COMMITTEE ON HEALTH

CHRISTINA HENDERSON, CHAIRPERSON
FISCAL YEAR 2025 COMMITTEE BUDGET REPORT

TO: Members of the Council of the District of Columbia

FROM: Councilmember Christina Henderson
Chairperson, Committee on Health

DATE: May 9, 2024

SUBJECT: Draft Report and Recommendations of the Committee on Health on the Fiscal Year 2025 Local Budget Act of 2024 and the Fiscal Year 2025 Budget Support Act Of 2024 for the Agencies Under Its Purview

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The Committee on Health ("Committee") having conducted hearings and received testimony on the Mayor's proposed operating and capital budgets for Fiscal Year 2025 ("FY 2025") for the agencies under its purview, reports its recommendations for review and consideration by the Committee of the Whole. The Committee also comments on several sections in the Fiscal Year 2025 Budget Support Act of 2024, as proposed by the Mayor.

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Executive Summary

This report of the Committee on Health on the Fiscal Year 2025 Proposed Budget for the agencies within its jurisdiction was developed after several months of hearings, testimony, meetings, and other forms of public engagement. The summary below highlights many of the Committee's notable investments in the FY 2025 budget, including the approval of proposed investments by the Mayor (so noted as "Approves").

The Committee's recommended budget makes critical investments to:

Enhance Support for Behavioral Health and Substance Use Treatment

- Expand the Substance Abuse and Behavioral Health Services Targeted Outreach Grants by providing an additional **$800,000** from a transfer from the Committee on Recreation, Libraries, and Youth and the Opioid Abatement Settlement Fund, to provide support and connections to treatment for individuals in need of substance abuse and behavioral health services at 7 locations in Wards 1, 5, 6, 7, and 8 with concentrated outdoor drug use
- Extend the School-Based Behavioral Health Student Peer Educator Pilot for a second year by providing an additional **$325,000** from the Opioid Abatement Settlement Fund for grants to train and supervise students in behavioral health support and services for their peers
- Restore critical funding to the Office of the Chief Medical Examiner Illicit Drug Surveillance program by providing **$400,000** from the Opioid Abatement Settlement Fund to sustain the agency's forensic toxicology testing and development of new forensic testing methods
- Increase resources and support for individuals struggling with Problem Gambling Disorder by accepting a **$300,000** transfer from the Committee on Business and Economic Development

Improve Health for Birthing Parents and Families

- Fully fund D.C. Law 25-49, the Expanding Access to Fertility Treatment Amendment Act of 2023, by providing **$420,000** to defray the costs of fertility services for residents insured through DC Health Link
- Approve **$300,000** for a new grant for Childcare for Pregnant and Birthing Parents, which will provide childcare to pregnant and birthing parents and legal guardians who need urgent medical treatment at a birthing hospital or facility in the District
- Provide an additional **$74,600** to the Perinatal Quality Collaborative to implement the evidence-based Count the Kicks Initiative to decrease stillbirths
- Approve **$225,000** and provide an additional **$100,000** through a transfer from the Committee on Public Works and Operations for nurse-led home visiting for families
- Maintain distribution of diapers, formula, and other essential supplies for infants by approving **$400,000** in recurring funds as a grant to the DC Diaper Bank

Increase Healthy Food Access

- Provide an additional **$600,000** in recurring funding for Produce Plus, which provides funding for low-income residents to purchase fresh fruit and vegetables at farmers markets, to increase program participation by 2,500 for this high-demand program
- Fund a new Grocery Access Pilot Program at **$120,000**, enabling 1,000 residents who participate in educational programs under the Supplemental Nutrition Assistance Program (SNAP-Ed) to purchase groceries online without delivery fees
- Ensure stable funding for the Healthy Food Access Grant programs, including Healthy Corners, Joyful Food Markets, Home-Delivered Meals, and Produce Plus, by moving these critical grant programs from one-time funds to recurring funds, for a total of **$5,409,066** in recurring funds (plus the $600,000 increase mentioned above)

Enhance Patient Care and Outcomes

- Approves two new Directed Payments on qualifying hospitals, which will generate **$127,561,036** in additional revenue for District hospitals to spend on improving maternal and child health outcomes, discharge and transitions of care, substance use treatment, and workforce pipelines
- Ensure patients can access the medications and procedures they need by allocating **$1,280,612** to fund key provisions of D.C. Law 25-124, the Prior Authorization Reform Amendment Act of 2023
- Approves an increase of **$17,697,000** in Medicaid payments to nursing facilities, that will go directly towards increasing wages for certified nursing assistants (CNAs)

Promote Student Health and Achievement

- Provide an additional **$1,411,000** to enhance the School Health Services Program, including enhanced training for school nurses, health technicians, and staff, and increasing access to telehealth services in school health suites
- Allocate **$757,386** to fully fund D.C. Law 25-0124, the Access to Emergency Medications Amendment Act of 2023, which ensures that when a student is having a medical emergency, schools are prepared with emergency medication and staff trained to provide immediate medical care
- Fund a Sexual Health Peer Educators Grant at **$150,000**, which will provide training and stipends to high school students to serve as student health educators, teaching their fellow students about pregnancy prevention, consent, STIs, and other related topics
- Expand opportunities for middle schoolers to participate in summer programming focused on career exploration by transferring **$137,500** to the Committee on Executive Administration and Labor to add 50 participants to the DOES Middle School Career Ready Early Scholars Program

Improve Access to Critical Health Care Infrastructure

- Ensure increased patient services at the District's publicly owned psychiatric hospital by approving the proposed increases of **$9,372,000** in operating funds and **$7,280,000** in capital improvements for Saint Elizabeth's Hospital
- Restore **$907,000** for the Court Urgent Care Clinic located within the Superior Court of the District of Columbia Moultrie Courthouse
- Ensure the financial stability of United Medical Center as it prepares for closure in 2025 by approving an additional **$10,200,000** investment to cover severance and related employee benefits, as well as document destruction after the hospital closes
- Enhance critical animal rescue and animal control services by approving **$22,600,000** in capital funds to construct a new animal shelter to replace the current District-owned shelter at 1201 New York Avenue NE

Tackle Pressing Public Health Challenges

- Restore **$350,000** for at-home HIV and Sexually Transmitted Infection testing, a critical service used by almost 6,000 District residents each year, that lost its federal funding
- Create a new Tobacco Use Cessation Fund dedicatedto tobacco use prevention and cessation, specifically focused on youth vaping use, and allocate **$3,415,140** over the financial plan to the new Fund from the JUUL Settlement Funds collected by the Office of the Attorney General
- Support more accurate, comprehensive data collection on traffic-related injuries to improve Vision Zero by accepting a transfer of **one FTE** from the Committee of Transportation and the Environment for DC Health's Roadway Injury Surveillance Data Project
- Support the training of pediatric primary care providers on domestic violence, cultural humility, trauma informed care, and safety planning and crisis intervention by providing **$25,000** for this purpose
- Assist low-income tenants with remaining in their homes by transferring **$200,000** to the Committee on Housing to restore cuts to the Emergency Rental Assistance Program
- Enhance Access to Justice Initiatives at Office of Victim Services and Justice Grants by transferring **$100,000** to the Committee on the Judiciary and Public Safety for that purpose

Committee Adjustments Summary Tables

The following tables summarize the Committee's recommendations made to the Committee of the Whole pursuant to Rule 703 of the Council Period 25 Rules of Organization and Procedure for the Council of the District of Columbia. More detailed information can be found in the attachments.

Line-Item Budget and Revenue Adjustments

See Attachment A for a table of all budget attributes and comments for each recommended change to agency operating budgets and revenues as well as full budget attributes for Committee transfers.

Fiscal Year 2025 Agency Operating Budget by Cost Center Parent Level 1

Department of Behavioral Health					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT	$1,830,556	$2,495,073	$2,277,771	$0	$2,277,771
C0100 - NO COST CENTER	($201,670)	$0	$0	$0	$0
H5701 - DIVISION OF ADULT SERVICES	$67,548,186	$74,491,317	$122,249,958	($292,980)	$121,956,978
H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES	$119,850,765	$134,384,453	$79,817,893	$580,252	$80,398,144
H5901 - EXECUTIVE OFFICE OF THE DIRECTOR	$4,041,174	$5,000,866	$4,808,604	$0	$4,808,604
H6001 - OFFICE OF POLICY ADVISOR	$6,091,311	$6,292,334	$5,821,094	$0	$5,821,094
H6101 - OFFICE OF THE CHIEF CLINICAL OFFICER	$1,793,132	$202,510	$202,510	$0	$202,510
H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPIT	$109,130,313	$102,766,528	$107,705,313	($139,288)	$107,566,025
H6301 - OFFICE OF THE CHIEF OF STAFF	$5,592,130	$5,303,478	$5,127,471	$0	$5,127,471
H6401 - OFFICE OF THE CHIEF OPERATING OFFICER	$23,777,108	$26,397,586	$18,290,360	($316,414)	$17,973,946
H8001 - OFFICE OF OPIOID ABATEMENT	$0	$548,000	$14,655,500	$0	$14,655,500
H8300 - DIVISION OF CRISIS SERVICES	$14,939,253	$18,806,407	$21,735,920	($18,848)	$21,717,072
H8401 - DIVISION OF DATA, QUALITY and COMPLIANCE	$3,784,555	$3,411,485	$2,843,846	($46,227)	$2,797,619
TOTAL GROSS FUNDS	**$358,176,811**	**$380,100,036**	**$385,536,240**	**($233,506)**	**$385,302,734**
Department of Health					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT	$2,930,113	$3,471,596	$3,556,087	($2,000)	$3,554,087
C0100 - NO COST CENTER	$7,366	$0	$0	$0	$0
H0601 - CENTER FOR POLICY, PLANNING, AND EVALUATION	$14,525,894	$28,436,074	$41,025,838	$0	$41,025,838
H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	$95,530,869	$81,968,234	$83,561,460	$3,646,366	$87,207,826
H0702 - COMMUNITY HEALTH ADMINISTRATION	$7,490,920	$9,481,382	$9,136,206	($17,720)	$9,118,486
H0801 - HEALTH EMERGENCY PREPAREDNESS AND RESPONSE ADMI	$9,702,370	$6,084,920	$6,416,742	$167,541	$6,584,283
H0901 - HEALTH REGULATION AND LICENSING ADMINISTRATION	$34,573,549	$34,196,803	$33,987,351	($25,550)	$33,961,801
H1001 - HIV/AIDS, HEPATITIS, STD, AND TB ADMINISTRATION	$85,344,298	$90,324,448	$91,750,019	$500,000	$92,250,019
H1101 - OFFICE OF HEALTH EQUITY	$5,827,928	$6,045,793	$962,245	$0	$962,245
H1201 - OFFICE OF THE CHIEF OPERATING OFFICER	$27,593,155	$29,361,996	$31,388,997	$0	$31,388,997
H1202 - OFFICE OF THE CHIEF OF STAFF	$822,057	$1,056,599	$1,335,580	$0	$1,335,580
H1203 - OFFICE OF THE DIRECTOR	$4,249,839	$1,700,763	$1,708,472	($3,556)	$1,704,916
H7401 - COMMUNITY HEALTH ADMINISTRATION	$98,187	$0	$0	$0	$0
TOTAL GROSS FUNDS	**$288,696,544**	**$292,128,607**	**$304,828,997**	**$4,265,081**	**$309,094,078**

Committee on Health
Fiscal Year 2025 Budget Recommendations

DIFS Cost Center (Parent Level 1)	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health Care Finance					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT	$4,343,349	$8,229,872	$8,453,801	$0	$8,453,801
H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	$51,197,999	$76,244,937	$77,467,320	$987,460	$78,454,780
H2902 - HEALTH AND HUMAN SERVICES FUNCTIONAL DIVISION	$0	$708,779	$0	$0	$0
H3001 - PROGRAM INTEGRITY ADMINISTRATION	$3,510,956	$3,986,654	$4,770,656	($16,367)	$4,754,289
H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION	$19,396,593	$28,898,692	$24,435,808	$899,570	$25,335,378
H3201 - MEDICAID PROVIDER PAYMENTS	$4,007,760,552	$3,846,495,100	$4,370,554,243	($2,322,593)	$4,368,231,650
H3202 - PUBLIC PROVIDER PAYMENTS	$134,405,174	$75,211,595	$75,617,394	$0	$75,617,394
H3203 - ALLIANCE PROVIDER PAYMENT	$111,194,270	$118,327,853	$132,493,843	$150,259	$132,644,102
H3301 - HEALTH CARE OPERATIONS ADMINISTRATION	$46,860,703	$54,702,920	$63,841,271	$0	$63,841,271
H3401 - HEALTH CARE POLICY AND RESEARCH ADMINISTRATION	$3,570,814	$6,972,630	$6,939,980	($352,415)	$6,587,565
H3501 - HEALTH CARE REFORM AND INNOVATION ADMINISTRATION	$12,381,968	$11,717,137	$17,696,495	$100,000	$17,796,495
H3601 - LONG TERM CARE ADMINISTRATION	$20,550,694	$25,691,760	$27,424,966	($141,660)	$27,283,306
H3701 - OFFICE OF THE OSMD	$1,168,431	$2,771,428	$4,454,885	($310,694)	$4,144,191
H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	$17,751,540	$31,450,280	$23,326,568	($1,013,466)	$22,313,102
H3703 - OFFICE OF THE DIRECTOR	$8,464,923	$12,654,090	$7,873,253	$0	$7,873,253
H3902 - INFORMATION SYSTEMS DIVISION	$0	$0	$5,350,673	($60,195)	$5,290,477
H3903 - PROGRAM REVIEW MONITORING AND INVESTIGATIONS DIVIS	$0	$0	$4,470,555	$0	$4,470,555
H8100 - DATA ANALYTICS AND RESEARCH ADMINSTRATION (DARA)	$0	$0	$2,089,445	($10,150)	$2,079,295
H8200 - OFFICE OF DDS FINANCE	$0	$0	$6,405,395	($10,553)	$6,394,842
TOTAL GROSS FUNDS	**$4,442,557,965**	**$4,304,063,725**	**$4,863,666,552**	**($2,100,804)**	**$4,861,565,747**
Health Benefit Exchange Authority					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT	$698,471	$829,047	$780,040	$0	$780,040
C0100 - NO COST CENTER	($3,806)	$0	$0	$0	$0
H1901 - DIRECTOR'S OFFICE	$6,720,373	$3,670,408	$3,877,010	$0	$3,877,010
H2001 - OPERATIONS DEPARTMENT	$2,361,056	$2,535,787	$2,557,107	$0	$2,557,107
H2201 - PROGRAM DEPARTMENT	$18,073,661	$14,818,917	$18,080,242	$0	$18,080,242
H6601 - COMMUNICATIONS AND CIVIC ENGAGEMENT DEPARTMENT	$2,071,797	$2,313,705	$2,316,786	$0	$2,316,786
H6701 - INFORMATION TECHNOLOGY DEPARTMENT	$17,636,357	$13,384,283	$14,141,599	$0	$14,141,599
TOTAL GROSS FUNDS	**$47,557,909**	**$37,552,148**	**$41,752,784**	**$0**	**$41,752,784**

DIFS Cost Center (Parent Level 1)	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Not-for-Profit Hospital Corporation					
C0100 - NO COST CENTER	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL GROSS FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy					
C0100 - NO COST CENTER	$22,000,000	$15,000,000	$25,200,000	$0	$25,200,000
TOTAL GROSS FUNDS	**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**
Office of the Deputy Mayor for Health and Human Services					
H1301 - CHIEF OF STAFF ADMINISTRATIVE OFFICE	$117,020	$405,671	$304,583	$0	$304,583
H1501 - OFFICE OF THE CHIEF OF STAFF	$71,577	$0	$0	$0	$0
H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS	$1,856,314	$2,071,890	$2,175,904	($29,368)	$2,146,536
TOTAL GROSS FUNDS	**$2,044,911**	**$2,477,561**	**$2,480,487**	**($29,368)**	**$2,451,119**
GRAND TOTAL	**$5,161,034,141**	**$5,186,322,077**	**$5,778,465,060**	**$1,901,402**	**$5,780,366,462**

See Attachment B for a table detailing recommended agency budgets and full-time equivalents at the Cost Center level.

