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Children, Youth, and Families
Senate Chair, Legislative Ethics



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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Testimony for Senate Bill 561
Maryland Medical Assistance Program – Community Violence Prevention Services –
Reimbursement and Provision of Services
Before the Finance Committee
February 24, 2026

Good afternoon Chair Beidle, members of the committee.

In 2021, the Biden-Harris Administration announced support states reimbursing community violence prevention services via Medicaid.¹ In response, the Maryland General Assembly passed legislation I introduced in 2022 to require the Maryland Medical Assistance Program to provide and reimburse community violence prevention services.²

As a provider testified in 2022, community violence prevention is a “critical behavioral health service that changes behavior by giving [people] the skills to think, feel, and act differently.”³ Techniques like hospital-based intervention programs and street outreach reduce gun violence by offering alternatives to retributive practices that otherwise often lead to further contact with the criminal justice system. One Baltimore City program saw that the rate of re-incarceration for their participants was 19% lower than the re-incarceration rate of their peers.⁴

¹ Off. of the President, *FACT SHEET: More Details on the Biden-Harris Administration’s Investments in Community Violence Interventions*, April 7, 2021. (Currently unavailable on official website; see archived link such as <https://web.archive.org/web/20240111192536/https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/07/fact-sheet-more-details-on-the-biden-harris-administrations-investments-in-community-violence-interventions/>).

² S.B. 350, 2022 Session. <https://mgaleg.maryland.gov/mgaweb/Legislation/Details/sb0350?ys=2022RS>

³ James Timpson, ROCA Baltimore, Testimony on SB 350 (Feb. 22, 2022) https://mgaleg.maryland.gov/cmtetestimony/2022/fin/1_GyL8BewNfK8uupReMApH_sQlwvWF60l.pdf

⁴ ROCA Baltimore, *6 Year Report*, <https://rocainc.org/how-we-do-it/outcomes/baltimore-young-men/> (accessed Feb. 18, 2026).

Medicaid in particular is a vital part of increasing accessibility of these services. A study in 2018 indicated that two-thirds of victims of gunshot wounds who sought treatment were either covered by Medicaid or uninsured entirely.⁵ Hospital-based violent intervention programs can engage these victims with cognitive behavioral support, community, and restorative justice solutions. With Medicaid funding, these programs can reach more of these victims who might not have other resources available.

Along with Connecticut, Maryland was a pioneer in creating policy to allow community violence prevention providers to be reimbursed from Medicaid. Unfortunately, being among the first to embrace a new solution also means that we're among the first to encounter growing pains. When testifying on Senate Bill 350 in 2022, I stated "SB 350 seeks to expand some services hospitals **and others** are currently providing to those affected by violence."

However, upon implementation of this legislation, the Maryland Department of Health required Community Violence Prevention provider affiliation with trauma-center hospitals, narrowing the impact. According to the Health Alliance for Violence Intervention (the HAVI), no program in Maryland has successfully received reimbursement for their services from Medicaid.

After discussions with members of the HAVI and with the Maryland Department of Health, we're trying to fix this access problem on two levels: the Department of Health is re-evaluating some of its internal policies, and I'm here today with Senate Bill 561 to clarify the intent of our prior legislation that was not intended to be this restrictive.

Senate Bill 561 does four things to accomplish this:

Firstly, it expands the number of recognized training and certifying organizations to at least three.⁶ Currently, only one organization, the HAVI, is authorized to train and certify violence prevention professionals. The HAVI focuses exclusively on hospital-based violence intervention programs, causing other evidence-based models like street outreach and cognitive behavioral interventions to be excluded. Senate Bill 561 broadens certification pathways to reflect the full range of proven violence prevention strategies.

Secondly, SB561 clarifies that eligible programs do not need to be affiliated with a trauma center.⁷ Maryland's violence intervention programs operate across trauma centers, community hospitals, and independent community-based settings. National best practices emphasize meeting patients where they are, particularly those who are hardest to reach. Removing this restriction ensures programs can operate in diverse settings that maximize engagement and impact.

⁵ Edouard Coupet et al., *Shift in U.S. payer responsibility for the acute care of violent injuries after the Affordable Care Act: Implications for prevention*, Am. J. Emergency Med. (Mar. 2018).

⁶ See proposed § 15-141.3(d).

⁷ See proposed § 15-141.3(e)(3).

Thirdly, it authorizes the delivery of services via telehealth, increasing accessibility and giving providers more flexibility in their efforts.⁸ Violence intervention programs often serve patients in non-traditional settings.

Lastly, it expands the locations where patients can receive reimbursable services.⁹ Current regulations limit reimbursement of hospital-based services, excluding community-based programs from eligibility. Additionally, they fail to reflect how hospital-based programs function. While care may begin in the hospital, most services are delivered over the following three months to a full year after discharge. Senate Bill 561 updates the policy to align reimbursement with the realities of effective violence intervention work.

In closing, Maryland has made real progress in reducing community violence. To sustain and build on this success, we must ensure our Medicaid violence prevention benefit is accessible and workable for the programs proven to be effective in saving lives every day. For these reasons, I ask for a favorable report on SB 561.

