence (defined as the intentional use of physical force or power against another individual by an individual or a small group of individuals) committed in public areas by individuals who are not family members or intimate partners of the victim.

CVP services are evidence-based, trauma-informed, supportive, and nonpsychotherapeutic services provided by a certified violence prevention professional, within or outside a clinical setting, for the purpose of promoting improved health outcomes and positive behavioral change, preventing injury recidivism, and reducing the likelihood that an individual who is the victim of community violence will commit or promote violence. CVP services include peer support and counseling, mentorship, conflict mediation, crisis intervention, targeted case management referrals to certified or licensed health care professionals or social services providers, patient education, and screening services to victims of violence.

CVP services must be provided to Medicaid recipients who have (1) been exposed to community violence or have a personal history of injury sustained as a result of an act of community violence and (2) have been referred by a health care provider or social services provider to a certified violence prevention professional. The referral must come after the provider determines that the recipient is at an elevated risk of violent injury or retaliation resulting from another act of community violence.

MDH must approve at least one accredited training and certification program for certified violence prevention professionals. An approved program must include (1) at least 35 hours of initial training addressing specified topics and (2) at least six hours of continuing education every two years.

An entity that employs or contracts with a certified violence prevention professional must maintain documentation that the individual has completed and maintains certification from an accredited program and must also ensure that the individual is providing CVP services in compliance with any applicable standard of care, rule, regulation, and State or federal law.

According to MDH, Medicaid designed the current CVP services benefit to require the initial contact to take place in a hospital setting to ensure that recipients had been referred by a health care provider or social services provider to a certified violence prevention professional. MDH identified one program, the Health Alliance for Violence Intervention (HAVI), that met the requirements for an accredited training and certification program for certified violence prevention professionals. As of January 2026, two organizations were enrolled as CVP providers and no CVP services have been billed by these providers.

HAVI's Maryland Working Group identified several challenges to CVP billing. In response, MDH is currently exploring allowing 15-minute units of service, expanding allowable places of service for follow-up encounters to include community-based locations, expanding the program to include audio-only telehealth services, removing trauma center designation requirements for hospitals affiliated with CVP providers, and updating provider guidance to clarify existing requirements. MDH advises that it is working to implement these changes beginning in spring 2026, beginning with allowing audio-only telehealth. Remaining changes require regulatory updates and an amendment to the State Plan and are anticipated to take effect in the second half of 2026, pending approval by the federal Centers for Medicare and Medicaid Services.

State Fiscal Effect: MDH has identified three community-based programs that could provide Medicaid CVP services under the bill. Two of the three programs served a combined total of 1,083 individuals in 2025 (data was not available for the third program). MDH assumes that all of these individuals would be eligible for Medicaid CVP services. MDH currently reimburses CVP services affiliated with a hospital at a rate of $32.76 per unit (30 minutes). Medicaid participants are eligible to receive up to 100 units of CVP services (50 hours) per 12-month period (for a total maximum cost per person of $3,276).

If an estimated 1,083 individuals receive the maximum number of services, Medicaid costs increase by $2.7 million in fiscal 2027, which reflects the bill's October 1, 2026 effective date, increasing to $3.5 million annually thereafter. MDH advises that this estimate reflects a minimum as data for the third organization is not available and new organizations may

elect to provide services under the bill. This estimate does not reflect any growth in utilization or rates in future years.

Thus, Medicaid expenditures increase by an estimated $2.7 million (60% federal funds, 40% general funds) in fiscal 2027 to expand provision of CVP services, increasing to $3.5 million (60% federal funds, 40% general funds) annually beginning in fiscal 2028 to reflect a full year of service provision. Federal fund revenues increase accordingly.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: None.

Information Source(s): Maryland Department of Health; Department of Legislative Services

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