Fiscal Year 2025 Agency Operating Budget by Program Parent Level 1

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
AFO000 - AGENCY FINANCIAL OPERATIONS					
AFO002 - AGENCY ACCOUNTING SERVICES	$896,554	$0	$690,651	$0	$690,651
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$671,436	$2,182,509	$1,009,890	$0	$1,009,890
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$222,377	$312,564	$577,230	$0	$577,230
AFO010 - PAYROLL DEFAULT	$0	$0	$0	$0	$0
AFO011 - P-CARD CLEARING	$37,998	$0	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$1,828,365**	**$2,495,073**	**$2,277,771**	**$0**	**$2,277,771**
AMP000 - AGENCY MANAGEMENT PROGRAM					
AMP002 - CLAIMS SERVICES	$2,157,390	$818,323	$844,135	$0	$844,135
AMP011 - HUMAN RESOURCE SERVICES	$2,369,028	$3,043,988	$2,790,285	$0	$2,790,285
AMP012 - INFORMATION TECHNOLOGY SERVICES	$5,671,105	$6,548,434	$5,066,119	$0	$5,066,119
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$2,533,069	$3,665,044	$3,669,108	($242,247)	$3,426,861
AMP022 - RECORDS MANAGEMENT	$686,471	$815,427	$807,991	$0	$807,991
AMP023 - RESOURCE MANAGEMENT	$12,729,073	$14,550,358	$7,903,008	($74,167)	$7,828,841
TOTAL PROGRAM PARENT L2 FUNDS	**$26,146,136**	**$29,441,574**	**$21,080,645**	**($316,414)**	**$20,764,231**
HS0042 - DATA, QUALITY AND COMPLIANCE PROGRAM					
H04201 - ACCOUNTABILITY ADMINISTRATIVE SERVICES	$236,061	$117,215	$225,264	($46,227)	$179,037
H04202 - CERTIFICATION SERVICES	$1,163,766	$943,177	$1,150,645	$0	$1,150,645
H04203 - INCIDENT, MANAGEMENT AND INVESTIGATION SERVICES	$519,707	$561,097	$536,194	$0	$536,194
H04204 - LICENSURE SERVICES	$603,488	$606,246	$576,868	$0	$576,868
H04205 - PROGRAM INTEGRITY SERVICES	$1,261,532	$1,183,750	$354,875	$0	$354,875
H04702 - DATA AND PERFORMANCE MEASUREMENT SERVICES	$1,562,309	$2,062,300	$2,386,854	$0	$2,386,854
H04703 - STRATEGIC PLANNING AND POLICY SERVICES	$576,589	$409,361	$351,351	$0	$351,351
H04704 - TRAINING INSTITUTE SERVICES	$1,651,832	$1,197,474	$989,902	$0	$989,902
TOTAL PROGRAM PARENT L2 FUNDS	**$7,575,285**	**$7,080,622**	**$6,571,953**	**($46,227)**	**$6,525,726**
HS0043 - ADULT/TRANSITIONAL YOUTH SERVICES PROGRAM					
H04303 - ADULT/TRANSITIONAL YOUTH SERVICES ADMINISTRATIVE SE	$88,510	$0	$0	$0	$0
H04309 - IMPLEM OF DRUG TREATMENT CHOICE SERVICES	($15,988)	$0	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$72,522**	**$0**	**$0**	**$0**	**$0**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
HS0044 - BEHAVIORAL HEALTH AUTHORITY PROGRAM					
H04402 - CONSUMER AND FAMILY AFFAIRS	$1,996,907	$993,354	$1,018,515	$0	$1,018,515
H04403 - EXECUTIVE DIRECTOR	$2,038,329	$2,708,261	$2,609,773	$0	$2,609,773
H04404 - LEGAL SERVICES	$1,049,390	$1,040,560	$1,046,625	$0	$1,046,625
H04405 - LEGISLATIVE AND PUBLIC SERVICES	$932,635	$963,828	$917,518	$0	$917,518
H04406 - OMBUDSMAN	$293,560	$302,307	$401,154	$0	$401,154
TOTAL PROGRAM PARENT L2 FUNDS	**$6,310,822**	**$6,008,311**	**$5,993,584**	**$0**	**$5,993,584**
HS0045 - CHILD/ADOLESCENT/FAMILY SERVICES PROGRAM					
H04501 - BEHAVIORAL SERVICES - HOWARD ROAD	$0	$216,507	$217,385	$0	$217,385
H04502 - CHILD/ADOLESCENT/FAMILY SERVICES ADMINISTRATIVE SE	$290,361	$0	$0	$0	$0
H04503 - COURT ASSESSMENT SERVICES	$1,557,064	$1,630,847	$1,063,032	$0	$1,063,032
H04504 - CRISIS SERVICES	$989,085	$1,466,544	$100,000	$0	$100,000
H04505 - EARLY CHILDHOOD SERVICES	$3,387,559	$3,896,600	$3,501,668	($75,968)	$3,425,700
H04506 - EVIDENCE BASED PRACTICES SERVICES	$1,336,351	$1,259,287	$1,258,065	$0	$1,258,065
H04507 - MH/SUD BEHAVIORAL HEALTH SERVICES (CHILD & FAMILY)	$1,942,512	$1,378,285	$1,349,674	$0	$1,349,674
H04508 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES	$28,069,439	$38,339,743	$28,362,409	($593,780)	$27,768,629
H04509 - SPECIALTY SERVICES	$899,210	$1,066,899	$941,013	$0	$941,013
TOTAL PROGRAM PARENT L2 FUNDS	**$38,471,582**	**$49,254,713**	**$36,793,246**	**($669,748)**	**$36,123,498**
HS0046 - CLINICAL SERVICES PROGRAM					
H04601 - BEHAVIORAL HEALTH SERVICES	$207,569	$115,681	$490,080	$0	$490,080
H04602 - BEHAVIORAL HEALTH SERVICES-PHARMACY	$478,545	$202,510	$202,510	$0	$202,510
H04604 - DISASTER BEHAVIORAL HEALTH SERVICES AND SUPPORT S	$1,314,587	$0	$0	$0	$0
H04605 - FORENSICS SERVICES	$4,335,674	$4,734,130	$4,102,385	$0	$4,102,385
TOTAL PROGRAM PARENT L2 FUNDS	**$6,336,376**	**$5,052,321**	**$4,794,975**	**$0**	**$4,794,975**
HS0047 - POLICY, PLANNING, AND EVALUATION ADMINISTRATION PROGRAM					
H04701 - BEHAVIORAL HEALTH GRANT OVERSIGHT SERVICES	$2,300,581	$2,623,198	$2,092,987	$0	$2,092,987
TOTAL PROGRAM PARENT L2 FUNDS	**$2,300,581**	**$2,623,198**	**$2,092,987**	**$0**	**$2,092,987**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
HS0048 - ST. ELIZABETHS HOSPITAL PROGRAM					
H04801 - CLINICAL ADMINISTRATIVE SERVICES	$11,897,527	$12,605,564	$12,833,528	($9,044)	$12,824,484
H04802 - CLINICAL AND MEDICAL SERVICES	$21,786,123	$21,153,193	$22,867,584	($27,168)	$22,840,416
H04803 - ENIGINEERING AND MAINTENANCE SERVICES	$5,615,293	$4,853,078	$4,843,077	($29,093)	$4,813,984
H04804 - FISCAL AND SUPPORT SERVICES	$461,748	$951,917	$874,419	$0	$874,419
H04805 - HOSPITAL ADMINISTRATIVE SERVICES	$1,147,716	$1,180,735	$5,737,277	($46,175)	$5,691,101
H04806 - HOUSEKEEPING SERVICES	$3,023,269	$2,788,853	$2,659,363	$0	$2,659,363
H04807 - MATERIAL MANAGEMENT SERVICES	$1,307,104	$1,586,638	$1,511,558	($4,562)	$1,506,996
H04808 - NURSING SERVICES	$53,997,718	$46,290,762	$50,248,168	$0	$50,248,168
H04809 - NUTRITIONAL SERVICES	$3,391,505	$4,375,449	$3,414,479	$0	$3,414,479
H04810 - QUALITY AND DATA MANAGEMENT SERVICES	$1,454,629	$1,571,602	$1,575,347	($11,275)	$1,564,072
H04811 - SECURITY AND SAFETY SERVICES	$5,257,172	$4,741,694	$4,941,617	($744)	$4,940,873
H04812 - TRANSPORATION AND GROUNDS SERVICES	$675,905	$667,042	$632,457	($11,226)	$621,231
TOTAL PROGRAM PARENT L2 FUNDS	**$110,015,709**	**$102,766,528**	**$112,138,872**	**($139,288)**	**$111,999,584**
HS0052 - OPIOID ABATEMENT PROGRAM					
H05201 - DIRECTOR AND COMMISSION SUPPORT	$0	$548,000	$14,655,500	$0	$14,655,500
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$548,000**	**$14,655,500**	**$0**	**$14,655,500**
HS0053 - CRISIS SERVICES					
H04302 - ACCESS HELPLINE	$1,729,525	$2,987,375	$2,630,514	$0	$2,630,514
H04306 - COMMUNITY RESPONSE TEAM	$8,146,729	$10,644,554	$9,982,467	$0	$9,982,467
H04603 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	$5,098,748	$5,174,478	$7,756,394	($18,848)	$7,737,546
H05301 - CHILD/YOUTH CRISIS & COMMUNITY TRAUMA RESPONS	$0	$0	$1,366,544	$0	$1,366,544
TOTAL PROGRAM PARENT L2 FUNDS	**$14,975,002**	**$18,806,407**	**$21,735,920**	**($18,848)**	**$21,717,072**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
HS0054 - ADULT SERVICES ADMINISTRATION PROGRAM					
H04301 - 35 K STREET ADULT CLINICAL SERVICES	$110,595	$2,783,877	$2,058,635	$0	$2,058,635
H04304 - ASSESSMENT AND REFERRAL CENTER SERVICES	$1,765,180	$2,273,267	$2,393,309	$0	$2,393,309
H04305 - CO-LOCATED SERVICES	$759,341	$289,175	$292,557	$0	$292,557
H04307 - GAMBLING ADDICTION TREATMENT SERVICES	$27,540	$0	$0	$0	$0
H04308 - HOUSING SUPPORT SERVICES	$27,419,358	$29,637,309	$28,987,309	($292,980)	$28,694,329
H04310 - MENTAL HEALTH AND REHAB SERVICES	$63,209,155	$65,255,442	$20,213,562	$0	$20,213,562
H04311 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	$15,827,069	$15,418,371	$14,338,644	$1,250,000	$15,588,644
H04312 - PROVIDER RELATIONS SERVICES	$953,455	$1,252,045	$1,152,206	$0	$1,152,206
H04313 - RESIDENTIAL SUPPORT AND CONTINUITY OF CARE SERVICE	$614,491	$582,907	$599,614	$0	$599,614
H04314 - SPECIALTY SERVICES	$7,060,175	$7,416,635	$5,514,618	$0	$5,514,618
H04315 - SUBSTANCE USE DISORDER TREATMENT SERVICES	$1,192,931	$1,267,195	$1,197,609	$0	$1,197,609
H04316 - STATE OPIOID RESPONSE PROGRAM	$25,404,622	$29,847,071	$36,014,647	$0	$36,014,647
H04317 - BEHAVIORAL HEALTH REHABILITATION - LOCAL MATCH	$0	$0	$44,638,076	$0	$44,638,076
TOTAL PROGRAM PARENT L2 FUNDS	**$144,343,913**	**$156,023,292**	**$157,400,787**	**$957,020**	**$158,357,807**
TOTAL AGENCY FUNDS	**$358,176,811**	**$380,100,036**	**$385,536,240**	**($233,506)**	**$385,302,734**
Department of Health					
AFO000 - AGENCY FINANCIAL OPERATIONS					
AFO002 - AGENCY ACCOUNTING SERVICES	$1,054,412	$1,329,845	$1,277,475	$0	$1,277,475
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$1,124,210	$1,272,746	$1,315,053	($2,000)	$1,313,053
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$751,491	$869,005	$857,559	$0	$857,559
TOTAL PROGRAM PARENT L2 FUNDS	**$2,930,113**	**$3,471,596**	**$3,450,087**	**($2,000)**	**$3,448,087**

Committee on Health
Fiscal Year 2025 Budget Recommendations

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health					
AMP000 - AGENCY MANAGEMENT PROGRAM					
AMP003 - COMMUNICATIONS	$822,057	$1,056,599	$1,441,580	$0	$1,441,580
AMP005 - CONTRACTING AND PROCUREMENT	$870,607	$785,676	$1,261,399	$0	$1,261,399
AMP011 - HUMAN RESOURCE SERVICES	$1,386,869	$1,742,355	$2,060,721	$0	$2,060,721
AMP012 - INFORMATION TECHNOLOGY SERVICES	$6,405,450	$4,165,806	$8,070,145	$0	$8,070,145
AMP013 - LABOR RELATIONS	$115,021	$180,829	$170,800	$0	$170,800
AMP014 - LEGAL SERVICES	$2,293,932	$2,716,132	$2,702,454	$0	$2,702,454
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$16,404,285	$19,639,133	$16,991,359	$0	$16,991,359
AMP024 - RISK MANAGEMENT	$125,012	$132,064	$132,119	$0	$132,119
AMP030 - EXECUTIVE ADMINISTRATION	$4,242,384	$1,700,763	$1,708,472	($3,556)	$1,704,916
TOTAL PROGRAM PARENT L2 FUNDS	**$32,665,616**	**$32,119,357**	**$34,539,050**	**($3,556)**	**$34,535,493**
HS0004 - COMMUNITY HEALTH SERVICES					
H00401 - CANCER AND CHRONIC DISEASE PREVENTION	$11,384,446	$9,710,496	$10,702,362	$771,160	$11,473,522
H00403 - COMMUNITY OF HEALTH SUPPORT SERVICES	$7,367,002	$9,481,382	$9,136,206	($17,720)	$9,118,486
H00405 - FAMILY HEALTH	$41,757,053	$39,868,174	$39,722,688	$2,155,206	$41,877,894
H00406 - HEALTH CARE ACCESS	$20,090,982	$9,589,010	$10,278,374	$0	$10,278,374
H00407 - NUTRITION AND PHYSICAL FITNESS	$22,255,563	$22,474,173	$22,523,173	$720,000	$23,243,173
H00408 - PERINATAL AND INFANT HEALTH	$166,744	$326,381	$334,864	$0	$334,864
H00409 - PCPA SUPPORT SERVICES	$98,187	$0	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$103,119,976**	**$91,449,616**	**$92,697,666**	**$3,628,646**	**$96,326,312**
HS0006 - FOOD, DRUG, RADIATION AND COMMUNITY HYGIENE PROGRAM					
H00601 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE	$14,548,361	$14,128,003	$14,032,978	($25,550)	$14,007,428
TOTAL PROGRAM PARENT L2 FUNDS	**$14,548,361**	**$14,128,003**	**$14,032,978**	**($25,550)**	**$14,007,428**
HS0007 - HEALTH EQUITY SERVICES					
H00701 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLIC'	$43,031	$231,663	$254,888	$0	$254,888
H00702 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATIO	$125,182	$102,390	$12,333	$0	$12,333
H00703 - MULTI SECTOR COLLABORATION	$478,091	$567,539	$695,024	$0	$695,024
TOTAL PROGRAM PARENT L2 FUNDS	**$646,304**	**$901,593**	**$962,245**	**$0**	**$962,245**

Agency Operating Budget by Program Parent L2 and Parent L1					
Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health					
HS0008 - HIV/AIDS, HEPATITIS, STD, AND TB PREVENTION					
H00801 - DIRECT CARE SERVICES FOR TUBERCULOSIS	$2,058,048	$1,751,308	$1,987,553	$0	$1,987,553
H00802 - DRUG ASSISTANCE	$12,123,755	$9,081,291	$10,782,274	$0	$10,782,274
H00803 - GRANTS AND CONTRACTS MANAGEMENT	$1,591,651	$1,918,229	$1,639,108	$0	$1,639,108
H00804 - HIV HEALTH AND SUPPORT SERVICES	$36,937,310	$39,975,052	$38,221,847	$0	$38,221,847
H00805 - HIV/AIDS DATA AND RESEARCH	$2,037,954	$4,165,821	$3,991,618	$0	$3,991,618
H00806 - HIV/AIDS HOUSING AND SUPPORTIVE SERVICES	$11,863,045	$13,664,395	$13,980,418	$0	$13,980,418
H00807 - HIV/AIDS POLICY AND PLANNING	$4,008,263	$5,477,633	$6,126,224	$0	$6,126,224
H00808 - PREVENTION AND INTERVENTION SERVICES	$11,238,316	$11,099,079	$11,834,332	$500,000	$12,334,332
H00809 - STD CONTROL	$3,485,957	$3,191,638	$3,168,803	$0	$3,168,803
TOTAL PROGRAM PARENT L2 FUNDS	**$85,344,298**	**$90,324,448**	**$91,732,178**	**$500,000**	**$92,232,178**
HS0009 - MEDICAL AND PUBLIC HEALTH EMERGENCIES					
H00902 - PUBLIC HEALTH EMERGENCY OPERATIONS AND PROGRAM	$7,572,780	$4,381,480	$4,799,908	$0	$4,799,908
H00903 - PUBLIC HEALTH EMERGENCY PREPAREDNESS	$2,023,169	$1,502,138	$1,481,355	$0	$1,481,355
TOTAL PROGRAM PARENT L2 FUNDS	**$9,595,949**	**$5,883,618**	**$6,281,263**	**$0**	**$6,281,263**
HS0011 - OFFICE OF HEALTH CARE FACILITIES					
H01101 - HEALTH CARE FACILITIES REGULATION	$6,217,104	$8,215,422	$7,372,921	$0	$7,372,921
TOTAL PROGRAM PARENT L2 FUNDS	**$6,217,104**	**$8,215,422**	**$7,372,921**	**$0**	**$7,372,921**
HS0012 - PROFESSIONAL LICENSING					
H01201 - HEALTH LICENSING	$13,808,084	$11,853,378	$12,599,294	$0	$12,599,294
TOTAL PROGRAM PARENT L2 FUNDS	**$13,808,084**	**$11,853,378**	**$12,599,294**	**$0**	**$12,599,294**
HS0013 - REGULATORY OVERSIGHT OF EMERGENCY MEDICAL SERVICES					
H01301 - EMERGENCY MEDICAL SERVICES REGULATION	$106,421	$201,301	$135,479	$167,541	$303,020
TOTAL PROGRAM PARENT L2 FUNDS	**$106,421**	**$201,301**	**$135,479**	**$167,541**	**$303,020**
HS0014 - RESEARCH EVALUATION AND MEASUREMENT					
H01401 - EPIDEMIOLOGIC STUDIES AND OUTBREAK INVESTIGATION	$6,971,445	$7,737,812	$3,314,419	$0	$3,314,419
TOTAL PROGRAM PARENT L2 FUNDS	**$6,971,445**	**$7,737,812**	**$3,314,419**	**$0**	**$3,314,419**
HS0015 - STATE HEALTH PLANNING AND DEVELOPMENT					
H01501 - DEVELOPMENT OF THE STATE HEALTH PLAN AND ANNUAL I	$1,457,705	$1,582,930	$1,795,798	$0	$1,795,798
TOTAL PROGRAM PARENT L2 FUNDS	**$1,457,705**	**$1,582,930**	**$1,795,798**	**$0**	**$1,795,798**