⁸ See proposed § 15-141.3(a)(7)(9).

⁹ See proposed § 15-141.3(a)(5).

SB0561_FAV_MedChi_MMAP - Community Violence Preven

Uploaded by: Christine Krone

Position: FAV



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Senate Finance Committee
February 24, 2026

Senate Bill 561 – *Maryland Medical Assistance Program – Community Violence Prevention Services – Reimbursement and Provision of Services*
POSITION: SUPPORT

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** Senate Bill 561.

Medicaid is the largest public insurance program in the United States, making it ideal as an entry point for offering community violence prevention services. Research indicates that among victims of gunshot wounds, nearly two out of three patients are either on Medicaid or uninsured. A 2021 federal General Accounting Office report reported that initial gun injuries cost hospitals more than \$1 billion a year. When costs related to physician fees are included, the cost increases by another 20%. By requiring Medicaid coverage regardless of delivery setting, Senate Bill 561 removes barriers that may currently limit access for patients who may be at high risk for retaliation, transportation challenges, or other safety concerns. Telehealth flexibility is particularly important for reaching individuals in underserved communities.

MedChi supports the bill's establishment of certification and training standards for violence prevention professionals. Ensuring that services are delivered by qualified individuals strengthens accountability, quality, and integration with the broader health care system. At the same time, the bill removes hospital affiliation requirements, enabling community-based organizations to provide interventions while maintaining appropriate oversight.

Violence prevention is crucial to keeping Maryland communities safe and healthy. Prevention also saves public funds from being spent on the community and medical aftermath of violent interactions. For these reasons, MedChi urges a favorable report on Senate Bill 561.

For more information call:

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Position: FAV



Testimony in Support of SB561, Maryland Medical Assistance Program – Community Violence Prevention Services – Reimbursement and Provision of Services

Submitted by Kurtis Palermo, *Executive Vice President, Roca Maryland*
Senate Finance Committee
February 24, 2026

My name is Kurtis Palermo, and I am the Executive Vice President of Roca in Maryland. Thank you, Chair Beidle, for the opportunity to testify in favor of Senate Bill 561, legislation that would support Medicaid reimbursement for community violence prevention and, in the doing so, enhance health equity and public safety, save taxpayer resources and, most importantly, reduce violence and the tragic loss of young lives.

For nearly 40 years, including the last eight in Baltimore, Roca has been working with the highest risk young men, those most likely to be victims or perpetrators of violence, and changing the trajectory of their lives. Our intervention model is rooted in relentless outreach and a focus on using brain science and a non-clinical version of cognitive behavioral therapy we call Rewire CBT to heal trauma and support long-term behavior change.

We are proud that the data confirms the effectiveness of our work. In FY25, Roca Baltimore served 354 of the highest-risk young men in the city: 87% had histories of arrests; 84% were drug involved; and 84% were street or gang involved. 98% of those engaged in the program for at least 18 months demonstrated improved behavioral health. Of those enrolled 24 months or longer, 84% had no new arrests and 93% had no new incarcerations. An independent evaluation by Abt Associates from 2019-2021 revealed that Roca participants recidivate 19% less than their peers in Maryland. The evidence is clear: evidence-based, outcome-driven community violence prevention programs, like Roca, work.

While we are enormously proud of the positive impact our team makes daily and gratified that some have asked whether Baltimore is experiencing a miracle in regard to a consistent and dramatic decrease in homicides during the last three years, we know all-too-well that the level of violence remains unacceptable.

To continue to stem the tide, we must do more. And we commend Senator Sydnor for his efforts to achieve that goal with the advancement of SB561.

In 2021, President Biden's administration encouraged states to consider expanding Medicaid to include violence prevention. Shortly thereafter, Maryland was one of the first states in the nation to authorize Medicaid reimbursement for community violence prevention services, demonstrating the state's commitment to treating violence prevention as the health intervention it truly is. However, as implemented, the existing law contains structural barriers that prevent community-based organizations from accessing this benefit.

SB561 is attempting to address those barriers and, in the process, support a full continuum of violence intervention services—including both hospital- AND community-based programs. Among the changes in SB561 that we believe to be most significant, and worthy of the Committee's support are:

- Elimination of requirement that that agencies employing or contracting with a certified violence professional to provide community violence prevention services be affiliated with a hospital or trauma center;
- Requiring Medicaid reimbursement for violence prevention services delivered outside of a hospital;
- Correcting a drafting error in the original legislation that required violence prevention professionals to complete an accredited training and certification program—no such accreditation exists for the field of community violence prevention; and
- Mandating that the state approves at least three programs approved to train and certify violence prevention professionals, rather than the single program required under current law. There are a host of entities with the expertise to provide this training and certification—including our Roca Impact Institute—and the field of community violence intervention will be strengthened by expanding the resources available to professionally train and certify those working on the front lines of community violence prevention.

As I noted earlier, beyond the human impact, this bill makes sound fiscal sense. Effective community violence intervention that prevents a shooting or a retaliation reduces emergency department visits, hospitalizations, incarcerations, and long-term trauma-related health costs, which are borne by taxpayers. In addition, expanding Medicaid reimbursement for violence prevention services provided by community-based organizations would bring additional federal matching funds to Maryland.

