
Testimony on Senate Bill 39

Behavioral Health - Certified Community Behavioral Health Clinics and Outpatient Mental Health Centers -
Reimbursement Rates

Senate Finance Committee

March 3, 2026

POSITION: FAVORABLE WITH AMENDMENTS

My name is **Wunmi Adediji, LCPC, NCC**, and I serve as **Program Director at Hope Health Systems, Inc.**, a community-based behavioral health provider serving children, adolescents, and adults across Baltimore County, Baltimore City, and surrounding jurisdictions.

Hope Health Systems strongly supports the amended version of SB39 because it strengthens the integrity of Maryland's behavioral health rate study process by ensuring independence, transparency, and structured provider participation. The bill does not mandate automatic rate increases. Rather, it ensures that reimbursement methodology is grounded in actual service delivery costs and fiscal realities.

Hope Health Systems serves more than **2,500 Marylanders annually** through OMHC services, school-based mental health, psychiatric rehabilitation, medication management, and intensive outpatient programming. Demand for services continues to increase; however, reimbursement rates have not kept pace with inflation, workforce costs, or compliance requirements.

Workforce Cost Pressures and Medicaid Sustainability

Our licensed clinician vacancy rate has ranged between **15–20%**, driven primarily by compensation gaps between community providers and hospital systems, private telehealth platforms, and out-of-state employers. Recruitment packages must now account for higher salaries, supervision costs, licensure incentives, and retention supports. Without reimbursement rates that reflect market realities, community providers are forced to absorb these costs or reduce service capacity. Over time, this creates instability in the Medicaid behavioral health network.

Access Constraints and Downstream System Impact

Our outpatient intake wait times average **3–5 weeks**, with longer delays for psychiatric evaluation services. When community providers cannot expand capacity due to rate constraints, individuals often present in higher-cost settings such as emergency departments or inpatient units. Inadequate outpatient reimbursement therefore shifts costs downstream to more expensive levels of care, increasing overall system expenditures rather than containing them.

In addition, current rates do not account for the full cost of compliance with COMAR standards, electronic health record systems, measurement-based care implementation, reporting mandates, supervision structures, and quality oversight. These are not optional expenses—they are regulatory and accreditation requirements essential to safe, accountable care.

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Providers delivering care daily must have a structured role in informing how rates are studied and developed. The amended version of SB39 strengthens the methodology without pre-determining fiscal outcomes. It promotes transparency and ensures that rate-setting reflects operational data rather than assumptions.

A stable, data-informed reimbursement structure is essential to maintaining Maryland's community behavioral health infrastructure and preventing greater long-term system costs.

For these reasons, I respectfully request a favorable report on the amended version of SB39.

Sincerely,

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