Committee on Health
Fiscal Year 2025 Budget Recommendations

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health					
HS0016 - STATE HEALTH STATISTICS					
H01601 - BIRTH AND DEATH RECORD COLLECTION, PROCESSING, A	$11,278,368	$24,259,532	$35,915,620	$0	$35,915,620
TOTAL PROGRAM PARENT L2 FUNDS	**$11,278,368**	**$24,259,532**	**$35,915,620**	**$0**	**$35,915,620**
PRG000 - NO PROGRAM					
PRG001 - NO PROGRAM	$6,800	$0	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$6,800**	**$0**	**$0**	**$0**	**$0**
TOTAL AGENCY FUNDS	**$288,696,544**	**$292,128,607**	**$304,828,997**	**$4,265,081**	**$309,094,078**
Department of Health Care Finance					
AFO000 - AGENCY FINANCIAL OPERATIONS					
AFO002 - AGENCY ACCOUNTING SERVICES	$3,353,048	$7,133,253	$7,249,272	$0	$7,249,272
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$589,362	$740,233	$835,970	$0	$835,970
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$326,499	$356,386	$368,559	$0	$368,559
AFO010 - PAYROLL DEFAULT	$0	$0	$0	$0	$0
AFO011 - P-CARD CLEARING	$637	$0	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$4,269,546**	**$8,229,872**	**$8,453,801**	**$0**	**$8,453,801**
AMP000 - AGENCY MANAGEMENT PROGRAM					
AMP003 - COMMUNICATIONS	$649,379	$1,855,551	$36,000	$0	$36,000
AMP005 - CONTRACTING AND PROCUREMENT	$1,960,062	$1,875,735	$2,076,000	$0	$2,076,000
AMP006 - CUSTOMER SERVICE	$3,143,763	$4,700,046	$0	$0	$0
AMP010 - GRANTS ADMINISTRATION	$10,824,067	$1,857,541	$0	$0	$0
AMP011 - HUMAN RESOURCE SERVICES	$1,044,114	$2,047,874	$1,514,471	$0	$1,514,471
AMP012 - INFORMATION TECHNOLOGY SERVICES	$5,537,551	$11,944,268	$12,997,403	($757,043)	$12,240,360
AMP014 - LEGAL SERVICES	$1,220,335	$1,633,025	$1,470,759	$0	$1,470,759
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$2,750,902	$11,770,256	$4,024,851	$0	$4,024,851
AMP021 - RATES, REIMBURSEMENT, FINANCIAL ANALYSIS	$3,406,849	$5,084,658	$0	$0	$0
AMP026 - TRAINING AND DEVELOPMENT	$1,040,455	$16,809	$0	$0	$0
AMP030 - EXECUTIVE ADMINISTRATION	$1,225,519	$1,409,438	$1,445,209	$0	$1,445,209
AMP037 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	$0	$0	$4,418,885	($310,694)	$4,108,191
AMP038 - SENIOR DEPUTY DIRECTOR/FINANCE	$0	$0	$6,405,395	($10,553)	$6,394,842
AMP039 - CHIEF OPERATING OFFICE	$0	$0	$2,615,172	($256,423)	$2,358,750
AMP040 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	$0	$0	$2,089,445	($10,150)	$2,079,295
AMP041 - PROGRAM INTEGRITY	$0	$0	$4,770,656	($16,367)	$4,754,289
AMP042 - HEALTH CARE OMBUDSMAN	$0	$0	$4,957,285	$0	$4,957,285
TOTAL PROGRAM PARENT L2 FUNDS	**$32,802,996**	**$44,195,203**	**$48,821,532**	**($1,361,230)**	**$47,460,302**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health Care Finance					
AMP066 - HEALTH CARE DELIVERY MANAGEMENT					
AMP043 - HEALTH CARE DELIVERY MGT SUPPORT SVCS	$0	$0	$1,445,848	($2,351)	$1,443,498
AMP044 - MANAGED CARE MGT	$0	$0	$9,885,450	($300,000)	$9,585,450
AMP045 - CHILDREN'S HEALTH SERVICES	$0	$0	$1,291,675	$0	$1,291,675
AMP046 - HEALTH CARE QUALITY AND HEALTH OUTCOMES	$0	$0	$2,948,407	$0	$2,948,407
AMP047 - CLINICIANS, RX AND ACUTE CARE	$0	$0	$8,363,600	$1,201,921	$9,565,521
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$0**	**$23,934,980**	**$899,570**	**$24,834,551**
AMP067 - LONG TERM CARE PROGRAM					
AMP048 - LONG TERM CARE SUPPORT SERVICES	$0	$0	$866,068	($6,660)	$859,408
AMP049 - OVERSIGHT	$0	$0	$2,100,082	$0	$2,100,082
AMP050 - OPERATIONS	$0	$0	$12,557,880	($135,000)	$12,422,880
AMP051 - INTAKE AND ASSESSMENT	$0	$0	$9,775,936	$0	$9,775,936
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$0**	**$25,299,966**	**($141,660)**	**$25,158,306**
AMP068 - HEALTH CARE POLICY AND RESEARCH					
AMP052 - HEALTH CARE POLICY	$0	$0	$1,004,024	$0	$1,004,024
AMP053 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES	$0	$0	$1,957,327	($352,415)	$1,604,912
AMP054 - ELIGIBILITY POLICY & OVERSIGHT	$0	$0	$3,978,628	$0	$3,978,628
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$0**	**$6,939,980**	**($352,415)**	**$6,587,565**
AMP069 - DC ACCESS SYSTEM					
AMP055 - DCAS PROGRAM MANAGEMENT	$0	$0	$1,807,361	($209,776)	$1,597,585
AMP056 - DCAS PROJECT MANAGEMENT	$0	$0	$4,350,037	($22,281)	$4,327,756
AMP057 - DCAS HHS FUNCTIONAL	$0	$0	$814,115	$0	$814,115
AMP058 - DCAS ORGANIZATIONAL CHANGE MANAGEMENT	$0	$0	$13,202,557	$0	$13,202,557
AMP059 - DCAS INFORMATION TECHNOLOGY	$0	$0	$57,293,250	$1,219,517	$58,512,767
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$0**	**$77,467,320**	**$987,460**	**$78,454,780**
AMP070 - HEALTH CARE OPERATIONS					
AMP060 - CLAIMS MANAGEMENT	$0	$0	$59,722,222	$0	$59,722,222
AMP061 - HCOA SUPPORT SERVICES	$0	$0	$454,445	$0	$454,445
AMP062 - PUBLIC AND PRIVATE PROVIDER SERVICES	$0	$0	$3,664,604	$0	$3,664,604
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$0**	**$63,841,271**	**$0**	**$63,841,271**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health Care Finance					
AMP071 - HEALTH CARE REFORM AND INNOVATION					
AMP063 - HC REFORM AND INNOVATIVE SUPPORT SVS	$0	$0	$454,012	$0	$454,012
AMP064 - GRANTS ADMINISTRATION FUNCTION	$0	$0	$5,921,060	$100,000	$6,021,060
AMP065 - HIE: HEALTH INFORMATION EXCHANGE	$0	$0	$11,321,423	$0	$11,321,423
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$0**	**$17,696,495**	**$100,000**	**$17,796,495**
HS0023 - ELIGIBILITY & ENROLLMENT					
H02301 - E & E SYSTEMS	$40,471,460	$53,190,564	$98,671	$0	$98,671
H02302 - E&E OVERSIGHT & MANAGEMENT	$786,962	$1,301,808	$0	$0	$0
H02305 - E&E SUPPORT - PMO/SME - DCAS	$14,766,622	$23,992,806	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$56,025,043**	**$78,485,178**	**$98,671**	**$0**	**$98,671**
HS0024 - HEALTH CARE ANALYTICS					
H02401 - HEALTH CARE AGENCY MONITORING AND KPIS	$1,200,031	$2,173,055	$0	$0	$0
H02402 - HEALTH CARE DATA ANALYTICS	$1,164,399	$2,350,527	$0	$0	$0
H02403 - HEALTH CARE INNOVATION	$9,550,927	$9,859,596	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$11,915,358**	**$14,383,179**	**$0**	**$0**	**$0**
HS0025 - MMIS SYSTEM AND INFRASTRUCTURE					
H02501 - CLAIMS PROCESSING & QUALITY ASSURANCE/CONTROL	$43,855,271	$51,481,198	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$43,855,271**	**$51,481,198**	**$0**	**$0**	**$0**
HS0026 - PROGRAM OVERSIGHT					
H02601 - ASSESSMENTS AND CARE COORDINATION	$972,146	$1,133,956	$0	$0	$0
H02602 - FRAUD, WASTE, AND ABUSE	$3,494,872	$3,986,654	$0	$0	$0
H02603 - POLICY	$2,784,417	$5,455,721	$0	$0	$0
H02604 - PROVIDER OVERSIGHT	$38,840,732	$51,946,617	$2,125,000	$0	$2,125,000
H02605 - QUALITY & HEALTH OUTCOMES	$3,163,423	$4,731,601	$500,827	$0	$500,827
TOTAL PROGRAM PARENT L2 FUNDS	**$49,255,589**	**$67,254,548**	**$2,625,827**	**$0**	**$2,625,827**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health Care Finance					
HS0027 - PROVIDER SERVICES					
H02703 - 1115/1915 - MEDICAID	$456,081,846	$422,481,022	$439,257,068	$0	$439,257,068
H02704 - FFS - CHILDLESS ADULTS (GROUP 8)	$8,829,284	$43,574,114	$49,225,265	$0	$49,225,265
H02705 - FFS - CHIP	$7,000,970	$10,171,550	$8,565,942	$0	$8,565,942
H02706 - FFS - MEDICAID	$1,345,709,365	$1,326,335,113	$1,221,596,634	$0	$1,221,596,634
H02707 - MCO - ALLIANCE	$111,194,270	$118,327,853	$132,493,843	$150,259	$132,644,102
H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	$770,921,572	$668,545,729	$932,119,710	($1,141,071)	$930,978,639
H02709 - MCO - CHIP	$52,093,788	$94,379,291	$72,535,053	($3,785)	$72,531,268
H02710 - MCO - IMMIGRANT CHILDREN	$15,118,596	$10,491,795	$18,270,916	($29,121)	$18,241,795
H02711 - MCO - MEDICAID	$1,248,648,704	$1,201,967,187	$1,526,896,949	($1,208,812)	$1,525,688,138
H02712 - MCO- WAIVER	$146,010,822	$143,269,843	$187,300,552	$0	$187,300,552
H02713 - HCBS ARPA INITIATIVE	$82,824,946	$491,050	$224,775	$0	$224,775
TOTAL PROGRAM PARENT L2 FUNDS	**$4,244,434,162**	**$4,040,034,548**	**$4,588,486,708**	**($2,232,529)**	**$4,586,254,178**
TOTAL AGENCY FUNDS	**$4,442,557,965**	**$4,304,063,725**	**$4,863,666,552**	**($2,100,804)**	**$4,861,565,747**
Health Benefit Exchange Authority					
AFO000 - AGENCY FINANCIAL OPERATIONS					
AFO002 - AGENCY ACCOUNTING SERVICES	$136,302	$207,584	$161,150	$0	$161,150
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$208,124	$207,584	$206,407	$0	$206,407
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$350,239	$413,879	$412,483	$0	$412,483
AFO011 - P-CARD CLEARING	$3,806	$0	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$698,471**	**$829,047**	**$780,040**	**$0**	**$780,040**
AMP000 - AGENCY MANAGEMENT PROGRAM					
AMP005 - CONTRACTING AND PROCUREMENT	$691,214	$651,920	$678,608	$0	$678,608
AMP011 - HUMAN RESOURCE SERVICES	$353,898	$377,369	$386,089	$0	$386,089
AMP012 - INFORMATION TECHNOLOGY SERVICES	$17,636,357	$13,384,283	$14,141,599	$0	$14,141,599
AMP014 - LEGAL SERVICES	$1,071,716	$1,278,375	$1,303,422	$0	$1,303,422
AMP016 - PERFORMANCE AND STRATEGIC MANAGEMENT	$5,648,657	$2,392,033	$2,573,589	$0	$2,573,589
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	$1,315,943	$1,506,499	$1,492,410	$0	$1,492,410
TOTAL PROGRAM PARENT L2 FUNDS	**$26,717,786**	**$19,590,478**	**$20,575,716**	**$0**	**$20,575,716**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Health Benefit Exchange Authority					
HS0019 - CONSUMER EDUCATION AND OUTREACH PROGRAM					
H01901 - CONSUMER EDUCATION AND OUTREACH SUPPORT SERVIC	$1,143,862	$1,340,759	$1,353,335	$0	$1,353,335
H01902 - MARKETING AND COMMUNICATION	$927,936	$972,946	$963,451	$0	$963,451
H01903 - NAVIGATORS, CERTIFIED APPLICATION COUNSELORS AND	$962,820	$1,050,000	$1,050,000	$0	$1,050,000
TOTAL PROGRAM PARENT L2 FUNDS	**$3,034,617**	**$3,363,705**	**$3,366,786**	**$0**	**$3,366,786**
HS0020 - MARKETPLACE INNOVATION, POLICY AND OPERATIONS					
H02001 - CONTACT CENTER SERVICES	$4,087,031	$3,906,947	$6,156,717	$0	$6,156,717
H02002 - DATA ANALYTICS AND REPORTING	$106,891	$182,253	$181,932	$0	$181,932
H02003 - ELIGIBILITY AND ENROLLMENT	$1,274,035	$1,785,931	$1,950,590	$0	$1,950,590
H02004 - MEMBER SERVICES	$6,532,352	$1,977,168	$2,119,831	$0	$2,119,831
H02005 - PLAN MANAGEMENT	$1,890,079	$2,235,723	$2,215,018	$0	$2,215,018
H02006 - S.H.O.P.	$3,220,453	$3,680,894	$4,406,154	$0	$4,406,154
TOTAL PROGRAM PARENT L2 FUNDS	**$17,110,841**	**$13,768,917**	**$17,030,242**	**$0**	**$17,030,242**
TOTAL AGENCY FUNDS	**$47,557,909**	**$37,552,148**	**$41,752,784**	**$0**	**$41,752,784**
Not-for-Profit Hospital Corporation					
CO0020 - CFO OPERATIONS					
C02001 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL PROGRAM PARENT L2 FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
TOTAL AGENCY FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy					
CO0021 - CFO OPERATIONS					
C02101 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY FUNDING	$22,000,000	$15,000,000	$25,200,000	$0	$25,200,000
TOTAL PROGRAM PARENT L2 FUNDS	**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**
TOTAL AGENCY FUNDS	**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**

Program Parent L1	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Office of the Deputy Mayor for Health and Human Services					
AMP000 - AGENCY MANAGEMENT PROGRAM					
AMP030 - EXECUTIVE ADMINISTRATION	$1,856,314	$2,071,890	$2,175,904	($29,368)	$2,146,536
TOTAL PROGRAM PARENT L2 FUNDS	**$1,856,314**	**$2,071,890**	**$2,175,904**	**($29,368)**	**$2,146,536**
HS0017 - HUMAN SUPPORT OPERATIONS					
H01701 - AGENCY OVERSIGHT AND SUPPORT SERVICES	$117,020	$405,671	$304,583	$0	$304,583
H01702 - COMMUNITY ENGAGEMENT SERVICES	$71,577	$0	$0	$0	$0
TOTAL PROGRAM PARENT L2 FUNDS	**$188,597**	**$405,671**	**$304,583**	**$0**	**$304,583**
TOTAL AGENCY FUNDS	**$2,044,911**	**$2,477,561**	**$2,480,487**	**($29,368)**	**$2,451,119**
GRAND TOTAL	**$5,161,034,141**	**$5,186,322,077**	**$5,778,465,060**	**$1,901,402**	**$5,780,366,462**

See Attachment C for a table detailing recommended agency budgets and full-time equivalents at the Program level.

Fiscal Year 2025 Agency Operating Budget by Fund Type

DIFS Appropriated Fund	DIFS Fund	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health						
1011 - DEDICATED TAXES	1011012 - GAMBLING ADDICTION TREATMENT & RESEARCH	$27,540	$0	$0	$0	$0
4020 - FEDERAL GRANT FUND - FPR	4020002 - FEDERAL GRANTS	$37,665,294	$42,461,978	$48,705,424	$0	$48,705,424
4020 - FEDERAL GRANT FUND - FPR	4020023 - FEDERAL GRANTS - COVID-19	$2,081,684	$1,100,000	$1,578,560	$0	$1,578,560
4020 - FEDERAL GRANT FUND - FPR	4020999 - MEDICAID PUBLIC PROVIDER RECOVERY GRANT	$0	$10,963,387	$16,191,464	$0	$16,191,464
4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	$2,650,500	$3,316,674	$4,257,265	$0	$4,257,265
4015 - FEDERAL PAYMENTS	4015917 - ARPA - COUNTY	$632,238	$1,148,000	$0	$0	$0
4015 - FEDERAL PAYMENTS	4015918 - ARPA - MUNICIPAL	$4,027,878	$6,303,314	$0	$0	$0
4015 - FEDERAL PAYMENTS	4015916 - ARPA - STATE	$1,479,376	$2,162,278	$0	$0	$0
1010 - LOCAL FUND	1010001 - LOCAL FUNDS	$309,128,825	$308,738,582	$295,785,027	($233,506)	$295,551,522
4045 - PRIVATE DONATIONS -FPR	4045001 - PRIVATE DONATIONS	$1,927	$93,000	$93,000	$0	$93,000
4040 - PRIVATE GRANT FUND -FPR	4040002 - PRIVATE GRANT FUND	$123,827	$255,000	$295,000	$0	$295,000
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060123 - AGREEMENT WITH INDEPENDENT AGENCIES	$0	$50,000	$50,000	$0	$50,000
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060148 - DMH ENTERPRISE FUND	$0	$25,000	$25,000	$0	$25,000
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060070 - DMH FEDERAL BENEFICIARY REIMBURSEMENT	$0	$2,200,191	$1,000,000	$0	$1,000,000
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060145 - DMH MEDICARE & 3RD PARTY REIMBURSEMENT	$357,723	$734,632	$2,900,000	$0	$2,900,000
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060418 - OPIOID ABATEMENT FUND	$0	$548,000	$14,655,500	$0	$14,655,500
TOTAL GROSS FUNDS		**$358,176,811**	**$380,100,036**	**$385,536,240**	**($233,506)**	**$385,302,734**
Department of Health						
4020 - FEDERAL GRANT FUND - FPR	4020002 - FEDERAL GRANTS	$137,988,072	$147,120,193	$159,886,840	$0	$159,886,840
4020 - FEDERAL GRANT FUND - FPR	4020023 - FEDERAL GRANTS - COVID-19	$22,071,126	$25,590,560	$27,658,044	$0	$27,658,044
4020 - FEDERAL GRANT FUND - FPR	4020027 - PUBLIC HEALTH CRISIS RESPONSE	$2,311,807	$1,088,624	$0	$0	$0
4015 - FEDERAL PAYMENTS	4015110 - FEDERAL PAYMENTS - INTERNAL	$3,545,819	$5,000,000	$5,000,000	$0	$5,000,000
1010 - LOCAL FUND	1010190 - ARPA - LOCAL REVENUE REPLACEMENT	$3,192,339	$0	$0	$0	$0
1010 - LOCAL FUND	1010096 - HEALTH PROFESSIONAL RECRUITMENT FUND	$98,187	$0	$0	$0	$0
1010 - LOCAL FUND	1010001 - LOCAL FUNDS	$96,388,902	$91,020,261	$87,129,521	$4,265,081	$91,394,602
4040 - PRIVATE GRANT FUND -FPR	4040002 - PRIVATE GRANT FUND	$168,708	$0	$749,759	$0	$749,759
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060151 - BOARD OF MEDICINE	$14,534,216	$12,081,993	$12,891,295	$0	$12,891,295
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060188 - COMMUNICABLE AND CHRONIC DISEASE	$2,591,030	$3,234,572	$4,114,081	$0	$4,114,081
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060168 - EMS FEES	$106,674	$213,130	$147,279	$0	$147,279
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060171 - ICF / MR FEES & FINES	$195,410	$178,971	$178,971	$0	$178,971
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060133 - PHARMACY PROTECTION	$1,779,420	$2,263,850	$2,312,201	$0	$2,312,201
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060136 - RADIATION PROTECTION	$0	$145,802	$150,782	$0	$150,782
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060166 - SHPDA ADMISSION FEE	$558,260	$519,881	$531,079	$0	$531,079
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060050 - SHPDA FEES	$858,813	$1,059,329	$1,264,719	$0	$1,264,719
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060053 - VITAL RECORDS REVENUE	$2,307,762	$2,611,442	$2,814,426	$0	$2,814,426
TOTAL GROSS FUNDS		**$288,696,544**	**$292,128,607**	**$304,828,997**	**$4,265,081**	**$309,094,078**

Committee on Health
Fiscal Year 2025 Budget Recommendations

DIFS Appropriated Fund	DIFS Fund	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Health Care Finance						
1011 - DEDICATED TAXES	1011011 - DC PROVIDER FEE	$0	$5,310,255	$5,532,061	$0	$5,532,061
1011 - DEDICATED TAXES	1011007 - HEALTHY DC FUND	$66,752,894	$78,475,094	$74,690,002	$0	$74,690,002
1011 - DEDICATED TAXES	1011010 - HOSPITAL ASSESSMENT TAX	$8,454,037	$8,454,037	$8,454,037	$0	$8,454,037
1011 - DEDICATED TAXES	1011018 - INPATIENT HOSPITAL DIRECTED PAYMENTS PROVID	$0	$0	$81,163,742	($814,563)	$80,349,179
1011 - DEDICATED TAXES	1011003 - NURSING HOMES QUALITY OF CARE FUND	$15,731,021	$16,659,004	$18,633,354	$0	$18,633,354
1011 - DEDICATED TAXES	1011019 - OUTPATIENT HOSPITAL DIRECTED PAYMENTS PROV	$0	$0	$46,397,805	($466,049)	$45,931,756
1011 - DEDICATED TAXES	1011009 - STEVIE SELLOW'S	$5,682,850	$5,637,568	$5,538,639	$0	$5,538,639
4020 - FEDERAL GRANT FUND - FPR	4020002 - FEDERAL GRANTS	$4,007,091	$4,550,493	$5,136,131	$0	$5,136,131
4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	$3,389,502,049	$3,187,761,854	$3,567,190,111	($973,519)	$3,566,216,592
1010 - LOCAL FUND	1010207 - LOCAL ARPA - MUNICIPAL	$1,877,752	$0	$0	$0	$0
1010 - LOCAL FUND	1010001 - LOCAL FUNDS	$914,710,009	$988,309,875	$1,043,922,407	$153,327	$1,044,075,734
1010 - LOCAL FUND	1010208 - THE MEDICAID HCBS ENHANCEMENT FUND	$33,263,660	$0	$0	$0	$0
4040 - PRIVATE GRANT FUND -FPR	4040002 - PRIVATE GRANT FUND	$0	$100,000	$0	$0	$0
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060132 - BILL OF RIGHTS-(GRIEVANCE & APPEALS)	$1,603,851	$2,622,988	$2,613,415	$0	$2,613,415
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060386 - INDIVIDUAL INSUR MKT AFFORD & STABILITY	$0	$600,000	$600,000	$0	$600,000
1060 - SPECIAL PURPOSE REVENUE FUNDS	1060128 - MEDICAID COLLECTIONS-3RD PARTY LIABILITY	$972,751	$5,582,557	$3,794,846	$0	$3,794,846
TOTAL GROSS FUNDS		**$4,442,557,965**	**$4,304,063,725**	**$4,863,666,552**	**($2,100,804)**	**$4,861,565,747**
Health Benefit Exchange Authority						
8362 - ENTERPRISE AND OTHER FUNDS - HBX	8362005 - HBX LEVEL 1 FUND - ACA GRANT	$160,323	$0	$0	$0	$0
8362 - ENTERPRISE AND OTHER FUNDS - HBX	8362003 - HEALTH BENEFIT EXCHANGE AUTHORITY FUND	$39,208,096	$37,552,148	$41,752,784	$0	$41,752,784
8362 - ENTERPRISE AND OTHER FUNDS - HBX	8362012 - HEALTH CARE 4 CHILD CARE	$4,552,512	$0	$0	$0	$0
8362 - ENTERPRISE AND OTHER FUNDS - HBX	8362009 - MASSACHUSETTS HEALTH CONECTOR	$3,636,978	$0	$0	$0	$0
TOTAL GROSS FUNDS		**$47,557,909**	**$37,552,148**	**$41,752,784**	**$0**	**$41,752,784**
Not-for-Profit Hospital Corporation						
8262 - ENTERPRISE AND OTHER - UMC	8262001 - ENTERPRISE AND OTHER FUNDS - HW0	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL GROSS FUNDS		**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy						
1010 - LOCAL FUND	1010138 - CONTINGENCY RESERVE	$7,000,000	$0	$0	$0	$0
1010 - LOCAL FUND	1010001 - LOCAL FUNDS	$15,000,000	$15,000,000	$25,200,000	$0	$25,200,000
TOTAL GROSS FUNDS		**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**
Office of the Deputy Mayor for Health and Human Services						
1010 - LOCAL FUND	1010001 - LOCAL FUNDS	$2,044,911	$2,477,561	$2,480,487	($29,368)	$2,451,119
TOTAL GROSS FUNDS		**$2,044,911**	**$2,477,561**	**$2,480,487**	**($29,368)**	**$2,451,119**
GRAND TOTAL		**$5,161,034,141**	**$5,186,322,077**	**$5,778,465,060**	**$1,901,402**	**$5,780,366,462**

Recommended agency budgets by fund type can be found in Attachment D.