Maryland has already demonstrated its commitment to treating violence as a public health issue. Senate Bill 561 ensures that commitment extends to organizations on the very front lines of community-based violence prevention. Roca urges the Committee to advance this bill, as we believe our young men, and the communities they live in, are worthy of the support and the more robust continuum of violence prevention services that SB561 seeks to bolster.

Thank you for the opportunity to provide testimony on this important issue. Should you have any questions for me, I would be happy to address them. I can be reached via email at kurtis_palermo@rocainc.com.

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Uploaded by: Justin Graves

Position: FAV



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R Adams Crowley Shock Trauma Center
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February 24, 2026

Written Testimony in Support (FAV) of Senate Bill 561
Maryland Medical Assistance Program - Community Violence Prevention Services -
Reimbursement and Provision of Services
Senate Finance Committee

Good afternoon, Chairwoman Beidle and Members of the Committee.

My name is Justin Graves and I am the Director of Trauma Programs at the R Adams Cowley Shock Trauma Center and I'm here in strong support of Senate Bill 561.

As a leader of a hospital-based Violence Intervention Program, I have seen firsthand the lifesaving impact of community violence prevention services. The original legislation allowing Medicaid reimbursement for this work was an important and visionary step aimed at helping stabilize services for victims of violence at a critical moment in their recovery.

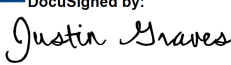
However, we recognized that not all individuals doing this work had access to coverage, and many community-based organizations face significant financial challenges sustaining these services. SB561 thoughtfully expands the scope to be more inclusive, ensuring that more programs, and more patients, can benefit.

The bill's expansion of telehealth is particularly important. Phone coaching and case management sessions are not just convenient, they are essential. Not every patient has reliable transportation, broadband access, or the ability to attend formal telehealth visits. Phone-based engagement allows us to meet patients where they are. It is how we connect, coach, monitor progress, and hold individuals accountable to their goals. For many of our clients, this consistent contact is the difference between disengagement and continued recovery.

Additionally, expanding the number of approved certification programs strengthens the workforce. Having more training options allows programs to better manage staff turnover and build a sustainable pipeline of qualified professionals.

SB561 strengthens access, equity, and sustainability in community violence prevention. I respectfully urge a favorable report.

Thank you for your consideration.

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Justin Graves
Director of Trauma Programs

SB561 HAVI Letter of Support.pdf

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Position: FAV



To: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Charles E. Sydnor, III

From: The Health Alliance for Violence Intervention

RE: **SUPPORT** – Senate Bill 561 – *Maryland Medical Assistance Program – Community Violence Prevention Services – Reimbursement and Provision of Services*

February 20, 2026

The Health Alliance for Violence Intervention (HAVI) is proud to support Senate Bill 561 to enhance Medicaid coverage for violence prevention services. The HAVI represents 70 hospital-based and hospital-linked member programs across the United States. We are proud to represent eight Maryland programs, including a founding member of the HAVI, the Shock Trauma Violence Intervention Program.

HAVI member programs provide services to violently injured patients in both traditional health care settings as well as the community. Hospital-based violence intervention programs (HVIPs) vary in the specifics of their design and scope but typically include immediate intervention in the hospital or emergency department after an injury, followed by intensive, community-based care for approximately one year after discharge. Research shows HVIPs are effective in reducing patients' risk of repeat injuries, addressing critical needs such as mental health, alcohol and substance misuse, and a variety of other patient-centered outcomes.

In 2022, the Maryland General Assembly wisely elected to create a Medicaid benefit for violence prevention services to expand access to these life-saving interventions. However, in the four years since passage, *the benefit has not been successfully utilized by any community violence intervention program to date.*

Given the lack of implementation progress, the HAVI assembled a working group in 2025 with the goal of providing technical assistance to programs to enroll as Medicaid providers and navigate technical aspects of the reimbursement process, including documentation, billing and coding practices, and compliance. Members of the working group included community violence intervention programs, hospitals, national experts, and were attended by staff from the Maryland Department of Health.

After 10 months of work, the group concluded that the current benefit design is unintentionally restrictive, having the practical effect of leaving large swaths of violence intervention programs



ineligible. In fact, many of the same programs the General Assembly highlighted to benefit from the the 2022 legislation have no pathway to utilization. This legislation would fix the majority of these barriers, which are summarized below:

Key reforms in SB561:

- Increases number of training and certifying organizations to at least 3
 - Currently, only one organization (The HAVI) is recognized to train and certify violence prevention professionals. Given that the HAVI only conducts trainings for hospital-based violence intervention programs, this functionally excludes evidence-based violence intervention programs such as street outreach and cognitive behavioral interventions.
- Removes requirement that eligible programs be affiliated with a trauma center
 - Maryland has a variety of community violence intervention programs out of both trauma centers and community hospitals, as well community-based programs. National best practices recommend that to enroll difficult-to-reach patients, violence intervention programs should operate in a variety of settings.
- Improves telehealth access
 - Violence intervention programs engage difficult-to-reach patients in a variety of settings. This amendment will allow delivery of services via telehealth.
- Expands locations patients are eligible to receive services
 - Current regulations only offer reimbursement for services conducted at hospital-based locations. This effectively excludes all community-based violence intervention programs from eligibility. In addition, the current regulations misunderstand the work of hospital-based violence intervention programs, which begin care with patients in the hospital, but continue to deliver most services for 3-12 months after the patient is discharged.

For these reasons, the HAVI respectfully asks the Senate Finance Committee to provide a favorable report on SB561 – Maryland Medical Assistance Program – Community Violence Prevention Services - Reimbursement and Provision of Services.

Sincerely,

Kyle Fischer, MD, MPH
Policy Director
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Uploaded by: Lydia Watts

Position: FAV

Testimony in Support of
SB 561, Maryland Medical Assistance Program – Community Violence Prevention
Services- Reimbursement and Provision of Services

Presented by Lydia C. Watts, Esq., MPH, Executive Director,
The Rebuild, Overcome, and Rise (ROAR) Center at University of Maryland, Baltimore

February 24, 2026

My name is Lydia Watts. I am the Executive Director of the Rebuild, Overcome, and Rise (ROAR) Center at the University of Maryland, Baltimore. I submit this written testimony **in support of SB 561, Maryland Medical Assistance Program – Community Violence Prevention Services – Reimbursement and Provision of Services**. The views expressed are my own, offered in my professional capacity, and do not represent those of the University of Maryland, Baltimore.

ROAR provides wraparound services to victims of crime in Baltimore City, with a particular focus on survivors who are least likely to seek assistance from law enforcement and who are at the highest risk of violent victimization. These include people of color, low-income individuals, immigrants, LGBTQIA+ individuals, people who are unhoused, people who use street drugs, people who exchange sex for money or drugs, people living with mental illness, and people who have been formerly incarcerated.

While law enforcement is the traditional public safety response to crime, many survivors do not contact police for valid reasons, including fear of police or immigration enforcement, fear of arrest for survival activities, concern about the consequences for the person who harmed them, and the recognition that police involvement does not address immediate needs such as housing, income, medical care, and employment.¹

Since opening in June 2019, ROAR has served more than 900 survivors of homicide, non-fatal shootings, sexual assault, intimate partner violence, and other serious harms. In designing our programs, we partnered with the University of Maryland Medical Center’s R Adams Cowley Shock Trauma Center to create a medical-legal partnership. This evidence-based model improves health outcomes by addressing the social and legal determinants of health.² Civil legal aid helps resolve issues such as unlawful eviction, foreclosure, domestic violence, wrongful denial of public benefits, employment barriers, and access to education and health care.³ When medical providers collaborate with civil legal attorneys, the underlying causes of poor health are often mitigated or resolved.²

Homicide is the leading cause of death for Black men ages 15–34 in the United States, who are approximately six times more likely to die by homicide than their white counterparts.⁴ As is true

across cities in the United States, in Baltimore City, most shooting victims are young Black men with prior criminal legal system involvement who are disconnected from education, employment, and health care due to structural inequities.⁵ Prior victimization and network exposure to violence are among the strongest predictors of future violent injury, making immediate, trauma-informed intervention critical to prevention.⁶

Gun violence survivors frequently report feeling abandoned after hospital discharge and face barriers to recovery including untreated trauma, unstable housing, lack of transportation, lost income, and medical debt.⁷ Exposure to violent crime harms not only individual victims but also families and entire communities, with disproportionate impacts on low-income communities and communities of color.⁸

I have been an attorney for survivors of crime for more than 29 years and have worked in victim services for 34 years. I have led three organizations providing legal services to survivors and founded a fourth. Across types of victimization, survivors' civil legal needs are remarkably consistent. The most common needs include housing stability, education and employment accommodations, family law matters, consumer issues related to medical debt, appeals of denials of victim compensation, access to public benefits, protection or peace orders, enforcement of crime victims' rights⁹, and civil rights issues related to property seized by law enforcement in hospital settings.

ROAR's medical-legal partnership addresses these legal needs as part of a comprehensive health intervention. Evidence shows that hospital-based and community violence intervention programs reduce reinjury and retaliation, resulting in significant Medicaid cost savings; multi-site evaluations have found that every dollar invested generates multiple dollars in avoided health care and criminal legal system costs.¹⁰ Repeat firearm injury admissions are among the most expensive trauma-related expenditures for Medicaid, meaning that preventing even a small number of reinjuries can offset the cost of reimbursing community violence prevention services.¹¹

Although Maryland Medical Assistance expanded to cover hospital-based violence intervention services, unintentional statutory and administrative barriers have prevented community-based programs like ROAR from qualifying for reimbursement. As a result, this essential, evidence-based work remains financially unstable despite demonstrated impact.

For these reasons, I respectfully **urge the Senate Finance Committee to support SB 561** to ensure sustainable funding for community violence prevention services and the medical-legal partnerships that improve health, safety, and recovery for survivors.