Fiscal Year 2025 Agency Operating Budget Full-Time Equivalents

DIFS Appropriated Fund Type	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health	1,251.39	1,439.50	1,411.94	0.00	1,411.94
Department of Health	612.45	765.84	810.92	3.00	813.92
Department of Health Care Finance	299.15	366.65	378.09	0.00	378.09
Health Benefit Exchange Authority	110.72	123.00	128.00	0.00	128.00
Not-for-Profit Hospital Corporation	0.00	0.00	0.00	0.00	0.00
Not-for-Profit Hospital Corporation Subsidy	0.00	0.00	0.00	0.00	0.00
Office of the Deputy Mayor for Health and Human Services	11.75	12.75	12.75	0.00	12.75

See Attachments B and C for a table detailing recommended agency budgets and full-time equivalents at the Cost Center level and Program level for each Agency.

Fiscal Year 2025 Agency Capital Budget Changes

The Committee made no changes to the Mayor's Capital Budget as proposed.

Committee Transfers

Sending Committee	Receiving Committee	Receiving Agency	Amount	FTEs	Frequency	Purpose
Transfers In						
PW&O	Health	DHCF	$500,000	0	One-Time	$100,000 for the Nurse Family Partnership and $400,000 toward Home Visiting
PW&O	Health	DBH	$750,000	0	One-Time	For Substance Abuse and Behavioral Health Services Targeted Outreach
JPS	Health	DOH	$771,160	0	One-Time	Transfer from the Litigation Support Fund for appropriation to the new Smoking Cessation Fund SPR
T&E	Health	DOH	$167,541	1	Recurring	To fund salary and fringe for 1 FTE Data Analyst for HEPRA Trauma Registry
Total			$2,188,701	1		

Sending Committee	Receiving Committee	Receiving Agency	Amount	FTEs	Frequency	Purpose
Transfers Out						
Health	Housing	Human Services	$200,000	0	One-Time	To restore cuts to the Emergency Rental Assistance Program.
	JPS	OVSJG	$100,000	0	One-Time	To restore cuts to Access to Justice Initiatives
	COW	OSSE	$112,780	2	Recurring	To fund 1 FTE (Grade 12, Step 5) salary and fringe for a Management Analyst in the Division of Health and Wellness to oversee compliance and complete reporting requirements of the Access to Emergency Medications Amendment Act of 2023.
	CEAL	DOES	$137,500 (FY24)		One-Time	To add 50 participants to the DOES Middle School Career Ready Early Scholars Program in the summer of 2024.
		Total	$550,280			

Revenue Adjustments

No Adjustments.

Funding of Legislation

Bill, Law, or Subtitle	Status	Agency	Cost Center / Program/ Account (Parent Level 1)	FY 2025 Amount	Financial Plan Amount	FTEs
D.C. Law 25-0100, Prior Authorization Reform Amendment Act of 2023	Passed subject to funding	DHCF	See BSA Chapter	$1,224,000	$5,021,000	0
D.C. Law, 25-0124, Access to Emergency Medications Amendment Act of 2023	Passed subject to funding	DC Health, OSSE	See BSA Chapter	$757,386	$2,912,436	1
D.C. Law 25-0034, Expanding Access to Fertility Treatment Amendment Act of 2023	Passed subject to funding	HBX	See BSA Chapter	$0	$420,000	0
Grocery Access Pilot Program Amendment Act of 2024	BSA Subtitle	DC Health	See BSA Chapter	$120,000	$120,000	0
Mental Health Court Urgent Care Clinic Act of 2024	BSA Subtitle	DBH	See BSA Chapter	$907,000	$907,000	0
Opioid Abatement Directed Funding Amendment Act of 2024	BSA Subtitle	DBH	See BSA Chapter	$1,125,000	$1,125,000	0
School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2024	BSA Subtitle	DBH	See BSA Chapter	$325,000	$325,000	0

Bill, Law, or Subtitle	Status	Agency	Cost Center / Program/ Account (Parent Level 1)	FY 2025 Amount	Financial Plan Amount	FTEs
Substance Abuse and Behavioral Health Services Targeted Outreach Grant Act of 2024	BSA Subtitle	DBH	See BSA Chapter	$1,200,000	$1,200,000	0
Sexual Health Peer Educators Grant Amendment Act of 2024	BSA Subtitle	DC Health	See BSA Chapter	$150,000	$600,000	0
Tobacco Use Cessation Initiatives Amendment Act of 2024	BSA Subtitle	DC Health	See BSA Chapter	$1,624,945	$3,415,140	0
Total				**$7,433,331**	**$16,045,576**	**1**

New Budget Attributes – Explanation and Crosswalk

In Fiscal Year 2023, the District government started using the District Integrated Financial System (DIFS) for its financial recordkeeping. DIFS uses a new system of budget attributes to detail what part of an agency is responsible for a certain portion of the budget, shown as the Cost Center attribute, and what programmatic purpose the budgeted funds are for, shown as the Program attribute. Both Cost Center and Program have "parent levels" that group related Cost Centers and Programs into larger themes. Fiscal Year 2025 is the first year that DIFS budget attributes are being used to construct the District's budget.

A guide to translating budget attributes used in previous budgets to the new DIFS budget attributes can be found in Attachment E.

Committee Budget Process and Purview

The Committee on Health is responsible for matters concerning health, including environmental health; the regulation of health occupations and professions, and health care inspectors; and joint jurisdiction with the Committee on Hospital and Health Equity on matters and agencies within the purview of the Committee on Hospital and Health Equity.

The District agencies, boards, and commissions that come under the Committee's purview are as follows:

- Department of Health
- Department of Behavioral Health
- Department of Health Care Finance
- Office of the Deputy Mayor for Health and Human Services
- Not-for-Profit Hospital Corporation (United Medical Center)
- DC Health Benefit Exchange Authority
- Advisory Committee on Acupuncture
- Advisory Committee on Anesthesiologist Assistants
- Advisory Committee on Clinical Laboratory Practitioners
- Advisory Committee on Naturopathic Medicine
- Advisory Committee on Physician Assistants
- Advisory Committee on Polysomnography
- Advisory Committee on Surgical Assistants
- Board of Allied Health
- Board of Audiology and Speech-Language Pathology
- Board of Behavioral Health
- Board of Chiropractic
- Board of Dentistry
- Board of Dietetics and Nutrition
- Board of Long-Term Care Administration
- Board of Marriage and Family Therapy
- Board of Massage Therapy
- Board of Medicine
- Board of Nursing
- Board of Occupational Therapy
- Board of Optometry
- Board of Pharmacy
- Board of Physical Therapy
- Board of Podiatry
- Board of Professional Counseling
- Board of Psychology
- Board of Respiratory Care
- Board of Social Work

- Board of Veterinary Medicine
- Cedar Hill Hospital on the St. Elizabeth's campus
- Commission on Health Disparities
- Commission on Health Equity
- Commission on HIV/AIDS
- Committee on Metabolic Disorders
- Council on Physical Fitness, Health, and Nutrition
- Food Policy Council
- Health Information Exchange Policy Board
- Health Literacy Council
- Medicaid Reserve
- Mental Health Planning Council
- Metropolitan Washington Regional Ryan White Planning Council
- Perinatal and Infant Health Advisory Committee
- Statewide Health Coordinating Council

The Committee is chaired by Councilmember Christina Henderson. The other members of the Committee are Ward 6 Councilmember Charles Allen, Ward 7 Councilmember Vincent C. Gray, Ward 1 Councilmember Brianne K. Nadeau, and Ward 5 Councilmember Zachary Parker.

The Committee held performance and budget oversight hearings on the following dates:

Performance Oversight Hearings	
Date	**Title**
January 18, 2024	FY 2023 Performance Oversight of DC Health (Public Witnesses Only)
January 22, 2024	FY 2023 Performance Oversight of DC Health (Government Only)
January 25, 2024	FY 2023 Performance Oversight of the Not-For-Profit Hospital Corporation (United Medical Center)
January 29, 2024	FY 2023 Performance Oversight of the Department of Behavioral Health (Public Witnesses Only)
January 31, 2024	FY 2023 Performance Oversight of the Department of Behavioral Health (Government Witnesses)
February 8, 2024	FY 2023 Performance Oversight of the Deputy Mayor for Health and Human Services
February 8, 2024	FY 2023 Performance Oversight of the Department of Health Care Finance
February 14, 2024	FY 2023 Performance Oversight of the D.C. Health Benefit Exchange
February 14, 2024	FY 2023 Performance Oversight of the Board of Nursing
February 14, 2024	FY 2023 Performance Oversight of the Board of Veterinary Medicine
February 14, 2024	FY 2023 Performance Oversight of the Board of Massage Therapy
February 14, 2024	FY 2023 Performance Oversight of the Board of Dietetics and Nutrition

Budget Oversight Hearings	
Date	**Title**
April 8, 2024	FY 2025 Budget Oversight of the Health Benefit Exchange
April 8, 2024	FY 2025 Budget Oversight of the Not-for-Profit Hospital Corporation (UMC)
April 10, 2024	FY 2025 Budget Oversight of DC Health (Public Witnesses)

Budget Oversight Hearings	
Date	**Title**
April 10, 2024	FY 2025 Budget Oversight of the Department of Behavioral Health (Public Witnesses)
April 11, 2024	FY 2025 Budget Oversight of the Department of Behavioral Health (Government Witnesses)
April 11, 2024	FY 2025 Budget Oversight of DC Health (Government Witnesses)
April 29, 2024	FY 2025 Budget Oversight of the Deputy Mayor for Health and Human Services
April 29, 2024	FY 2025 Budget Oversight of the Department of Health Care Finance

The Committee received comments from members of the public during these hearings. Copies of witness testimonies are included in this report as Attachments H, I, J, and K. A video recording of the hearings can be obtained through the Office of Cable Television, Film, Music and Entertainment or at entertainment.dc.gov.

Fiscal Year 2025 Agency Recommendations

Full information about the agency's recommended budget and related adjustments can be found in the earlier summary tables, as well as in Attachments A, B, C, D, and E.

Department of Health (HC0)

1. AGENCY MISSION AND OVERVIEW

The District of Columbia Department of Health (DC Health) promotes health, wellness and equity, across the District, and protects the safety of residents, visitors and those doing business in our nation's capital.

The Department of Health provides programs and services with the ultimate goal of reducing the burden of disease and improving opportunities for health and well-being for all District residents and visitors. DC Health does this through a number of mechanisms that center around prevention, promotion of health, expanding access to health care, and increasing health equity. The department provides public health management and leadership through policy, planning, and evaluation; fiscal oversight; human resource management; grants and contracts management; information technology; government relations; risk management; communication and community relations; legal oversight; and facilities management. The DC Health performance plan is based on three priority areas: (1) health and wellness promotion, (2) promoting health equity, and (3) public health systems enhancement.

The Department of Health operates through the following 9 divisions:

Health Emergency Preparedness and Response Administration (HEPRA) – provides regulatory oversight of Emergency Medical Services and ensures that DOH and its partners are prepared to respond to citywide medical and public health emergencies, such as those resulting from terrorist attacks, large accidents, or natural events such as weather-related emergencies. This division contains the following 5 activities:

- Public Health Emergency Preparedness
- Public Health Emergency Operations and Program Support
- Epidemiology Disease Surveillance and Investigation
- Emergency Medical Services Regulation
- Office of the Senior Deputy Director

HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) – partners with health and community-based organizations to provide HIV/AIDS, hepatitis, STD, and TB prevention and care services. Services include prevention tools and interventions, medical care and supportive services, housing services for persons living with HIV/AIDS, HIV counseling and testing, and data and information on disease-specific programs and services. Furthermore, the administration provides information on the impact of these diseases on the community as well as education, referrals, and intervention services. The AIDS Drug Assistance Program (ADAP) provides drugs at no cost to eligible District residents who are HIV-positive or have AIDS. HAHSTA administers the District's

budget for HIV/AIDS, hepatitis, STD, and TB programs; provides grants to service providers; provides direct services for TB and STDs; monitors programs; and tracks the rates of HIV, hepatitis, STDs, and TB in the District of Columbia. This division contains the following 10 activities:

- HIV/AIDS Support Services
- HIV/AIDS Policy and Planning
- HIV Health and Support Services
- HIV/AIDS Data and Research
- Prevention and Intervention Services
- AIDS Drug Assistance Program (ADAP)
- Grants and Contracts Management
- Sexually Transmitted Disease (STD) Control
- Tuberculosis Control
- HIV/AIDS Housing and Supportive Services

Health Regulation and Licensing Administration (HRLA) – is comprised of the Office of Health Professional Licensing Boards, the Office of Health Care Facilities, the Office of Food, Drug, Radiation and Community Hygiene, and HRLA Support services. This division contains the following 3 activities:

- Office of Health Professional License Administration
- Office of Food, Drug, Radiation and Community Hygiene Regulation
- Office of Health Care Facilities Regulation

Office of Health Equity (OHE) – works to address the root cause of health disparities, beyond health care, and health behaviors by supporting projects, policies and research that will enable every resident to achieve their optimal level of health. The Office achieves its mission by informing, educating, and empowering people about health issues and facilitating multi-sector partnerships to identify and solve community health problems related to the social determinants of health. As the newest division of DC Health, this Office is charged with providing leadership to the evidence-based paradigm and practice change effort essential to promoting and achieving health equity, including practitioners not only within DC Health, but across District government, as well as with other public, private and non-profit entities, including community residents. This division contains the following 3 activities:

- Multi Sector Collaboration
- Community Based Participatory Research and Policy Evaluation
- Health Equity Practice and Program Implementation

Center for Policy, Planning, and Evaluation (CPPE) – is responsible for developing an integrated public health information system to support health policy decisions, state health planning activities, performance analysis, and direction setting for department programs; health policy, health planning and development; health research and analysis; vital records; disease surveillance and outbreak investigation; and planning, directing, coordinating, administering, and

supervising a comprehensive Epidemiology and Health Risk Assessment program, which involves federal, state, county, and municipal functions. This division contains the following 4 activities:

- Epidemiology Disease Surveillance and Investigation
- Research, Evaluation, and Measurement
- State Center for Health Statistics
- State Health Planning and Development

Community Health Administration (CHA) – promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA focuses on nutrition and physical fitness promotion; cancer and chronic disease prevention and control; access to quality health care services, particularly medical and dental homes; and the health of families across the lifespan. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change. This division contains the following 6 activities:

- Cancer and Chronic Disease Prevention
- Health Care Access Bureau
- Family Health Bureau
- Support Services
- Perinatal and Infant Health
- Nutrition and Physical Fitness

Public Health Laboratory – provides testing of biological and chemical samples that relate to public health and safety, such as infectious diseases, hazardous chemicals, or biological contamination, up to and including biological or chemical terrorist attacks. This is a new division of DC Health being proposed in the FY2024 budget. This division contains the following 2 activities:

- Administrative and Support Services
- Laboratory Services

Agency Management – provides for administrative support and the required tools to achieve operational and programmatic results. This division is standard for all agencies using performance-based budgeting.

Agency Financial Operations – provides comprehensive and efficient financial management services to, and on behalf, of District agencies so that the financial integrity of the District of Columbia is maintained. This division is standard for all agencies using performance-based budgeting.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2025 OPERATING BUDGET RECOMMENDATIONS

The Mayor's FY 2025 proposed operating budget for DC Health is $304,828,997, which represents a 4.3% increase compared with the approved FY 2024 budget. This is largely due to an increase of federal grant funds of $13,745,000 and 44.1 FTEs. The FY 2025 funding supports a total of 810.9 FTEs at DC Health, a 5.9% increase from the FY 2024 approved level.

Animal Care and Control Services

The Mayor's FY 2025 proposed budget maintains the FY 2024 funding for the animal care and control contract under DC Health, and adds a new capital project to build an animal shelter in Ward 8 to replace the current DC-owned shelter at 1201 New York Avenue NE. The Committee is pleased to see that the Mayor has not proposed cuts to the contract, as she did last year, and instead is maintaining the $4.7 million funding level restored by the Council in the FY 2024 approved budget. The Committee is also pleased to see that the FY 2024 Supplemental Budget includes an allocation of $1,114,478 to extend the current contract from its end date of June 30, 2024 to September 30, 2024, ensuring continuity of services until the new contract goes into effect on October 1, 2024.

Since the summer of 2023, the animal care and control contract has come under increasing scrutiny following media reports and testimony from current and former volunteers of the contractor reporting poor conditions for the animals under its care, increasing euthanasia rates, a lack of standard services such as regularly scheduled spay/neuter clinics, low-cost vaccination appointments, and spay and release clinics for cats, among other issues. At the FY 2023 DC Health Performance Oversight hearing, numerous members of the public testified raising concerns about this contract and advocated for improvements and more oversight over the contract.

The Committee has been in regular conversations with the agency and contractor over the past year. In FY 2025, DC Health has reported that there will be significant updates to the terms and requirements of the contract, which has been a sole source contract with the Humane Rescue Alliance since 1980 and lacks the needed specificity and accountability measures to be effective. DC Health and the contractor are also discussing transitioning some of the responsibilities and resources back in house at DC Health, where the agency can have increased oversight over importance public health and safety functions. Lastly, the construction of the new shelter and closing of the New York Avenue shelter in FY 2025 will enable the District to significantly improve living conditions for animals currently housed at New York Avenue, as well as enable the District to consider competitively bidding this contract in future fiscal years.

The Committee recommends maintaining the Mayor's proposed FY 2025 budget for animal care and control services, and will actively monitori the development and approval of the new FY 2025 contract. Specifically, the Committee hopes to see improvements in the contract that include more detailed requirements related to impoundment, rescue operation and maintenance, staffing, recordkeeping of wild animals, and overall outcome goals. The Committee will also look forward to seeing the timely commencement of construction of the new shelter and will encourage and support transitions of services back to DC Health over the course of the next year.

HIV/AIDS and Sexual Health

The majority of the funding for DC Health's HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) is federal funding ($82.29 million of the $91.73 million total budget). In FY 2025, HAHSTA foresees a $4.2 million reduction in federal grants that support HIV prevention and surveillance, ending the HIV epidemic (EHE), STI prevention, and treatment. At the FY 2025 Budget Oversight Hearing, DC Health testified that the District's federal grant allocation for HIV prevention and surveillance is decreasing because the District has been successful in lowering new cases of HIV/AIDS. Specifically, the District's grant will decrease by 8% in the next iteration of this award to begin on August 1, 2024, likely due to steadily decreasing incidence and prevalence of HIV in the city (11% decrease between 2007-2021 per CDC). DC Health posits that the rates have gone down because of the effectiveness of the programs funded by these federal grants, which will now need to be scaled back due to the grant reduction. DC Health also testified that the lack of funding will hamper their efforts to reach the populations that have been more challenging to bring into care, particularly Black and Latino men and Black women, all of whom experience higher rates of HIV than the general population, and young people aged 17-24, who are a growing percentage of newly diagnosed HIV infections.[1]

Although the Committee does not have sufficient funds to restore the entire $4.2 million reduction in federal grants, the Committee does make several budget recommendations to support HIV and STI reduction efforts in the District.

First, the Committee recommends restoring the at-home HIV and STI self-testing through GetChecked DC, with an enhancement of $350,000 in recurring local funds for Program 700041 Prevention And Intervention Services, Cost Center 70079 Prevention & Intervention Services and Account 7132001 Contractual Services. In calendar year 2023, GetCheckedDC served 5,985 unique District residents through 8,192 total tests (5,021 being at-home tests). There are other national programs that offer self-test kits, however, wait times and types of tests vary. And while LabCorp and the Health and Wellness Center would continue to offer testing on-site at the Center, it would only serve a total of 3,000 clients. The Committee's recommended funding would fully restore the funding for the at-home self-testing component of GetCheckedDC.