Lydia Watts, Esq., MPH
Executive Director, ROAR Center
University of Maryland, Baltimore

Footnotes

1. National Crime Victimization Survey; see also Langton et al., *Victimizations Not Reported to Police*, Bureau of Justice Statistics (BJS).
2. National Center for Medical-Legal Partnership, *The Evidence Base for Medical-Legal Partnerships* (2019).
3. Legal Services Corporation, *The Justice Gap: The Unmet Civil Legal Needs of Low-Income Americans* (2022).
4. Centers for Disease Control and Prevention (CDC), WISQARS Fatal Injury Reports (latest available year).
5. Baltimore City Health Department, *Baltimore City Violence Data and Trends*; see also Maryland Department of Health, firearm injury reports.
6. National Institute of Justice, *Five Things About Deterrence*; Papachristos et al., network exposure and gun violence research; Cure Violence model evaluations.
7. Healthcare-based Violence Intervention Programs (HVIP) literature; see Cooper et al., *Hospital-Based Violence Intervention Programs Work* (Journal of Trauma and Acute Care Surgery).
8. National Institute of Justice, *The Impacts of Violence on Communities*; CDC, *Adverse Community Experiences and Health*.
9. National Crime Victim Law Institute; National Consumer Law Center (medical debt); Maryland Crime Victims' Resource Center materials on victim compensation and rights.
10. Health Alliance for Violence Intervention (HAVI), *Demonstrating the Value of Hospital-Based Violence Intervention Programs* (2022) (documenting reduced reinjury and positive cost savings across systems).
11. Maryland Health Services Cost Review Commission (HSCRC) trauma cost data; CDC, *Costs of Firearm Injuries in the United States* (showing high per-patient hospitalization costs, with a substantial share borne by Medicaid).

Additional Information about Race and the Criminal Justice System That Would be Exacerbated by the Passage of SB 604

Dating back to 1993, Kimberle Crenshaw wrote: “Women of color [in work cited, the author is referring to survivors of intimate partner violence] are often reluctant to call the police, a hesitancy likely due to a general unwillingness among people of color to subject their private lives to the scrutiny and control of a police force that is frequently hostile. There is also a more generalized community ethic against public intervention, the product of a desire to create a private world free from the diverse assaults on the public lives of racially subordinated people.”¹ “[F]or some people subjected to abuse, the criminal justice system – indeed, any state system – is not a safe and comfortable place within which to seek justice. People of color, who are already overrepresented in the criminal justice system, may have concerns about approaching the state for assistance, fearing that the state will intervene punitively against their partners or against them.”² And their fears are often warranted. Sometimes calling the police results in homelessness for victims of intimate partner violence,³ or in their own arrest. These same fears are present – perhaps even heightened – for survivors of gun and other forms of community violence.

Black men are over-represented among those accused of and convicted of violent crime though there is no evidence to suggest that men of color are more prone to violence than white men,⁴ though the media certainly portrays otherwise.⁵ The perception of men – particularly young men – of color as inherently more violent has inexorably and negatively shaped lives, communities, history, and political landscapes.⁶ Not only are young men of color disproportionately

¹ Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1257 (1993).

² Leigh Goodmark, “*Law and Justice are Not Always the Same*”: *Creating Community-Based Justice Forums for People Subjected to Intimate Partner Abuse*”, Florida State University Law Review Vol. 42:707, 720 (year?).

³ There have been many housing authorities across the country who were exposed in the early 2000s for evicting domestic violence victims for violating the policy that no illegal activity could take place on public housing property, and since she called the police for help, the housing authority was alerted that a crime had occurred – an assault against the victim who is now getting evicted as a result. This practice is still occurring today on privately owned properties. See Jenny Kutner, “Domestic Violence Victims can be Evicted for Calling the Police”, July 14, 2016, <https://mic.com/articles/148484/domestic-violence-victims-can-be-evicted-for-calling-police-here-s-why#.oJfYfDbSK>.

⁴ Kim Farbota, *Black Crime Rates: What Happens When Numbers Aren't Neutral*, January 19, 2016, http://www.huffingtonpost.com/kim-farbota/black-crime-rates-your-st_b_8078586.html.

⁵ In *Tough Guise: Violence, Media and the Crisis in Masculinity*, Jackson Katz and Jeremy Earp argue that the media provide an important perspective on social attitudes – and that while the media are not the cause of violent behavior in men and boys, they do portray male violence as a normal expression of masculinity. Earp, Jeremy and Jackson Katz. *Tough Guise: Violence, Media & the Crisis in Masculinity* (study guide). Media Education Foundation, 1999. In 1999, Children Now, a California-based organization that examines the impact of media on children and youth, released a report entitled *Boys to Men: Media Messages About Masculinity*. The report observes that... non-white male characters are more likely to experience personal problems and are more likely to use physical aggression or violence to solve those problems. *Boys to Men: Media Messages About Masculinity*. Children Now, 1999. <http://mediasmarts.ca/gender-representation/men-and-masculinity/how-media-define-masculinity>, last visited 8.23.16.

⁶ “This far-reaching form of stereotyping and oppression—what Toni Morrison and others call the “white gaze”—has shaped individual lives and collective histories within communities of color.” David J. Knight, *Beyond the Stereotypical Image of Young Men of Color*, The Atlantic, January 5, 2015. <http://www.theatlantic.com/education/archive/2015/01/beyond-the-stereotypical-image-of-young-men-of-color/384194/>

represented among those accused of using violence, but also of being victims of violence.⁷ Yet, their needs as victims of crime, and the commensurate trauma that often comes with victimization, are largely ignored, thereby exacerbating the devastating impact of the continued assault of structural racism.

Since men of color are *perceived* as more prone to be violent, it is likely that they will adopt behaviors to support that perception or assumption. Michelle Alexander in The New Jim Crow poses the question, “Are we willing to demonize a population, declare a war against them, and then stand back and heap shame and contempt upon them for failing to behave like model citizens while under attack?”⁸ She goes on to say “[t]here is nothing abnormal or surprising about a severely stigmatized group embracing their stigma... Indeed, the act of embracing one’s stigma ...is a political act – an act of resistance and defiance in a society that seeks to demean a group based on an inalterable trait... [E]mbracing the stigma of criminality is an act of rebellion – an attempt to carve out a positive identity in a society that offers them little more than scorn, contempt, and constant surveillance.”⁹ The “dance” - or “minstrel show” as Alexander calls it¹⁰ - of men of color acting “ghetto”, violent, posturing to gain some sense of respect and control, plays perfectly into stereotypes and implicit racism that men of color are in fact more violent.

It is important to note, that rates of incarceration have skyrocketed for women during this same time period, at even greater and more astonishing rates.¹¹ “There are 14 times more women in jail in this country today than there were in the 1970s... [And] women typically become incarcerated after experiencing gender-based trauma throughout their lives. About eight in ten [incarcerated women] have experienced domestic partner abuse. A large majority has survived sexual violence.”¹² Again, women of color are disproportionately represented among the incarcerated. Many of these women are in jail or prison because a violent partner forced them into illegal activity, most typically assisting in some portion of a drug exchange, but also in sex work.¹³ Other times, women may engage in illegal activity to survive in an environment that does not support poor mothers well, if at all. Over the past 20 years, public benefits have been dramatically cut, affordable housing stock has plummeted, and childcare costs and other costs of living have soared. Livable wages are almost non-existent for those working in certain sectors of

⁷ Danielle Sered, *Young Men of Color and the Other Side of Harm*, Vera Institute of Justice, December 2014. <http://archive.vera.org/sites/default/files/resources/downloads/young-men-color-disparities-responses-violence.pdf>

⁸ Michelle Alexander, The New Jim Crow: Mass Incarceration in the Age of Colorblindness (2010), p. 170.

⁹ Id at p. 171.

¹⁰ Alexander writes about how the media portrays men of color as caricatures of “racial stereotypes and images associated with the era of mass incarceration – an era in which black people are criminalized and portrayed as out-of-control, shameless, violent, over-sexed and generally underserving.” Id at pg. 173.

¹¹ Coker & Macquoid, *Opposing Hyper-Incarceration*, *supra* note 15 at 588 (2015).

¹² Micelle Chen, *Why Are There So Many Women in Jail? The number of women in jails has skyrocketed over the past four decades*, <https://www.thenation.com/article/why-are-there-so-many-women-in-jail/>, August 22, 2016.

¹³ “Survivors who were forced into criminal activity by abusive partners could also be eligible for alternative sentencing under the legislation [Domestic Violence Survivors Justice Act, passed in May 2016 in New York state]. Advocates stress that abusers often use violence to coerce survivors into committing crimes like robbery or drug trafficking.” Melissa Jeltsen, *Should Domestic Violence Victims go to Prison for Killing Their Abusers?*, May 26, 2016, http://www.huffingtonpost.com/entry/domestic-violence-prison-legislation_us_573deaa3e4b0ace7b8e94236.

our economy. Working in illegal economies may literally feel like the only choice to financially support oneself and a family.¹⁴

All of this is true also for those selling and buying street-drugs through the State of Maryland. To criminalize those caught in this matrix of racism and poverty will only compound the harm.

¹⁴ “Particularly for women, their interactions with the justice system are often the result of survival efforts,” said Liz Swavola of the Vera Institute of Justice, one of the report’s principal authors. “They are predominantly women of color, and they are overwhelmingly poor.” Rebecca McCray, *There are More Women in U.S. Jails Than Ever Before*, August 17, 2016, <http://www.takepart.com/article/2016/08/16/women-jails?cmpid=tp-twtr>. “Women often become involved with the justice system as a result of efforts to cope with life challenges such as poverty, unemployment, and significant physical or behavioral health struggles.” Vera Institute of Justice, *Overlooked: Women and Jails in an Era of Reform*, August 2016.

SB0561-FIN-FAV.pdf

Uploaded by: Nina Themelis

Position: FAV



BRANDON M. SCOTT
MAYOR

*Office of Government Relations
88 State Circle
Annapolis, Maryland 21401*

SB 0561

February 24, 2026

TO: Members of the Senate Finance Committee

FROM: Nina Themelis, Director, Mayor's Office of Government Relations

RE: Senate Bill 561: Maryland Medical Assistance Program – Community Violence Prevention 2 Services – Reimbursement and Provision of Services

POSITION: SUPPORT

Chair Beidle, Vice Chair Hayes, and Members of the Committee, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 561.