Second, the Committee recommends an enhancement of $150,000 to restart the evidence-based peer-to-peer sexual health grant that DC Health used to administer, but that was cut during the COVID-19 public health emergency when schools moved to virtual learning. A number of high school student representatives from the Young Women's Project advocated at the Budget Oversight Hearing for this grant program as a way to better reach them and their peers. DC Health testified that peer-based sexual health programs have strong evidence to support their effectiveness, and that the District should invest in such programs. As middle school and high school youth have returned to in-person learning and extracurricular activities, the need for peer-led sexual education once again has become increasingly crucial. According to a 2022 Young Women's Project Sexual Health Survey of 600 students from 22 schools, 84% of high school

[1] District of Columbia Department of Health, HIV/AIDS, Hepatitis, STI, & TB Administration 2023. Annual Epidemiology & Surveillance Report: Data Through December 2022. Accessed April 19, 2024 at https://dchealth.dc.gov/service/hiv-reports-and-publications.

students in the District received less than one hour of sex education in 2022.[2] Further, of the 24% of teens who reported being sexually active, only 46% reported using a condom in their last encounter (down from 57% in 2019). Although DC Health is supporting a Sexual Health Youth Advisory Board through an MOU with OSSE, that group currently includes only 8 active students representing 5 schools. Advocates had asked for this program to be funded at $300,000, but the Committee was not able to identify that amount of funds this year, but hopes to expand the program in future fiscal years. **The Committee therefore recommends an enhancement of $150,000 in in recurring local funds for Program 700041 Prevention And Intervention Services, Cost Center 70079 Prevention & Intervention Services and Account 7141007 Grants & Gratuities for implementation of the Sexual Health Peer Educators Grant.** The Committee also includes a BSA subtitle, "Sexual Health Peer Educators Grant", that stipulates the requirements for this program. It can be found in Attachment G.

Third, to aid in expanding the services that will be reduced due to the federal grant funding shortfall, the Committee also recommends that the DC Council fully fund the Whitman-Walker Entities at St. Elizabeths Tax Rebate Amendment Act of 2022. The Center provides several services including HIV treatment, HIV research, and specialized care for members of the LGBTQ+ community. The tax abatement was requested in order to expand the Center's potential treatment capacity from 5,000 patients to 15,000 patients and includes services centered on primary medical care, behavioral health, substance abuse, dental, and other supportive services. Additionally, the Center's expansion will transform Whitman-Walker Health's research, education, and training scope by more than tripling its research portfolio and ability to provide treatment breakthroughs in areas such as HIV, cancer, and COVID-19. To fund this expansion, Whitman-Walker Health requested tax relief from the District government valued at $46.6 million through 2047, including $5.5 million during the current financial plan.

Food Access

Many District residents do not consistently have enough food to feed themselves or their families. According to the Capital Area Food Bank, 35% of District residents experienced food insecurity in 2023.[3] Black households, seniors, and households with children consistently experience food insecurity at higher rates than the general population. DC Health plays a critical role in addressing food insecurity and increasing healthy food access in the District. DC Health administers several federal nutrition assistance programs, including:

- The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);
- The Commodity Supplemental Food Program (CSFP), also known as Grocery Plus, for low-income seniors;
- The Supplemental Nutrition Assistance Program Education (SNAP-Ed), which provides nutrition education to populations eligible for SNAP benefits; and
- the Senior and WIC Farmers Market Nutrition Programs.

Young Women's Project. "YWP Sexual Health & Wellness Survey: Preliminary Results." (Dec. 26, 2022). Accessed April 24, 2024 at: https://docs.google.com/document/d/1MOuwMBVfKRLt1V3ToH8dKiNHONwQhL_jMQ7XyHKWzNg/edit

[3] Capital Area Food Bank. "Hunger Report 2023." (Sept. 2023). Accessed May 7, 2024 at: https://hunger-report.capitalareafoodbank.org/ report-2023/

DC Health also administers several locally funded nutrition assistance programs, including:

- Produce Plus, which provides low-income DC residents with $40 per month to purchase local produce at farmers markets;
- Healthy Corners, which empowers small businesses in underserved neighborhoods to sell nutritious, affordable food, and provides a $5 SNAP match at several stores;
- Joyful Food Markets, which hosts monthly free markets at 53 elementary schools in Wards 7 and 8; and
- Home Delivered Meals, which provides medically tailored meals to homebound DC residents with chronic diseases, including HIV/AIDS, cancer, and diabetes.

In FY 2025, these programs will be particularly important as the Mayor's proposed budget does not include recurring funding for the Give SNAP a Raise Amendment Act of 2022, which is currently providing a 10% locally funded increase for SNAP beneficiaries using one-time funding in FY 2024, beginning January 1, 2024 and ending September 30, 2024. This means that the more than 140,000 residents currently enrolled in the Supplemental Nutrition Assistance Program (SNAP), will see their benefits decrease at the beginning of FY 2025. Although the Committee could not identify funding to continue the SNAP increase in FY 2025, **the Committee encourages the DC Council to continue to prioritize identifying recurring funding for Give SNAP a Raise Amendment Act of 2022.**

In many cases, the demand for federal and local nutrition assistance programs at DC Health exceeds funding levels. In the FY 2023 Performance Oversight pre-hearing responses, DC Health reported that Produce Plus received 11,396 applications from eligible individuals and was able to serve 7,579 in 2023, leading to a 3,817 waitlist (a 34% gap). Grocery Plus boxes for low-income seniors served 5,700 seniors, with 1,326 on the waitlist. The Senior Farmers Market Nutrition Program served 8,000 seniors, but plans to reduce benefits after the expiration of ARPA funds.

In FY 2024, the Healthy Food Access grants were funded with recurring dollars at their pre-COVID amounts, and the Council added one-time enhancements to continue the ARPA-funded boosts that the Mayor had proposed dicontinuing. In FY 2025, the Mayor maintained the Council's FY 2024 enhancements, and although DC Health's Agency Fiscal Officer testified at the FY 2025 Budget Oversight Hearing that the enhancements for these programs are one-time, the Council Budget Office has confirmed that the FY 2025 allocations were entered as recurring funding. **The Committee strongly supports maintaining this recurring funding, which will allow these programs to operate with more stability and certainty of funding in future years, and to better meet the demand for these essential services.**

Healthy Food Access Grant Project	**FY24 Approved Budget**	**Proposed FY25 Budget**
Martha's Table Joyful Food Markets	$1,824,066 ($1,500,000 recurring; $324,066 one-time)	$1,824,066 ($1,500,000 recurring; $324,066 recurring)
DC Central Kitchen Healthy Corners	$750,000 ($650,000 recurring; $100,000 one-time)	$750,000 ($650,000 recurring; $100,000 recurring)
FRESHFARM Produce Plus	$1,500,000 ($1,300,000 recurring; $200,000 one-time)	$1,500,000 ($1,370,934 recurring; $129,066 recurring)
Food and Friends Medically Tailored Home Delivered Meals	$1,335,000 ($1,000,000 recurring; $335,000 one-time)	$1,335,000 ($1,135,000 recurring; $200,000 recurring)

In particular, the Committee heard from several Produce Plus Market Champions at the Budget Oversight Hearing for the need to increase investment in this program to reduce the waitlist. In April 2024, a historic 5,000 people applied for Produce Plus in the first 24 hours, an increase from 3,000 in 2023. This put the program on track to have an even larger waitlist than the 3,817 last summer, if funding remained flat. **The Committee therefore recommends an enhancement of $600,000 in FY 2025 in recurring local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau and Account 7141007 Grants & Gratuities to allow Produce Plus to serve an additional 2,500-3,000 residents and decrease the waitlist.**

The Committee also takes a critical step to expand healthy food access in District communities with low food access by proposing a BSA subtitle, the "Grocery Access Grant Pilot Program Act of 2024" (found in Attachment G), which will provide membership to a grocery delivery service at no cost for one year to 1,000 eligible residents. This pilot aims to address food access challenges for residents with low food access. Despite the District's longstanding efforts to attract new supermarkets to low food access areas, little progress has been made. Over the past 4 years, even with $58 million of ARPA funds dedicated a new Food Access Fund, only one new full-service grocery store has opened in Wards 7 and 8. This pilot program will specifically serve District residents currently enrolled in the District's SNAP-Ed program, nearly 80% of whom are Ward 5, 7, and 8 residents. The Committee also looks forward to reporting on how this pilot affects food purchasing for participating residents. **The Committee therefore recommends an enhancement of $120,000 in one time local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau and Account 7141007 Grants & Gratuities to implement the Committee's BSA subtitle, "Grocery Access Pilot Program Amendment Act of 2024".**

The Committee also recommends that the DC Council fund the Universal Free School Meals Amendment Act of 2023. The legislation would provide free universal school breakfast, lunch, and after-school snacks to students in public, charter, and participating private schools in the District. The Committee of the Whole held a public hearing on the bill on November 30, 2023. The research on the benefits of having access to nutritional school meals is very clear. Students who receive free school meals have shown improved academic achievement, experienced lower obesity rates, consumed more fruits and vegetables, lowered risk of behavioral issues, and experienced reduced nutrition deficiencies. The Office of Revenue Analysis provided an updated Fiscal Impact for this legislation that indicates that the Office of the State Superintendent for Education (OSSE) would need one year of lead-up time to prepare the schools for the program's implementation. Thus, if funded in the FY 2025 budget, it would cost $2,191,000 in FY 2025 and $8,882,000 in FY 2026, with small increases for growth in the remainder of the financial plan.

School Health Services Program

DC Health awards a non-competitive grant to Children's School Services (CSS) to provide staffing for the District's 183 school health suites and approximately 90,000 public school children through the School Health Services Program (SHSP). The FY 2025 proposed budget maintains the funding for CSS at $25,133,727, the same as the FY 2024 approved budget level. However, DC Health

also provided CSS with a supplemental $469,348 in FY 2024 to install the equipment for and operate the telehealth program, so the FY 2025 budget in effect is a reduction of available funds for CSS.

After years of chronic high vacancies among school nurses, DC Health and CSS rolled out a new staffing model for the health suites in School Year 2023-2024, with the goal of getting to 40 hours/week staffing coverage for all schools. This new model, based on those in surrounding jurisdictions, has nurses and school health technicians work together in a cluster of 3-4 schools in close geographic proximity to each other. Depending on the health needs of the student body, some schools would have a designated RN, while others would have a dedicated health technician, who could call in an RN for more severe health emergencies.

At a July 2023 hearing, Dr. Andrea Boudreaux from Children's testified that she was "confident" that the Program would be fully staffed by the beginning of the school year. Yet at a Public Oversight Roundtable the Committee held in January 2024 on the staffing of school health suites, CSS had filled only 169 out of 230 FTE positions, representing a 26% vacancy rate. This has led to only 56% of the health suites that participate in SHSP with 40 hours/week of staffing coverage. Therefore the Committee was happy to hear from Dr. Bennett during the FY 2025 Budget Oversight Hearing that 95% of schools now have 40 hours/week of staffing coverage for their health suites. The chart below shows how many of each type of health professional are staffing the health suites. The responses to the FY 2025 pre-hearing questions also provide a detailed chart of the number of hours of coverage and type of health professional for each school.

Role Type	**Count of Health Suites Covered at 24hrs by Role Type**	**Count of Health Suites Covered at 32hrs by Role Type**	**Count of Health Suites Covered at 40hrs by Role Type**	**Total Health Suites Covered at any Role Type**
Health Technician	0	3	75	78
Licensed Practical Nurse	2	0	37	39
Registered Nurse	4	1	60	65
Total	6	4	172	182*
Total (%)	3.3%	2.2%	94.5%	100%

*Figures exclude Roosevelt Stay as it is an approved health suite but is currently not staffed. The total health suite count for SHSP is 183.

At the FY 2025 Budget Oversight hearing and later in e-mail communication to the Committee, CSS stated that they need an additional $2,726,000 to operate SHSP in FY 2025, including $700,000 for staff salaries, $711,000 for training of the staff and Administration of Medication training, $600,000 for telehealth, and $715,000 for care management. DC Health strongly disagreed with these estimates, telling the Committee that CSS only needs $25,191,652 to cover health suite staffing, administrative core staffing, care coordination & telehealth, onboarding training, and fees and supplies. DC Health based this estimate on an algorithm for health suite staffing and the projected 186 health suites for the 2025-2026 school year.

The Committee urges DC Health to enhance the SHSP program to ensure high-quality, full-tim staffing, telehealth options, increased opportunities for the Administration of Medication training, and generally better oversight of the grant. **To enhance the School Health Services Program, the Committee recommends an enhancement of $1,411,000 in one time local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7141007 Grants & Gratuities.**

Access to Emergency Medication in Schools

On December 5, 2023, the Council passed B25-0226, the "Access to Emergency Medications Amendment Act of 2023". This bill, crafted in close collaboration with Children's National Hospital, ensures that when a student is having a medical emergency, schools are prepared with emergency medication and staff trained to provide immediate medical care. The bill requires DC Health to develop an Undesignated Emergency Medications Action Plan to create a system for stocking undesignated emergency medications in schools, including undesignated albuterol for students suffering from an asthma attack and undesignated glucagon for students suffering from hypoglycemia due to diabetes.

Current law mandates students enrolled in public and public charter schools to have a medication action plan to self-administer asthma or diabetes medication. The parent, legal guardian, or student must obtain authorization on the medication action plan from a licensed practitioner to enable self-administration of medication. In the case of an emergency where a student without a medication action plan is showing signs of an asthma attack or of hypoglycemia due to diabetes, school staff are currently not trained to administer undesignated medication and there is no undesignated medication available at schools.

This exponentially increases health risks for many students, since only 15.2% of students with asthma have an asthma action plan and 71.7% of students with diabetes have a diabetes management plan. Therefore, in the case of a medical emergency, almost 9 in 10 children with asthma would not be able to access albuterol and 1 in 3 children with diabetes would not be able to access glucagon immediately. Public witnesses testified at the hearing for this legislation that this is also a health equity issue, since Black and Latino children experience asthma at significantly higher rates than white children and are more likely to visit an emergency room due to the condition.

The Committee is pleased to be able to fully fund B25-0226, the "Access to Emergency Medications Amendment Act of 2023", by allocating the amounts indicated in the OCFO's updated Fiscal Impact Statement below, provided to the Committee in April 2024, to DC Health and to the Office of the State Superintendent for Education through a transfer to the Committee of the Whole.

Bill 25-226, Access to Emergency Medications Amendment act of 2023 Total DC Health Cost					
	FY2025	**FY2026**	**FY2027**	**FY2028**	**TOTAL**
Salary (a)	$164,431	$167,555	$170,739	$173,983	$676,708
Fringe	$36,175	$37,728	$39,349	$41,039	$154,291
Medication Storage (b)	$46,000	$0	$0	$0	$46,000
Training Update	$22,000	$0	$0	$0	$22,000
Medication Procurement and Distribution (c)	$376,000	$383,144	$390,424	$397,842	$1,547,410
TOTAL	**$644,606**	**$588,428**	**$600,511**	**$612,863**	**$2,446,408**

(a) Assumes salary for one Grade 12, Step 1 Nurse Consultant ($98,335) and one Grade 9, Step 5 Program Support Specialist.($66,078) Assumes fringe rate of 22.0 percent, cost growth of 1.9 percent, and fringe growth of 2.35 percent. Assumes October 1, 2024 start date.
(b) Assumes one-time costs of $650 for procure and install 71 locking medication cabinets.
(c) Includes annual procurement and distribution of albuterol and glucagon to 252 schools.

Bill 25-226, Access to Emergency Medications Amendment act of 2023 Total OSSE Cost					
	FY2025	**FY2026**	**FY2027**	**FY2028**	**TOTAL**
Salary	$90,805	$92,349	$93,919	$95,515	$372,588
Fringe	$21,975	$22,874	$23,809	$24,783	$93,440
TOTAL	**$112,780**	**$115,222**	**$117,728**	**$120,298**	**$466,028**

(a) Assumes salary for one Grade 12, Step 5 Management Analyst. ($90,805) Assumes fringe rate of 24.2 percent, cost growth of 1.9 percent, and fringe growth of 2.35 percent. Assumes October 1, 2024 start date.

Bill 25-226, Access to Emergency Medications Amendment Act of 2023 Total Cost					
	FY2025	**FY2026**	**FY2027**	**FY2028**	**TOTAL**
DC HEALTH	$644,606	$588,428	$600,511	$612,863	$2,446,408
OSSE	$112,780	$115,222	$117,728	$120,298	$466,028
TOTAL	**$757,386**	**$703,650**	**$718,239**	**$733,161**	**$2,912,436**

Maternal Health

On December 14, 2023, the Committee held a Public Roundtable on Maternal and Infant Health in the District. At the Roundtable, the Committee heard from maternal health professionals, including doulas, midwives, OBGYNs, and more, about their experiences on the ground ensuring the safety and health of expectant parents and infants. The Committee also questioned DC Health and the Department of Health Care Finance about whether current investments in maternal health were effectively decreasing incidences of maternal morbidity and mortality.

The most recent Perinatal and Infant Mortality Report from DC Health shows that, based on 2019-2020 data, the percentage of preterm births was significantly higher for non-Hispanic black mothers compared to non-Hispanic white mothers; unmarried mothers versus married mothers; births covered by Medicaid versus private insurance; births to mothers with less than a high school education compared to mothers with more than high school education; and births occurring to women who reside in ward 7 and 8 compared to wards 1, 2, 4 and 6. While Black birthing people constitute roughly half of all births in DC, they account for 90% of all pregnancy-related deaths and 93% of pregnancy-associated, non-related deaths. This is in stark contrast with White birthing people, who comprise about 30% of births but experienced no pregnancy-related deaths, and one pregnancy-associated, non-related death during 2014-2018.

At the Roundtable, the Committee discussed several initial ideas for further investments in maternal health that the Committee further researched and developed into FY 2025 budget recommendations:

- **The Committee recommends an enhancement of $74,600 in one time local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7141007 Grants & Gratuities to incorporate the evidence-based Count the Kicks Initiative to decrease stillbirths into the Perinatal Quality Collaborative grant, which is currently awarded to the DC Hospital Association.** The District has the 4th highest fetal mortality rate in the United States, and Black families are more than 2x as likely to experience a stillbirth than white families.[4] In the first decade of Count the Kicks in Iowa, the state's stillbirth rate decreased nearly 32% while the rest of the country remained relatively stagnant.[5] DC does not currently provide reliable data collection on stillbirth: while DC Health's Vital Records only reports 4 stillbirth certificates issues in FY 2023, hospital data provided to the Committee shows 77 stillbirths in 2023. Incorporating Count the Kicks into the PQC will increase education for maternal health care providers on stillbirths and provide pregnant individuals with free education and an app to help track fetal movement in the third trimester.
- **The Committee recommends maintaining the Mayor's proposed Budget Support Act subtitle to create a $300,000 grant to provide childcare for pregnant and birthing parents, "Childcare for Pregnant and Birthing Parents Grants Amendment Act of 2024", including in Attachment F.** Councilmember Henderson included this request in

[4] Gregory, E., Valenzuela, C., Hoyert, D. Fetal Mortality: United States, 2020. National Vital Statistics Reports, Vol. 71, 4, published August 4, 2022. Accessed May 5, 2024 at: https://www.cdc.gov/nchs/data/nvsr/nvsr71/nvsr71-04.pdf

[5] Association of Maternal & Child Health Programs. Best Practice: Count the Kicks. Accessed May 5, 2024 at: https://amchp.org/database_entry/count-the-kicks/

her FY 2025 Budget Letter to the Mayor after hearing testimony at the December Roundtable. Several OBGYN physicians testified that a major barrier to emergency, sometimes life-saving treatments for their patients was a lack of childcare. Most hospitals have a policy that children cannot be left alone in the hospital, so patients who arrive at an Emergency Department because of a pregnancy emergency, but have their children with them, have no choice but to decline treatment. The Committee makes several enhancements to the subtitle as introduced, including specifying that the childcare must be provided on-site for the first 5 hours, and specifying that the grant is for urgent treatment outside of standard prenatal care.

Domestic Violence Prevention

The Committee recommends an enhancement of $25,000 in recurring local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7132001 Contractual Services - Other for for the Pediatric Mental Health Care Access (PMHCA) Program. This program partners with the Department of Behavioral Health to implement its DC Mental Health in Pediatrics Program (DC MAP). The purpose of this program is to expand access and promote behavioral health integration into pediatric primary care. This funding will support a three-hour training on the dynamics of domestic violence, cultural humility, trauma informed care, safety planning and crisis intervention, and local resources for staff persons supporting pediatric health care. Each of the four workshops will be tailored to different partners, with a final workshop bringing teams together for cross training and teamwork.