SB 561 would allow community violence prevention organizations to be able to be reimbursed through the Maryland Medical Assistance Program regardless of the location at which the services were provided, remove requirements outlined in HB 1005/SB 350 that community violence prevention organizations maintain affiliations with a hospital or trauma center in order to be eligible for reimbursement, and expands training requirements for violence prevention workers.

Following President Biden's announcement that Medicaid was eligible to support community violence prevention programs in 2021, in 2023 Maryland became one of the first states to pass legislation making these services eligible for reimbursement. We are at the front lines in treating violence as a public health epidemic. However, eligibility for reimbursement is currently limited and does not cover the full breadth of the community violence intervention ecosystem. SB 561 builds on that foundation to expand eligibility to programs that are actively helping drive down violence in Baltimore and across Maryland by doing neighborhood-based violence intervention work and offering conflict mediation hotlines.

While American Rescue Plan Act (ARPA) dollars and federal grants previously helped support this work, community violence prevention programs across the country are facing significant funding gaps. Expanding Medicaid eligibility to help cover the costs of these programs would help ensure this work that is making a difference is able to continue and grow to meet the needs of our communities.

For these reasons, the BCA respectfully requests a **favorable** report on SB 561.

CFH FAV Senate Bill 561 Maryland Medical Assistan

Uploaded by: Yuvelqui Rattigan

Position: FAV



Date: February 24, 2026

SB 561-Maryland Medical Assistance Program – Community Violence Prevention Services –
Reimbursement and Provision of Services
Senate Finance Committee

Position: Support

Dear Chair, Beidle, and Members of the Senate Finance Committee:

On behalf of Center for Hope, Safe Streets Baltimore Programs, and allied community violence intervention organizations, we respectfully submit this testimony in support of Senate Bill 561. This legislation meaningfully advances the sustainability and effectiveness of community-based violence prevention services by modernizing Maryland’s Maryland Medical Assistance Program reimbursement structure and aligning it with real-world service delivery needs.

SB 561 appropriately requires Maryland Medicaid to reimburse for community violence prevention services provided in person regardless of location — ensuring that community-based programs are compensated for the services they already deliver in homes, neighborhoods, and other non-clinical settings.

The bill authorizes the Maryland Medical Assistance Program to provide and reimburse community violence prevention services delivered through telehealth, including both synchronous (e.g., live video or audio interactions) and asynchronous formats where appropriate, which expands access and flexibility for participants. This inclusion of telehealth reflects how programs have innovated their engagement strategies and allows trusted professionals to maintain continuity of care in contexts where in-person contact may be challenging. Importantly, the legislation specifically prohibits the exclusion of coverage solely because services delivered via telehealth, ensuring that telehealth becomes a viable reimbursement pathway rather than a barrier to funding.

Current Medicaid regulations can discourage community organizations from participating in the program unless they have formal ties with hospitals or trauma centers. SB 561 eliminates this requirement, ensuring that trusted community-based entities employing certified violence prevention professionals can participate directly in Medicaid reimbursement after becoming an approved provider. This change will help expand the network of providers capable of delivering services tailored to the unique needs of victims and individuals at risk of community violence.

The bill maintains important training and certification standards for certified violence prevention professionals — including initial training and ongoing continuing education — which ensures high-quality service delivery while facilitating a broader pool of qualified providers.

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Community violence intervention is a proven public health strategy rooted in outreach, trauma-informed support, mentoring, advocacy, and conflict mediation. By improving Medicaid reimbursement mechanisms and modernizing delivery standards, SB 561 strengthens program sustainability and expands equitable access to services for communities disproportionately impacted by violence. There are still issues to address regarding federal rules inconsistent with Medicaid reimbursement and a provider still must be approved by Maryland Medicaid, so we will need to continue to make reforms to ensure the success of this benefit.

For these reasons, we urge the Committee to favorably report Senate Bill 561. This bill will strengthen the infrastructure that supports community-based violence prevention, broaden access to essential services through telehealth, and ensure that experienced, local programs are reimbursed effectively for the lifesaving work they perform every day.

Thank you for your attention and consideration.

Respectfully submitted,
Yuvelqui Rattigan, LCSW-C, RPT
Director of Clinical Services
Center for Hope
yrattigan@lifebridgehealth.org

Jennifer Witten, Vice President Government Affairs
LifeBridge Health
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SB561 - SUP - Community Violence Prevention.pdf

Uploaded by: Zachary Arciaga

Position: FAV

TO: The Honorable Pamela Beidle Name, Chair
Senate Finance Committee

SB561

FROM: Zakk Arciaga
Assistant Director, Trauma Program/Break the Cycle Violence Intervention

Favorable

DATE: February 24, 2026

RE: SB561 Maryland Medical Assistance Program - Community Violence Prevention Services - Reimbursement and Provision of Services

Johns Hopkins **supports SB561 Maryland Medical Assistance Program - Community Violence Prevention Services - Reimbursement and Provision of Services**. This bill expands reimbursement and delivery options for community violence prevention services.

Johns Hopkins Healthsystem has the Break the Cycle Program, which is a hospital based violence intervention program, that helps victims of violence cope with deep psychological and emotional trauma. The Break the Cycle team integrates healthcare and social support services to break cycles of violence and support survivors of traumatic injuries. Through collaborative efforts and evidence-based practices, we address the immediate and long-term needs of patients affected by violence, striving to reduce trauma and promote safety within our community.

Break the Cycle has begun to cover multiple hospitals and has experienced significant growth, with closed cases increasing approximately fourfold from FY25 to FY26 while engaged clients increased from roughly 50 per quarter to nearly 200, demonstrating both rising demand and improved engagement efficiency. The majority of patients served are ages 15–35 and are injured within Baltimore City, with assaults representing roughly half to two-thirds of cases across sites and recent increases in underdeveloped Victim Service areas, such as Baltimore County, Montgomery County, and Anne Arundel County gunshot wound volume.

One of the components of the bill is to allow community violence prevention services to be allowed to be delivered through telehealth. Virtual connection, telehealth, has become a critical engagement tool, allowing continued contact with patients facing transportation, safety, work, or housing barriers. additionally helps keep our staff safe from high-risk engagements. Expansion of telehealth-supported violence intervention is directly associated with improved follow-up success and continuity of care. Johns Hopkins is very supportive of this component of the legislation.

We also appreciate the expansion of allowing community violence prevention services through programs that are not only associated with hospitals. Johns Hopkins has seen incredible value in our violence intervention program and believe that more programs with the goal of reducing trauma and promoting safety within our communities would be beneficial.

Accordingly, Johns Hopkins respectfully requests a **FAVORABLE** committee report on SB561.

SB 561 - FIN - MDH - LOO.docx (1).pdf

Uploaded by: Meghan Lynch

Position: UNF



DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

February 24, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 561 – Maryland Medical Assistance Program - Community Violence Prevention Services - Reimbursement and Provision of Services – Letter of Opposition

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (the Department) respectfully submits this letter of opposition for Senate Bill (SB) 561 – Maryland Medical Assistance Program - Community Violence Prevention Services - Reimbursement and Provision of Services. SB 561 would expand the existing community violence prevention (CVP) Medicaid benefit to: allow service provision in any setting; allow telehealth services; and remove hospital affiliation requirements of CVP providers. Additionally, SB 561 would require the Department to identify three certification and training programs for certified violence prevention professionals.

The expansion to providers without a hospital affiliation is expected to have a significant fiscal impact, estimated at \$2.7 million total funds (TF) (\$1.6 million federal funds (FF), \$1.1 million general funds (GF) in FY27. In assessing the fiscal impact, the Department has identified three non-hospital affiliated programs eligible for the CVP program expansion established by SB 561, all three of which are based in Baltimore City. Based on published utilization numbers for 2025, Safe Streets¹ and Roca Baltimore², served a combined total of 1,083 individuals. Information for Living Classroom's Operation Respond Program is not publicly available. Assuming services delivered to these individuals were eligible for Medicaid reimbursement, there would be a fiscal impact of \$2.7 million TF (\$1.6M FF and \$1.1M GF) for FY27. However, actual costs may be higher.

As further background, the Department implemented coverage for CVP in 2023 as required by HB1005/SB350 (Chs. 504, 505, Acts of 2022). The Department designed the benefit to require that the initial contact take place in a hospital setting to ensure that recipients had been referred by a certified or licensed health care provider or social services provider as required by the bill and consistent with federal requirements for preventive and rehabilitative benefits authorized by the Medicaid State Plan. The hospital integration makes it possible for the state to oversee these services and ensure they are in compliance with federal requirements. The community based

¹ <https://cc-md.org/about/annual-reports/>

² <https://rocainc.org/how-we-do-it/outcomes/baltimore-young-men/>

providers would need to have a licensed medical professional in-house to support this referral or be tracking a referral from elsewhere. The Department identified the Health Alliance for Violence Intervention (HAVI) as the only program that met legislative requirements for an accredited training and certification program for certified violence prevention professionals. Removing hospital affiliation requirements and opening places of service to any community-based setting increases the risk of services being rendered in the absence of a required referral.

As of January 2026, two organizations have enrolled as CVP providers. The Department has been working closely with HAVI's Maryland Working Group to address challenges to CVP billing. The Department recently committed to taking the following steps to facilitate billing: investigating the possibility of allowing 15 minute units of service, expanding allowable places of service for follow-up encounters to include community-based places of service, 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. The Department is currently working on implementing these changes, starting in Spring 2026 with allowing audio-only telehealth. The remaining updates require regulatory changes and an amendment to the State Plan and are anticipated to take effect in the second half of 2026, pending approval by the Centers for Medicare & Medicaid Services (CMS) and promulgation of regulations.

If you would like to discuss this further, please do not hesitate to contact Meghan Lynch, Director of Government Affairs at meghan.lynch@maryland.gov.

Sincerely,



Meena Seshamani, M.D., Ph.D.
Secretary of Health