JUUL Settlement Funds and Vaping Cessation

The DC Office of the Attorney General (OAG) reached a legal settlement with JUUL Labs, Inc. in April 2023, resolving allegations of violating consumer protection laws related to youth marketing and sales practices. Through the settlement, the District will receive a total of $13.67 million over eight years, or $1.7 million per year. There is currently two years' worth of Settlement Funds available in FY 2025, totaling $3.42 million, because the FY 2024 funds were loaded after the budget was finalized. The Settlement Agreement mandates that at least 50% of the funds, totaling $7.56M, be used for vaping remediation efforts, including cessation, education, and prevention initiatives. OAG proposes keeping 25% of the funds with OAG's Litigation Support Fund (LSF) and allocating the remaining 75% to the General Fund.

Through it's BSA subtitle "Tobacco Use Cessation Initiatives Amendment Act of 2024", the Committee creates a new Tobacco Use Cessation Fund dedicated to tobacco use prevention and cessation, specifically focused on youth vaping use, and allocates **$3,415,140** over the financial plan to the new Fund from the JUUL Settlement Funds collected by the Office of the Attorney General. This includes a transfer from the Committee on the Judiciary of **$771,160** in FY 2025 in one-time local funds for Program 700023 Cancer And Chronic Disease Prevention, Cost Center 70059 Cancer & Chronic Disease Bureau and Account 7141007 Grants & Gratuities for the Vaping Prevention and Cessation Program with proceeds from Juul Litigation Funding. **$853,785** in recurring funds will be directly allocated from the Litigation Support Fund in the outyears to the new Fund. The Committee also includes a Budget Support Act Subtitle XX, Tobacco Use

Cessation Initiatives Amendment Act of 2024, which requires DC Health to spend the funds on tobacco use prevention, education, and cessation programs, including:

- Investigators, including youth associates, to attempt vaping purchases;
- Social media countermarking campaign featuring District youth; and
- Developing and conducting a bi-annual survey on District youth use of vaping products; and
- Developing a bi-annual report detailing how the Settlement Funds allocated to the DC Health have been spent and providing updated data from the survey described above.

Taking a Public Health Approach to Vision Zero

Although Mayor Bowser published the Vision Zero report in 2015, setting a goal of zero traffic-related fatalities by 2024, the District has experienced increased traffic fatalities since the Vision Zero report was published. In 2023, 52 individuals died due to traffic fatalities, 24 of whom were pedestrians, bicyclists, or scooters. This is up from 35 fatalities in 2022 (25 ped/bike/scooter) and almost double the 28 fatalities (13 ped/bike) in 2017, when the District first started recording the data. In addition to fatalities, there were 95 pedestrians with major injuries, 31 bicyclists with major injuries, and 6,300 total minor injuries from traffic accidents.

One major shortcoming in the District's approach to Vision Zero is its failure to see traffic violence as a public health issue and to incorporate the primary public health agency into the development of strategies and solutions. The 2022 Vision Zero Update highlights the interagency nature of Vision Zero, outlining the roles of DDOT, DMV, MPD, and DPW, but only mentions DC Health in the context of post-crash care.

DC Health's Roadway Injury Surveillance Data Project within its Health Emergency Preparedness and Response Administration is integrating traffic-related injury data from trauma centers, emergency medical services, and MPD, with the ultimate goal of providing more accurate, comprehensive data to inform citywide roadway safety projects, including the Vision Zero Dashboard and DDOT infrastructure. The importance of these efforts has been proven in San Francisco where the city implemented a similar approach and found that existing singular datasets significantly undercounted injuries and their severity.[6] DC Health currently has only one Data Analyst supporting this project, leading to a slow rollout of these critical improvements that could impact the focus of millions of dollars of DDOT capital projects. **The Committee accepts a transfer from the Committee on Transportation and the Environment and recommends an enhancement of $137,329 in recurring local funds for Program 700050 Emergency Medical Services Regulation, Cost Center 70067 Emergency Medical Management Division and Account 7011001 Continuing Full Time for salary for a Data Analyst for HEPRA Trauma Registry FTE.**

[6] San Francisco Department of Public Health. "Vision Zero High Injury Network: 2022 Update." (November 2022). Accessed May 7, 2024 at: https://www.visionzerosf.org/wp-content/uploads/2023/03/2022_Vision_Zero_Network_Update_Methodology.pdf

b. FISCAL YEAR 2025 - 2030 CAPITAL BUDGET RECOMMENDATIONS

The Mayor's proposed FY 2025 – FY 20 capital budget request for DC Health is $24,345,000. $2,422,000. This represents an increase of $21,923,000, from the FY 2024 – FY 2029 Capital Plan. The FY 2024 – FY 2029 Capital Plan includes two capital projects:

AM0-100108-AM0.NAS23C. Future DC Health Animal Shelter

The Mayor's proposed FY 2025 Budget includes $22,500,000 of capital funds in FY 2025 to renovate an existing District-owned building to serve as a new animal shelter, replacing the existing shelter located at 1201 New York Avenue. The capital budget identifies the site, 4 DC Village Lane SW, which is currently a warehouse and will need significant renovations in order to be converted into an animal shelter. Notably, in Dr. Bennett's testimony at the FY 2025 Budget Hearing, she stated that the location has not yet been finalized, and the District is trying to find a site that will be more accessible for staff and visitors.

The Committee is extremely supportive of this new capital project, and applauds the Executive in including the full cost of building a new shelter, in contrast to the $4.5 million investment allocated in FY 2023 (and then swept in FY 2024). The current shelter on New York Avenue NE is old, crowded, and in disrepair, and advocates and the contractor have long been asking for a new shelter. The District has struggled to find a site for the new shelter—in FY 2023, it appeared the District had identified a site at 6500 Blair Road NE, but plans for that site fell through.

The Committee is concerned that all the capital funding for this project is loaded in FY 2025, when the Executive does not seem to have finalized a site. Further, at the Budget Oversight Hearing, Dr. Bennett testified that this is an 18-month project, starting in FY 2025 and finishing in FY 2026, but the capital funding does not reflect that project plan. The Committee urges DC Health and the Executive to finalize a location and ensure that the project is funded at appropriate levels.

HC0-101191-HC0.HFL24C. Fleet Replacement

The Committee recommends maintaining the Mayor's proposed $256,000 in FY 2025 and $2,338,065 over the capital plan for this project. This small, on-going capital project allows the agency to conduct regular replacement of vehicles as they reach the end of their useful liked. This fleet is used mainly for Food Safety and Rodent Control services. All vehicles being replaced are over 10 years old and have endured wear and tear and significant city mileage.

3. COMMITTEE POLICY RECOMMENDATIONS

1. Consider redesigning the School Based Health Centers to increase utilization and create a sustainable funding model.

The Mayor's proposed FY 2025 budget reduces the budget for School Based Health Centers (SBHC) from $2,100,000 to $600,000, a cut of $1,500,000. The seven current SBHCs provide

primary care services school year-round within District high schools. A SBHC can serve as a student's primary health care provider or supplement the services they would normally receive. Each SBHC offers medical, oral, social and mental health services, and education to enrolled students, and to the children of enrolled students. At the Budget Oversight Hearing, Dr. Bennett testified that the SBHCs were seeing fewer students than expected, and that the model needs to be reconsidered to "ensure that children who routinely seek care for basic needs in a school setting are not missing out on continuity and parent involvement, two essential elements of quality pediatric care." The Committee notes that utilization actually varied greatly across schools in the last fiscal year, according to the chart below provided by DC Health during FY 2023 performance oversight:

FY 23 School-Based Health Centers Utilization by Service and School (Oct 1, 2022 – Sep 30th, 2023)							
	Anacostia	Ballou	Cardozo	Coolidge	Dunbar	Roosevelt	Woodson
Total Visits	964	500	1931	1220	554	420	1068
Total number of students who visited SBHC	530	440	1204	943	474	271	750
Well Child Visits	114	41	296	77	61	76	218
Mental/ Behavioral Health Visits	114	29	1879	819	6	51	1050
Sexual Health Visits	459	53	340	336	13	129	229
Oral Health Visits	104	21	238	78	0	19	83
Asthma Care Visits	58	30	48	18	19	15	83

The Committee urges DC Health to use the remaining $600,000 budget for Fiscal Year 2025 to keep open at least the Cardozo High School SBHC, which serves a unique population of students who are underserved by other forms of public health insurance. The Committee also urges the agency to take the next year to develop creative solutions to increasing student usage of these Centers, including allowing for students to make confidential appointments for mental health and sexual health, and for students 16-years and older to make primary care appointments without parental consent, all of which is allowed under District law since the Council passed B25-0463, the Minor Access to Medical Records and Appointments Regulations Amendment Act of 2023, earlier this year.

2. Consider improvements and revised requirements for the Certificate of Need process.

The Mayor's proposed FY 2025 Budget Support Act included Subtitle XX. Certificate of Need, which would exempt providers will 10 or fewer full-time or part-time employees from the Certificate of Need (CoN) process. The Committee is not moving this subtitle because it takes too narrow a view of the need for Certificate of Needs reforms, and bases the exemption on number

of employees rather than types of services provided, but the Committee does agree on the need for a larger conversation about reforming the Certificate of Need process.

Over the last year, the Committee has heard from several different types of healthcare entities about frustrations with the CoN process. Telehealth companies believe they should be exempt from the process because they are not brick-and-mortar health facilities. Smaller entities believe they should be exempt because they are not major health facilities. And larger entities, like hospitals, have shared that they believe the CoN process is too onerous for relatively small capital updates, like installing a new elevator.

The Committee looks forward to working with DC Health during the summer and fall of 2025 to consider revisions to the CoN process to ensure the District is appropriately balancing the need for oversight over the equitable distribution of health care infrastructure with the administrative requirements we are expecting of health care facilities.

3. Fully implement the High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022.

In the FY 2024 budget, the Committee fully funded D.C. Law 24-0313, the High Need Healthcare Career Scholarship and Health Professional Loan Repayment Program Amendment Act of 2022. This legislation created a High Need Healthcare Career Scholarship and Supports program available for costs related to education, training, transportation, and examinations. The program would preference District residents, those who agree to be educated in the District, and those who demonstrate a desire to reside in the District. The Act requires that those who benefit from this program must commit to working in the healthcare industry in the District for at least two years. The Act lists specific careers that would be designated as a high-need healthcare career eligible for participation for this scholarship, but also allows the Mayor the flexibility needed to add or remove listed health care careers.

In its response to the Budget pre-hearing questions, DC Health states that *none* of the scholarship funds have been allocated thus far in FY 2024. DC Health states that they are setting up the framework for the program including IT infrastructure, rulemaking, and connecting with education providers. DC Health is also actively recruiting, but has still not hired, the Program Coordinator for this program. In the FY 2024 Supplemental Budget, the Executive sweeps $417,000 from the funds allocated for the scholarships since the program has still not started. DC Health testifies that the program will be ready be fully implemented in FY 2025 and spend the full funding. The Committee is frustrated that the implementation of this law has been delayed, and that funds the Committee allocated for this purpose have been swept. The Committee urges the agency to finalize the framework for this program promptly and spend down the full remaining amount in FY 2024, as well as the full funding in FY 2025.

Department of Behavioral Health (RM0)

1. AGENCY MISSION AND OVERVIEW

The mission of the Department of Behavioral Health (DBH) is to support prevention, treatment, resiliency, and recovery for District residents with mental health and substance use disorders through the delivery of high-quality, integrated services.

Summary of Services

DBH will:

1. Ensure that every individual seeking services is assessed for both mental health and substance use disorder needs;
2. Increase the capacity of the provider network to treat co-occurring disorders;
3. Establish and measure outcomes for individuals with co-occurring mental health and substance use disorders as well as single illnesses with recovery as the goal;
4. Enhance provider monitoring to ensure high quality service.

Program Description

DBH operates through the following 11 divisions:

1. **Data, Quality and Compliance Program**: Oversees provider certification, mental health community residence facility licensure, program integrity, quality improvement, major investigations, incident management, claims audits, program integrity, and compliance monitoring. Issues annual Medicaid and local repayment demand letters, annual public provider performance reports. This administration also aggregates and analyses data to evaluate performance; develops strategic plans and programmatic regulations, policies and procedures; develops and implements learning opportunities to advance system changes; and identifies needs, resources, and strategies to improve performance. This division contains the following 8 activities:
    - Data, Quality and Compliance Services
    - Certification Services
    - Incident Management and Investigation Services
    - Licensure Services
    - Program Integrity Services
    - Data and Performance Measurement Services
    - Strategic Planning and Policy Services
    - Center of Excellence Services

2. **Behavioral Health Authority Program**: Plans for and develops mental health and substance use disorders (SUD) services; ensures access to services; monitors the service system; supports service providers by operating DBH's Fee for Service (FFS) system; provides grant or contract funding for services not covered through the FFS system; regulates the providers within the District's public behavioral health system; and identifies

the appropriate mix of programs, services, and supports necessary to meet the behavioral health needs of District residents. This division contains the following 5 activities:

- Consumer and Family Affairs
- Executive Director
- Legal Services
- Legislative and Public Affairs
- Ombudsman

3. **Child/Adolescent/Family Services Program**: Develops, implements, and monitors a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for children, youth, and their families that are culturally and linguistically competent; and supports resiliency, recovery, and overall well-being for District residents who have mental health and substance use disorders. This division contains the following 8 activities:
   - Behavioral Services - Howard Road
   - Court Assessment Services
   - Crisis Services
   - Early Childhood Services
   - Evidence-Based Practices Services
   - Parent Early Childhood Enhancement Program (Piece)
   - School Based Behavioral Health Services
   - Psychiatric Residential Treatment Facility (PRTF)

4. **Clinical Services Program**: Provides person-centered, culturally competent outpatient psychiatric treatment and supports to children, youth, and adults to support their recovery; and coordinates disaster and emergency mental health programs. This division contains the following 3 activities:
   - Behavioral Health Services
   - Behavioral Health Services - Pharmacy
   - Forensics Services

5. **Policy, Planning, and Evaluation Administration**: Aggregates and analyses data to evaluate performance; develops strategic plans and programmatic regulations, policies, and procedures; develops and implements learning opportunities to advance system change; identifies needs, resources, and strategies to improve performance. This division contains the following activity: Behavioral Health Grant Oversight Services.

6. **Saint Elizabeths Hospital Program**: Provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community. The hospital's goal is to maintain an active treatment program that fosters individual recovery and independence as much as possible. The hospital is licensed by the District's Department of Health and meets all the conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services. This division contains the following 12 activities:
   - Clinical Administrative Services
   - Clinical and Medical Services

- Engineering and Maintenance Services
- Fiscal and Support Services
- Hospital Administrative Services
- Housekeeping Services
- Material Management Services
- Nursing Services
- Nutritional Services
- Quality and Data Management Services
- Security and Safety Services
- Transportation and Grounds Services

7. **Opioid Abatement Program**: Established by the Opioid Litigation Proceeds Act of 2022, the Office of Opioid Abatement within the District's DBH authorizes DBH to support a 21 member Opioid Abatement Advisory Commission to oversee the disbursement of opioid settlement funds to fulfill District's goals and objectives to mitigate the opioid epidemic; manage resources focused on opioid use prevention, treatment, recovery, harm reduction programs, and direct resources and support to community members impacted by the opioid crisis within the District.

8. **Crisis Services**: Oversees the development, implementation, and monitoring of a comprehensive array of crisis services for children, youth and adults to include 24/7 crisis lines, mobile crisis and accessible crisis receiving facilities. Develops and maintains strong cross-agency partnerships with first responders and other public safety and health and human service agencies. Assures adequate resources are available to respond promptly to distressed communities in the aftermath of shared traumatic events such as violence including homicides or natural or man-made disasters such as extreme weather events or building fires impacting many households. Establishes and monitors quality metrics for crisis services as well as mechanisms for determining whether sufficient capacity exists. This division contains the following 4 activities:
   - Access Helpline
   - Community Response Team
   - Comprehensive Psychiatric Emergency Services
   - Child/Youth Crisis and Community Trauma Response

9. **Adult Services Administration Program**: Develops, implements, and monitors a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for adults and communities that are culturally and linguistically competent; which support resiliency, recovery, and overall well-being for District residents who have mental health and substance use disorders. This division contains the following 12 activities:
   - 35 K Street Adult Clinical Services
   - Assessment and Referral Center (ARC) Services
   - Co-Located Services
   - Housing, Residential Support and Continuity of Services
   - Mental Health and Rehabilitation Services (MHRS) Local Only
   - Adult Behavioral Health Services MH/SUD

- Network Management and Support Services
- Residential Support and Continuity of Care Services
- Integrated Care/Specialty Services
- Substance Use Disorder Treatment Services
- Long Live DC/State Opioid Response Program
- Behavioral Health Rehabilitation - Local Match

10. **Agency Financial Operations**: Provides comprehensive and efficient financial management services to, and on behalf of, District agencies so that the financial integrity of the District of Columbia is maintained. This division is standard for all agencies using performance-based budgeting.

11. **Agency Management**: Provides for administrative support and the required tools to achieve operational and programmatic results. This division is standard for all agencies using performance-based budgeting.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2025 OPERATING BUDGET RECOMMENDATIONS

The Mayor's FY 2025 proposed operating budget for the Department of Behavioral Health is $385,536,240, which represents a 1.4% increase compared with the approved FY 2024 budget. This is largely due to increases in the State Opioid Response Program, Saint Elizabeths Hospital, and the Behavioral Health Local Match for Medicaid. The funding supports 1,411.9 Full-Time Equivalents (FTEs), a 1.9% decrease from the FY 2024 approved level.

Opioid Response

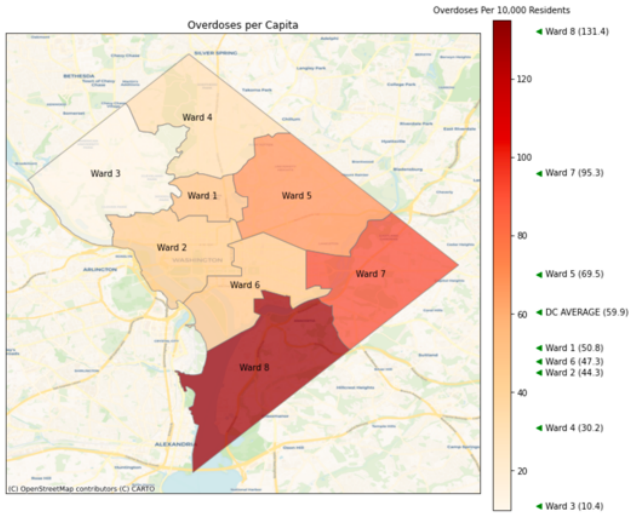
In March 2024, the Mayor introduced LIVE.LONG.DC 3.0 (LLDC 3.0) in response to the escalating opioid epidemic, emphasizing the establishment of a person-centered care system, enhancing connections throughout the care continuum, and fostering a proficient workforce. LLDC 3.0 marks the third update to the original LLDC campaign launched in 2017.

While the Committee acknowledges the Mayor's endeavors via the LLDC strategy to tackle this urgent crisis, the Committee is deeply concerned that, to date, the LDDC strategy has not effectively decreased opioid-related fatal overdoses. According to data from the Office of the Chief Medical Examiner (OCME), opioid-related fatal overdoses are at an all time high. In 2023, there were 522 opioid-related fatal overdoses, averaging 43 deaths per month, reflecting a 13% increase from 2022. Currently in 2024, 20 opioid-related fatalities have been certified by OCME (as of April 17, 2024). Fentanyl, a potent synthetic opioid used primarily for pain management, remains prevalent in nearly all overdose fatalities.

Opioid overdoses continue to disproportionately impact Black residents. OCME reports that in 2023, 83% of those who succumbed to opioid overdoses were Black residents, with the majority being Black men. Wards 7 and 8 experienced the highest number of fatal and non-fatal opioid

overdoses in the District in 2023. The map below illustrates overdoses per capita for each ward in the District in 2022.

Overdoses Per Capita



	Overdoses per 10,000 Residents
Ward 1	50.8
Ward 2	44.3
Ward 3	10.4
Ward 4	30.2
Ward 5	69.5
Ward 6	47.3
Ward 7	95.3
Ward 8	131.4
DC Average	59.9

LLDC 3.0 underscores once again the District's reliance on naloxone as a key strategy for addressing this crisis. Testimony from Dr. Barbara Bazron, DBH Director, during the FY 2025 budget oversight hearing testified that in 2023, Fire and Emergency Medical Services (FEMS) and community partners reported 8,500 suspected overdose reversals using naloxone. Although the Committee recognizes the important role of naloxone in combatting the opioid crisis, the Committee notes that the majority of fatal overdoses happen at home, where residents cannot self administer naloxone. The Committee believes DBH and its District partners must improve other areas of intervention to effectively decrease fatalities. Issues such as lack of agency coordination, obstacles to treatment and support services, and significant social determinants of health contribute to the rising opioid fatalities and the challenge of individuals accessing and staying in treatment.

On September 18, 2023, Councilmember Henderson, along with the 12 other members of the Council, introduced PR25-0386, the Sense of the Council on the Opioid and Fentanyl Epidemic Resolution of 2023. This resolution urged the Mayor to declare the opioid and fentanyl crisis in the District a public health emergency, recognizing its severity and committing sufficient resources to safeguard the well-being of District residents. The Sense of the Council was approved on November 7, 2023, and on November 13, 2023, Mayor Bowser issued Mayor's Order 2023-141, declaring a Public Emergency (PE) concerning the Opioid Crisis. This facilitated expedited procurement through contracts and authorized modifications to data sharing agreements between DBH, DC Health, and FEMS. The PE also enabled the deployment of outreach teams to overdose hotspots and affected areas, along with the provision of harm reduction services and supports. Subsequently, on February 27, 2024, the Mayor issued Mayor's Order 2024-035, declaring a second PE, which the Council extended beyond its original expiration date of March 13, 2024, to instead expire on September 15, 2024.

The Committee applauds several continued investments in opioid response in the Mayor's proposed budget:

- $36 million to the State Opioid Response program and LLDC, supporting evidence-based prevention, harm reduction, treatment, and recovery strategies;
- $600,000 for the Substance Abuse and Behavioral Health Services Targeted Outreach Grants, which was established in the FY 2024 budget by the Council through the "Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2023." This pilot program aimed to assess the effectiveness of providing direct support, fostering relationships, and facilitating resource access for individuals in need of substance abuse and behavioral health services at three locations with concentrated outdoor drug use in Ward 1, 5, and 7; and
- $14.7 million for the Opioid Abatement Fund.

With nearly $50 million in settlement funds expected over 18 years, the District's Opioid Abatement Fund was created in 2022 and is administered by the Office of the Attorney General. The fund is intended to support programs and initiatives that address the opioid crisis in the District. DBH's proposed FY 2025 budget includes $14,656,000 in the Opioid Abatement Fund. In the District, the use of the opioid settlement funds is governed by the Opioid Litigation Proceeds Amendment Act of 2022[7]. Under this law, DBH was required to establish an Office of Opioid Abatement and work with the Mayor and the DC Council to establish an Opioid Abatement Advisory Commission ("Commission"). The 21 member commission was seated in October 2023, the first meeting took place on October 25, 2023, and the Committee has met monthly since then. Details on the Commission, including a full list of Commission members, meeting minutes, and the links for meetings can be found on DBH's website.[8]

The Commission identified and recommended focus areas for spending during the February 2024 meeting, and DBH created a schedule to implement these recommendations. Within the initial 9 months of its launch, DBH has awarded $2.7 million in grants and contracts using Opioid Abatement Funds. The agency plans to award another $2.8 million by June 2024. Additionally, the agency released a Notice of Funding Availability for Opioid Abatement Strategic Impact Grants, amounting to up to $7 million, on its website on May 1, 2024. Initial grants and contracts include funding for a youth prevention media campaign, expansion of youth substance use disorder treatment services, enhancement of existing faith-based prevention programs, enhancements of the FEMS Overdose Response Team, and increasing housing services to consumers post-SUD treatment.

The Committee is working with DBH and the leadership of the Commission to ensure that settlement funds are being used strategically and equitably. After consultation with DBH and the Commission, **the Committee dedicates $1,125,000 of the Opioid Abatement Funds in its Budget Support Act Subtitle "Opioid Abatement Directed Funding Amendment Act of 2024", as follows:**

1. **$400,000 to expand the Substance Abuse and Behavioral Health Targeted Outreach Grant** through the Subtitle "Substance Abuse and Behavioral Health Services Targeted Outreach Grants Act of 2024" ($200,000 per site) to include sites in Wards 5 and 6. As

[7] Opioid Litigation Proceeds Amendment Act of 2022." D.C. Law 24-315.
[8] https://dbh.dc.gov/page/opioid-abatement-advisory-commission-01

described above, this initiative was established by the Council in the FY 2024 budget with the objective of assessing the effectiveness of offering direct assistance, cultivating connections, and streamlining resource accessibility for individuals requiring substance abuse and behavioral health services at opioid use hotspots. The areas that would be supported by Opioid Abatement Funds include:

- The vicinity of King Greenleaf Recreation Center located at 201 N Street, SW; and
- The vicinity of the of the 1300-1700 blocks of North Capitol Street, NW and 1600-1700 blocks of Lincoln, Road, NE.

2. **$325,000 to continue the School-Based Behavioral Health Peer to Peer Pilot** for a second year. This program, created by the Council in the FY 2024 budget, provides grants to a Community-Based Organization to train and supervise a team of students who enhance access to behavioral health services and resources while educating their peers on behavioral health topics, including opioid and drug prevention. Further details on the pilot and the School-Based Behavioral Health program are provided below. The continuation of this pilot is required under the Committee's subtitle "School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2024".
3. **$400,000 to restore the funding loss resulting from the expiration of a federal grant for the Office of the Chief Medical Examiner Illicit Drug Surveillance.** This funding sustains the Office of the Medical Examiner's forensic toxicology testing capabilities and supports the development of innovative forensic testing methods. These tests provide crucial data on suspected opioid-related fatalities, enabling agencies to respond effectively to the opioid crisis. They involve the analysis of tissue, blood, and other samples from individuals suspected to have died from an opioid overdose. Without this work, a comprehensive understanding of the role of opioids and other toxic substances in District fatalities would be unattainable.

Ward 8 has consistently recorded the highest number of drug overdose fatalities attributed to opioid use each year since 2018. Consistent and intensive outreach and support in Ward 8 could significantly enhance individuals' connection with services and resources, facilitating their entry into treatment and recovery. **Therefore, the Committee accepts a transfer from the Committee on Recreation, Libraries, and Youth Affairs and recommends an enhancement of $200,000 in one time local funds for Program 700286 Adult Behavioral Health Services Mh/Sud, Cost Center 70424 Sud Prevention Office and Account 7141007 Grants & Gratuities to establish an additional site within the Substance Abuse and Behavioral Health Targeted Outreach Pilot in the vicinity of the 1300-1800 blocks of Marion Barry Avenue, S.E.**

The Committee also accepts a transfer from the Committee on Public Works and Operations and recommends enhancement of $750,000 in one time local funds for Program 700286 Adult Behavioral Health Services Mh/Sud, Cost Center 70424 Sud Prevention Office and Account 7141007 Grants & Gratuities. These funds would be utilized by DBH to award a grant to an organization responsible for maintaining a Main Street corridor in Ward 1. The grant aims to provide direct support, foster relationship development, and facilitate resource brokering for individuals at the following locations:

- Columbia Heights Civic Plaza;
- The intersection of Mount Pleasant Street, NW and Kenyon Street, NW;
- Georgia Avenue, NW, between New Hampshire Avenue, NW, and Harvard Street, NW; and
- U Street, NW, between 14th Street, NW, and Georgia Avenue, NW.

Saint Elizabeths Hospital

DBH's FY 2025 proposed budget for Elizabeths Hospital is $112,139,000 representing a $9,372,000 increase from FY 2024. DBH attributes increases primarily to several personnel service increases, notably impacted by the Collective Bargaining Agreements, which fail to fully cover associated costs. Consequently, the agency encountered underfunding, especially concerning aspects such as night differential, weekend pay, and overtime, which were not adequately budgeted for. **The Committee recommends maintaining the proposed increase of funding for the District's only publicly owned behavioral health hospital and encourages DBH to ensure that the funding is focused on improving patient care and outcomes.**

School-Based Behavioral Health Services

The proposed funding for the School-Based Behavioral Health (SBBH) program in FY 2025 is $28,362,000, reflecting a $9,977,000 decrease from FY 2024. This funding includes grants to Community-Based Organizations (CBOs) at a rate of $80,819.67 per clinician. Notably, there's been a reduction from FY 2024 funding, which included a one-time American Rescue Plan Act (ARPA) funding for recruitment and retention bonuses, which brough the FY 2024 total to $89,366.22 per clinician. The Mayor's FY 2025 proposed budget excludes funding for such bonuses.

Funding Per Clinician for FY 2025

Core Budget Funded by Local Funds	Amount Per School Clinician
Clinician's salary for non-billable services	$63,153.00
Supervision (1:6 ratio)	+ $16,666.67
Workforce development	+ $ 1,000.00
Total FY 2025 Per School Clinician Funding	**$80,819.67**

The SBBH program aims to provide a comprehensive range of behavioral health services and resources to students attending public and public charter schools. To ensure the delivery of preventive and early intervention services not covered by Medicaid, the District government has opted to cover 50% of a clinician's salary. The program operates on a tiered intervention system: Tier 1 focuses on mental health promotion and prevention activities for all students. Tier 2 provides targeted interventions for students at risk of developing behavioral health problems. Tier 3 offers intensive supports and treatment for individual students experiencing behavioral health issues.

Last year, the Committee urged DBH to assess whether the financial model for the SBBH program required modification. In the agency's budget pre-hearing responses and during the budget oversight hearing, DBH shared its intent to reimagine the SBBH framework. DBH is exploring strategies such as clustering schools with a shared clinician, employing non-clinicians for Tier 1 and 2 services, and enhancing engagement with schools. DBH is also working with the Department of Healthcare Finance (DHCF) and the Insurance Commissioner to understand clinician Medicaid and private insurance billing and identify issues that the agency might need to address to improve billing for Tier 3 services.

During the FY 2025 performance and budget oversight hearings, the Committee received testimony from public witnesses advocating for additional funding to increase CBO clinician grants. While acknowledging the importance of adequate clinician compensation for a robust SBBH program, the Committee agrees with DBH's assessment that achieving full-time clinician coverage at every District public and public charter school remains a significant challenge. Despite efforts to recruit and retain clinicians, the percentage of schools with a clinician present has never surpassed 65%, even in years when CBOs received additional funding for hiring and retention initiatives.

During the 2023-24 school year, DBH initiated two SBBH pilots aimed at mitigating challenges with clinician hiring and retention. At the urging of the Committee and a number of public charter schools, Pilot 1B allocated funding directly to District public charter schools to hire full-time clinicians. Currently, there are seven schools participating in this initiative. Additionally, DBH introduced another pilot, implementing a hybrid telework model for public or public charter schools. This initiative prioritized adult-learner programs or high schools that are paired with a CBO but have a vacant clinician position, with three schools participating in this pilot.

The persistent workforce shortages in the behavioral health field further compound this issue, making it unlikely that all clinician positions will be filled. **Therefore, the Committee does not recommend increasing the FY 2025 budget for the SBBH program. However, the Committee commits to continuing to work with DBH to establish a new funding model prior to the FY 2026 budget formulation process.**

Peer-Based Mental Health Services

Over the past four years, the Committee has heard from numerous students during performance and budget oversight hearings, expressing concerns about the lack of accessible and quality behavioral health services and supports in their high schools. In response, the Committee proposed in the FY 2024 budget the addition of a subtitle, the School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023, aimed at closing the gap in access to behavioral health services by involving students in the initiative. By engaging students in this capacity, the District is able to tap into students' ability to relate to and connect with their peers, fostering a supportive environment conducive to open discussions on behavioral health topics. With an allocation of $325,000, DBH was tasked with awarding funds to one or two community-based organizations to recruit, train, and supervise at least 100 peer educators, with a preference for programs targeting high schools in Wards 5, 7, and 8.

Despite a detailed outline being provided in the subtitle, DBH took nearly five months to release the Request for Applications for the program, which was especially troublesome considering its intention to engage students during the school year. Following a competitive selection process, in April 2024, DBH awarded the Young Women's Project a grant to implement the School-Based Behavioral Health Student Peer Educator Pilot. The pilot was scheduled to begin in April or May 2024, and the Committee eagerly anticipates learning about the initial progress of the students' efforts.

The Mayor did not include funding in DBH's proposed FY 2025 budget for a second year of the pilot. **Therefore, the Committee recommends an enhancement of $325,000 in FY 2025 for a second year of the School-Based Behavioral Health Student Peer Educator Pilot,** pursuant to the Budget Support Act subtitle included in Appendix G. As described above, the Committee recommends that funding for this be allocated from the Opioid Abatement Settlement fund.

Court Urgent Care Clinic

In the proposed FY 2025 budget, the Mayor intended to eliminate the Urgent Care Clinic (UCC) located within the Superior Court of the District of Columbia Moultrie Courthouse and operated through a contract with DBH by Pathways to Housing. Established in 2008, the UCC serves individuals engaged with the court system who require mental health or substance use services. The clinic's mission is to broaden access to care, positively impacting community well-being by offering same-day psychiatric assessments and facilitating connections to community-based treatment providers and necessary support services for housing, clothing, or food. Through crisis intervention, temporary treatment provision, and long-term treatment referrals, the clinic plays a crucial role in breaking cycles of untreated mental illness and incarceration.

This innovative model effectively addresses the multifaceted needs of court-involved individuals, preempting costly and unnecessary interventions while fostering improved outcomes and community safety. Discontinuation of funding would disrupt vital services, potentially increasing reliance on law enforcement, and exacerbating mental health crises, thus undermining broader efforts to enhance mental health care access and reduce justice system disparities.

Since 2012, Pathways to Housing, a District non-profit, has operated the Urgent Care Clinic at DC Superior Court. According to testimony from the organization's President and CEO, Christy Respress, presented at the FY 2025 Department of Behavioral Health budget oversight hearing, the clinic has served over 7,100 unique adults and youth, with tens of thousands of follow-up visits. Despite reduced utilization during the pandemic due to virtual court proceedings, Pathways to Housing reported that the clinic served 132 clients in FY 2022, 189 clients in FY 2023, and as of April 2024, 315 clients in FY 2024 thus far. Sustaining the clinic's operation is crucial for ensuring equitable access to mental health services and preventing unnecessary crises.

The Committee heard from numerous agencies and organizations including the Public Defender Service for the District of Columbia (PDS), the United States Attorney's Office (USAO) for the District of Columbia, and the American Federation of Government Employees, AFL-CIO regarding the importance of the Urgent Care Clinic. Katerina Semyova, Special Counsel to the Director for Policy at PDS, highlighted the clinic's role in connecting individuals to treatment, thereby averting potential detention pending transfer to a treatment facility. She underscored the clinic's ability to intervene in mental health crises at the courthouse and facilitate referrals for necessary treatment after addressing acute crises. "Without access to this clinic, court-involved individuals with mental illness will be disenfranchised once ahao, as their access to voluntary services will be severed."[9]

[9] Semyonova, Katerina. "Urgent Care Clinic at DC Superior Court-Funding Concerns." Received by Marcia Huff, April 11, 2024.

In FY 2025, the Mayor intended to cut funding for the Urgent Care Clinic, although due to an error, the contract was included in DBH's budget. To maintain funding for the clinic in FY 2025, **the Committee recommends maintaining the $907,020 currently allocated for the Clinic in DBH's budget and requires DBH to spend this funding on the Clinic, pursuant to the Budget Support Act subtitle "Mental Health Court Urgent Care Clinic Amendment Act of 2024".**

Problem Gambling

The National Council on Problem Gambling estimates that between 12,000 and 15,000 District residents grapple with gambling addiction. In 2023, the National Problem Gambling Helpline (1-800-GAMBLER) received 6,572 calls, texts, and chats from District residents, highlighting the pressing need for support. Individuals struggling with gambling problems face heightened risks of suicide, substance dependence, and financial ruin.

On March 5, 2024, the Council unanimously approved the Problem Gambling Awareness Month Recognition Resolution of 2024, introduced by Councilmember Christina Henderson alongside Councilmembers Allen, Parker, McDuffie, Frumin, Bonds, Nadeau, and R. White. This resolution designated March 2024 as Problem Gambling Awareness Month in the District, acknowledging the importance of shedding light on problem gambling as a significant public health concern affecting millions across demographics.

In 2019, when sports betting was legalized in the District, the first $200,000 in revenue was designated to fund programs addressing gambling addiction through DBH. However, despite this allocation in DBH's budget for fiscal years 2020 to 2023, it remains unclear how these funds were utilized to tackle problem gambling. Disappointingly, DBH's budget for Gambling Addiction Treatment and Research was eliminated in FY 2024.

During the FY 2022 DBH performance oversight hearing, Cole Wogoman, Senior Manager of Government Relations and League Partnerships at the National Council on Problem Gambling, testified that DBH made minimal effort to use the allocated $200,000 for problem gambling initiatives. He shared that a solicitation issued by DBH in fall 2022 was closed within two weeks, citing a lack of satisfactory quotes submitted. Despite DBH's assertion in response to FY 2024 budget oversight questions that it can support gambling disorder treatment through existing mental health services, crucial information on problem gambling treatment and support remains absent from the DBH website, potentially hampering access to available services for those in need.

In response to the Committee's FY 2025 budget oversight post-hearing inquiries, DBH highlighted that District residents could access specialized services for Problem Gambling Disorders (PGD) via its network of certified substance use disorder providers, with Medicaid covering these services. The Committee welcomed the news that DBH organized 30 hours of training for network providers in September 2023, aimed at enhancing their proficiency in screening, assessing, and treating individuals with PGD, with participation from 44 community providers. **The Committee therefore accepts a transfer from the Committee on Business and Economic Development and recommends an enhancement of $300,000 in recurring local funds for Program 700286 Adult Behavioral Health Services Mh/Sud, Cost Center 70424 Sud Prevention Office and Account 7141007 Grants & Gratuities to increase resources and support for individuls struggling with Problem Gambling Disorder.**

b. FISCAL YEAR 2025 - 2030 CAPITAL BUDGET RECOMMENDATIONS

The Mayor's proposed FY 2025 – FY 2030 capital budget request for DBH is $7,280,000. The proposed capital budget is exclusively allocated for improvements to Saint Elizabeths Hospital facilities. **The Committee recommends maintaining the Mayor's proposed FY 2025 capital budget for DBH.** These projects address various vital aspects of infrastructure and safety within the hospital premises:

1. **Building Automation System Replacement ($1 million):** This funding will be used to replace the hospital's existing system and prevent violations of the DC Hospital Regulation code. Without it, the hospital's heating and cooling components would gradually deteriorate due to improper default settings.
2. **New Domestic Cold Water Bypass Line ($280K):** Installation of a new domestic cold water bypass line will provide the hospital with a secondary line from the city water main supply, enhancing reliability and resilience of water supply infrastructure.
3. **New Air Handler Unit ($3 million):** This funding will facilitate the installation of a new Air Handler Unit, crucial for regulating and circulating air within the hospital's heating, ventilation, and air conditioning (HVAC) systems.
4. **Critical Fire and Life Safety System Upgrade ($1.5 million):** This funding will bring the hospital's fire and life safety systems into compliance with industry standards. It involves the installation of smoke detectors, heat detectors, pull stations, and duct detectors to enhance safety for hospital occupants during emergencies such as fires, security breaches, gas leaks, or power failures.
5. **Replacement of Furniture in Patient Care Areas ($1.5 million):** This allocation will fund the replacement of furniture in patient care areas, ensuring a comfortable and conducive environment for patients undergoing treatment and recovery.

3. COMMITTEE POLICY RECOMMENDATIONS

The Committee recommends the agency adopt the following policy changes:

1. Reassess and revitalize the School-Based Behavioral Health Community of Practice.

A notable change in the FY 2025 budget is DBH's decision to terminate the contract with George Washington University for the SBBH Community of Practice (CoP). While the Committee does not recommend restoring funding for the CoP contract in this budget cycle, it encourages DBH to reassess the role of the CoP. The CoP was envisioned to bolster the District's Comprehensive Expansion of School-based Behavioral Health Services by fostering a peer learning environment for School Behavioral Health Coordinators, CBOs, DBH clinicians, and other school-based team members. However, it faced challenges in engaging CBOs, leading to structural adjustments aimed at enhancing effectiveness. These adjustments included accommodating different schedules, forming and merging various working groups, and recruiting new facilitators.

During the Committee's FY 2025 budget oversight hearing on DBH, witnesses advocated for the restoration of funds for the CoP. Testimony underscored its pivotal role in ensuring workforce sustainability, fostering practice improvement, and facilitating knowledge sharing. Amber Rieke,

Project Lead at A Path Forward, Children's Law Center, emphasized that "[t]he Community of Practice was essential to workforce sustainability, as it brought together providers, staff, and school leaders in a collaborative learning environment to share best practices, offer support, and engage in learning activities."

Recognizing the role of the CoP, the Committee recommends reevaluating its function with a proactive, goal-oriented, and benchmark-based approach. The CoP can act as a bridge between school communities, clinicians, and DBH, ensuring alignment towards unified goals while employing tailored strategies for each school, guided by common metrics. The relaunch should involve tailoring specific goals, conducting assessments, administering universal assessments, collaborating with stakeholders to devise support strategies, enhancing staff development, establishing an online platform for resource sharing, and serving as a gateway for engagement on mental health and wellness issues.

2. Develop online mental health crisis education and training materials for emergency response, healthcare professionals and laypersons.

On February 5, 2024, Councilmember Henderson, along with Councilmembers Nadeau, Parker and Bonds, introduced the Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024, aimed at improving mental health crisis support services and hospitalization procedures in the District. Scheduled for a hearing on July 11, 2024, this legislation seeks to enhance access to care and protect the rights of individuals undergoing involuntary commitment processes. The legislation would require DBH to develop online training modules for healthcare professionals and laypersons, focusing on the District's mental health law and voluntary and involuntary commitment procedures. Additionally, DBH would be required to create an online resource to educate individuals about their options for mental health treatment and protection, particularly those at risk of self-harm or harming others, ensuring accessible and comprehensive information.

The Committee urges DBH to develop online education and training materials as a proactive strategy to promote mental health awareness, provide support, and improve outcomes for individuals in crisis. Creating online education and training materials on emergency mental health treatment, including involuntary and voluntary hospitalization, serves several crucial purposes:

- Increasing Awareness and Understanding: These materials help increase awareness and understanding among both laypersons and health professionals about emergency mental health treatment options and criteria for involuntary hospitalization, reducing stigma and fostering empathy.
- Empowering Communities: Accessible information empowers communities to recognize signs of mental health emergencies and take appropriate action, potentially mitigating crisis severity and improving outcomes.
- Enhancing Collaboration: Online materials facilitate collaboration between DBH, other agencies, healthcare providers, and emergency services, ensuring access to up-to-date best practices and promoting consistency in care.
- Promoting Timely Intervention: Timely intervention is critical in mental health emergencies. Online training enables individuals and professionals to learn warning signs and appropriate response steps, facilitating earlier intervention and crisis prevention.

- Ensuring Informed Decision-Making: Clarifying legal and ethical considerations surrounding involuntary hospitalization is vital. Online materials provide comprehensive information to support informed decision-making by both laypersons and health professionals.
- Addressing Knowledge Gaps: Online resources bridge gaps in education and training accessibility, offering readily available information regardless of geographical location or time constraints.

4. Explore piloting a peer-response model for those struggling with hoarding disorder.

Last year, the Committee's FY 2024 Budget Report included recommendations urging DBH to increase resources for individuals grappling with hoarding disorder (HD). Additionally, this year, the Committee encourages DBH to explore piloting a peer-response team model to provide targeted support for those struggling with HD. During FY 2023 performance and FY 2025 budget oversight hearings, the Committee received testimony, including from Hilary Kacser, emphasizing the urgent need for DBH to increase support for individuals contending with both hoarding and related disorders. Kacser stressed the importance of early DBH intervention, stating that it would not only be cost-saving but also life-saving, underscoring the potential of a modest investment in training DBH providers to recognize and address harm associated with HD symptoms.

According to the International OCD Foundation, it is estimated that between 2% and 6% of the population may be affected by HD, yet individuals with this condition often face significant stigma, hindering their access to necessary assistance. HD can cause social isolation, financial strain, and health complications, with behaviors associated with hoarding posing risks of fire-related injuries and property damage. Accumulation of combustible materials such as paper and cardboard heightens the risk of fires, while cluttered environments impede both escape routes and firefighting efforts in the event of an emergency.

Peer-response teams can be a valuable tool in addressing HD by providing individuals with lived experience the opportunity to connect, share, and support each other in their recovery journey. Individuals struggling with HD can benefit from peer support in the following ways:

- Shared Experience, Understanding, Accountability, and Motivation: Peer-response teams supporting individuals with HD bring together those who have faced similar challenges, fostering empathy and validation. This environment promotes accountability as participants hold each other responsible for their actions and commitments.
- Role Modeling and Inspiration: These teams feature individuals successfully managing HD, serving as role models and sources of inspiration. Their stories demonstrate that recovery is possible, offering hope for a better future.
- Practical Coping Strategies: Beyond emotional support, peer-response teams offer practical coping techniques and skills. Participants share helpful strategies such as cognitive-behavioral techniques, mindfulness practices, and healthy lifestyle changes.
- Reduced Stigma and Isolation: HD sufferers often experience shame and isolation, but peer-response teams provide a safe, non-judgmental space. Here, individuals can openly discuss their experiences without fear of stigma, fostering a sense of belonging and acceptance that promotes healing.

5. Explore the establishment of a behavioral health urgent care clinic.

The Committee recommends that DBH explore the establishment of a Behavioral Health Urgent Care (BHUC) clinic in the District to address the pressing emergency and urgent behavioral health needs of District residents. The failure to provide meaningful care to our most vulnerable residents has profound consequences for both individuals and the District as a whole. Individuals grappling with serious mental illness (SMI) encounter heightened risks of homelessness, extreme poverty, and victimization, with mortality rates up to 25 years earlier than those without significant behavioral health diagnoses. Moreover, the current emergency department model often fails to adequately address the acute needs of patients in crisis, leading to prolonged wait times and disjointed care transitions.

During the Committee's FY 2025 budget oversight hearing for DBH, Dr. Sarah Goldman, an emergency medicine physician, presented a proposal for a BHUC. Dr. Goldman emphasized the importance of providing timely, evidence-based care in a compassionate and comprehensive manner. The proposed clinic would feature an Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) unit, specifically tailored to evaluate and treat individuals with acute psychiatric needs, such as suicidal ideation, in a calming and supportive environment. Additionally, a co-located walk-in center will offer services for individuals with lower acuity needs, including brief crisis intervention, medication refills, and Medication for Opioid Use Disorder (MOUD) services.

The clinic would foster integration between behavioral health and physical health services, guaranteeing that individuals receive comprehensive care tailored to their specific needs. The BHUC would not only provide immediate crisis intervention, but also facilitate ongoing care coordination and linkage to follow-up services. This includes referrals to outpatient counseling, medication management, and community support programs. By promoting continuity of care, the BHUC would ensure that individuals receive ongoing support and resources to address their behavioral health needs beyond the acute crisis period.

During the April 11, 2024 DBH FY 2025 budget oversight hearing, Dr. Bazron testifies that the BHUC model appeared similar to the services already provided through DBH's Comprehensive Psychiatric Emergency Program (CPEP). However, Dr. Patrick Canavan, a District psychiatrist with over 30 years of experience in mental health services, including leadership roles at Saint Elizabeths Hospital and Howard University Hospital, highlighted notable distinctions between CPEP and the proposed BHUC approach. Dr. Canavan identified three key differences between the BHUC and CPEP. First, care delivery via the BHUC would be both tailored to the individual's needs and definitive: clients requiring acute care for suicidal ideation will receive multimodal therapy and seamless transitions to trusted outpatient community services, whereas CPEP offers limited treatment options beyond medication management. Second, BHUC is designed to address whole-person care, incorporating onsite and/or virtual MOUD and physical health providers as part of routine treatment. Third, there is compelling evidence demonstrating that BHUCs have led to reduced ED visits and inpatient hospitalizations, increased satisfaction among patients and providers, and greater utilization of outpatient services.

Through investment in innovative care models like BHUCs and co-located walk-in centers, DBH can elevate patient outcomes, decrease healthcare costs, and ultimately, uplift the overall well-being of our community members.

6. Prioritize the preparation and timely release of grants to ensure efficient utilization of allocated funds.

The Committee recommends that DBH prioritize the preparation and timely release of grants to ensure efficient utilization of allocated funds and to prevent unnecessary delays in program implementation. Timely release of grants is crucial to prevent waste of funds and to expedite the launch of programs.

Delayed release of grants and contracts often results in underutilization of allocated funds, leading to missed opportunities to address pressing mental health and substance abuse challenges. Additionally, delayed release of grants and contracts can significantly impact the timely implementation of essential programs and initiatives, disrupting service delivery and hindering access for District residents. For instance, despite the allocation of funds in FY 2024 for the School-Based Behavioral Health Student Peer Educator Pilot, the Request for Applications was not released until February 2024, and the agreement with the grantee was not signed until April 2024. Despite the significant details provided in the BSA subtitle, DBH indicated in the agency's FY 2023 performance oversight pre-hearing responses that the scope of work was still being finalized. Consequently, the grantee organization commenced their work with less than three months left in the school year, underscoring the need for timely release of grants and contracts to ensure effective program implementation.

Timely release of grants allows DBH-funded grantees to effectively plan and execute their activities, leading to better outcomes for individuals seeking mental health and substance abuse services. By ensuring that programs are launched without delay, DBH can maximize the impact of its initiatives and better meet the needs of the community.

Department of Health Care Finance (HT0)

1. AGENCY MISSION AND OVERVIEW

The mission of the Department of Health Care Finance (DHCF) is to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of the District of Columbia.

Summary of Services

The Department of Health Care Finance provides health care services to low-income children, adults, the elderly, and persons with disabilities. More than 300,000 District of Columbia residents (approximately 45 percent of all residents) receive health care services through DHCF's Medicaid and Alliance programs. DHCF strives to provide these services in the most appropriate and cost-effective settings possible.

The Department of Health Care Finance Operates through the following 9 divisions:

1. **Health Care Delivery Management**: Ensures that quality services and practices pervade all activities that affect the delivery of health care to beneficiaries served by the District's Medicaid, Children's Health Insurance Program (CHIP), and Alliance programs. HCDM accomplishes this through informed benefit design; use of prospective, concurrent and retrospective utilization management; ongoing program evaluation; and the application of continuous quality measurement and improvement practices in furnishing preventive, acute, and chronic/long-term care services to children and adults through DHCF's managed care contractors and institutional and ambulatory fee-for-service providers. This division contains the following 5 activities:
    - Managed Care Management - provides oversight, evaluation, and enforcement of contracts with organizations managing the care and service delivery of Medicaid and Alliance beneficiaries, along with providing oversight and enrollment of eligible beneficiaries.
    - Preventive and Acute Care (Children's Health Services) - develops, implements, and monitors policies, benefits, and practices for children's health care services, including Health Check/EPSDT, CHIP, and the Immigrant Children's Program.
    - Quality and Health Outcome - continuously improves the quality (safe, effective, patient-centered, timely, efficient, and equitable services) of health care delivered by programs administered by DHCF; and ensures that quality and performance improvement principles and practices pervade all the components and activities that impact the delivery and outcomes of health care services to patients served by the District's Medicaid, CHIP, and Alliance programs.
    - Divisions of Clinicians, Pharmacy and Acute Provider Services - develops, implements, and oversees the programming for primary and specialty providers, hospitals, and other acute and preventive care services; and manages the non-emergency transportation contract.
    - Health Care Delivery Management Support Services – provides administrative support functions to the Health Care Delivery Management division.

2. **Long-Term Care Program**: Provides oversight and monitoring of programs targeted to the elderly, persons with physical disabilities, and persons with intellectual and developmental disabilities. Through program development and day-to-day operations, LTCA also ensures access to needed cost-effective, high-quality extended and long-term care services for Medicaid beneficiaries residing in home and community-based or institutional settings. The office also provides contract management of the long-term care supports and services contract. This division contains the following 4 activities:
    - Long-Term Care Support Services - provides administrative support functions to the Long-Term Care division.
    - Oversight - provides quality assurance (including compliance with six Centers for Medicare and Medicaid Services (CMS) assurances) and outcomes, oversight and audits/site visits, and corrective action plans.
    - Operations - provides day-to-day operations to ensure service delivery for both providers and beneficiaries; issue resolutions, ensuring timeliness of prior authorizations; training and technical assistance to providers; provider readiness; and compliant triage and resolution.
    - Intake and Assessment - oversees nurse unit responsible for access to Long Term Care Services and Support Assessments (LTCSS) including Delmarva assessments, Qualis Health Level of Care reviews, coordination with Aging and Disability Resource Center (ADRC), and Intellectual or Developmental Disabilities (IDD) acuity level reviews/approvals.

3. **Health Care Policy and Planning:** Maintains the Medicaid and CHIP state plans that govern eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP programs; develops policy for the Health Care Alliance program and other publicly funded health care programs that are administered or monitored by DHCF based on sound analysis of local and national health care and reimbursement policies and strategies; and ensures coordination and consistency among health care and reimbursement policies developed by the various divisions within DHCF. The division also designs and conducts research and evaluations of health care programs. This division contains the following 4 activities:
    - Policy Unit Management (Regulation and Policy Management) – maintains the Medicaid State Plan, which governs the eligibility, scope of benefits, and reimbursement policies of the Medicaid and CHIP programs; creates State Plan Amendments, waivers, and regulations that form the foundation of Medicaid policy and programs administered or monitored by DHCF.
    - Data Analysis (Division of Analytics and Policy Research) – gathers information, analyzes data, and evaluates all activities related to multiple District-wide components of Medicaid, CHIP, the Alliance, FY 2023 Approved Budget and Financial Plan Department of Health Care Finance and future healthcare delivery systems.
    - Member Management (Eligibility Policy) – serves as liaison to District and federal agencies regarding eligibility-related matters.
    - Health Care Policy and Planning Support (Health Care Policy and Research Support) – provides administrative support functions to the Health Care Policy and Planning Administration.

4. **DC Access System (DCAS):** Has responsibility to design, develop, implement, and manage the DC Access System (DCAS), which is an integrated eligibility system for all health and human services for the District. In addition, this administration is responsible for supporting the functionality and funding for all components of DCAS and their seamless interface with the Health Benefits Exchange and Department of Human Services program components. This division contains the following 4 activities:
    - DCAS Program Management - manages all operational and functional activities related to the DCAS project.
    - DCAS Project Management - manages all project management and functional activities related to the DCAS project.
    - DCAS Organizational Change Management - manages all historical, current, and forecasted project initiatives associated with Organization Change Management.
    - DCAS Information Technology - manages the operational tasks and maintenance for the DCAS project.

5. **Health Care Finance:** Provides provider payments for the following provider types: Medicaid providers, public providers, and Health Care Alliance Providers. This division contains the following 3 activities:
    - Medicaid Provider Payment – provides payment to Medicaid providers.
    - Medicaid Public Provider Payment – provides payment to Medicaid public providers.
    - Alliance Provider Payment – provides payment to Alliance providers.

6. **Health Care Operations:** Ensures the division of programs that pertain to the payment of claims and manages the fiscal agent contract, the administrative contracts, systems, and provider enrollment and requirements. The office provides contract management of the Pharmacy Benefits Manager, the Quality Improvement Organization contract, and the Medicaid Management Information System (MMIS) Fiscal Intermediary contract as well as additional administrative contracts. This division contains the following 3 activities:
    - Medicaid Information System (Claims Management) - oversees MMIS operations; systems requests; member services, including member out-of-pocket reimbursements; Consolidated Omnibus Budget Reconciliation Act (COBRA) payments; third-party liability processing; and processing of financial transactions.
    - Division of Public and Private Provider Services – manages the Administrative Services Organization contract, provider enrollment and recruitment, and internal and external provider services and inquiries.
    - Health Care Operations Support (Health Care Operations Support Services) – provides administrative support functions to the Health Care Operations division.

7. **Eligibility and Enrollment (E&E):** Identifies, validates, and disseminates information about new health care models and payment approaches serving Medicaid beneficiaries with the goal of enhancing health care quality, improving care and outcomes, promoting health equity, and enhancing the value and efficiency of DHCF programs. The division creates and tests new delivery system and payment models among providers in the District and build collaborative learning networks to facilitate innovation, implement effective

practices, and facilitate technology improvements to support delivery system re-design and improvement. This division contains the following 2 activities:

- Affordable Care Reform and Grants Development – develops and executes strategies for payment and delivery system reform in the District, including developing, implementing, and monitoring health reform activities as well as developing demonstration projects and grants to support various value–based purchasing and practice transformation strategies; and.
- Health Care Reform and Innovative Support Services – is responsible for advancing the use of information technology among health care providers in the District.

8. **Agency Financial Operations:** Provides comprehensive and efficient financial management services to, and on behalf of, District agencies so that the financial integrity of the District of Columbia is maintained. This division is standard for all agencies using performance/based budgeting.

9. **Agency Management:** Provides for administrative support and the required tools to achieve operational and programmatic results. This division is standard for all agencies using performance-based budgeting.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2025 OPERATING BUDGET RECOMMENDATIONS

The Mayor's FY 2025 proposed budget for the Department of Health Care Finance (DHCF) is $4,863,666,552, which includes $1,043,922,025 in local funds. The proposed FY 2025 budget includes 378.1 FTEs, a 3.1% increase from FY 2024 approved levels. A key consideration in the budget development processes for DHCF was balancing the challenging budget environment in 2025, compounded by the fact that FY 2025 will be the first year in the past 4 years without the enhanced federal Medicaid Assistance Percentage (EFMAP) as enacted during the COVID-19 public health emergency. However, DHCF is required to maintain eligibility for all DC residents eligible for public health care and ensure compliance with federal Centers for Medicare and Medicaid Services (CMS) requirements, maintain services based on reasonable clinical determinations, and support programs in the community to achieve better health outcomes.

Medicaid Inpatient and Outpatient Hospital Directed Payments

DHCF is proposing two Budget Support Act subtitles to codify the implementation and process to tax and reimburse hospitals using the Average Commercial Rate (ACR): the Medicaid Inpatient Hospital Directed Payment Act of 2024 and the Medicaid Outpatient Hospital Directed Payment Act of 2024. The two subtitles are similar and are structured as follows:

Medicaid Inpatient Hospital Directed Payment Act:
Beginning October 1, 2024, the District will tax each qualified hospital on their inpatient net revenue at a universal rate (the ACR). The tax will generate an amount sufficient to fund the Inpatient Hospital Directed Payment Fund, from which DHCF deducts a 12% District Retention. The District Retention will be used for Medicaid FFS local funding and will partially fund the salary and benefits of one FTE. MCOs administer the remainder (the local share of the fund),

which receives a federal match. The total amount (local share + funds from the federal match) is paid back to the hospitals as the Inpatient Hospital Directed Payment.

The expected local revenue of the Inpatient Hospital Directed Payment Fund is $81 million in FY2025 and $324.66 million over the financial plan. The subtitle sunsets on September 30, 2029, at the end of the financial plan.

Medicaid Outpatient Hospital Directed Payment Act
Beginning October 1, 2024, the District will tax each qualified hospital on their outpatient gross revenue at a universal rate (the ACR). The tax will generate an amount sufficient to fund the Outpatient Hospital Directed Payment Fund, from which DHCF deducts a 12% District Retention. The District Retention, same as the previous Act, will be used for Medicaid FFS local funding and will fund the remainder of the salary and benefits of one FTE. MCOs administer the remainder (the local share of the fund), which receives a federal match. The total amount (local share + funds from the federal match) is paid back to the hospitals as the Outpatient Hospital Directed Payment.

The expected local revenue of the Outpatient Hospital Directed Payment Fund is $46.4 million in FY2025 and $185.59 million over the financial plan. The subtitle sunsets on September 30, 2029, at the end of the financial plan.

Being reimbursed at the ACR means that participating hospitals are not eligible for supplemental federal payments, which means that participating hospitals will lose their Disproportionate Share Hospital (DSH) payments.[10] The loss of DSH payments would uniquely impact Howard University Hospital, who has a patient population that is over 80% Medicaid.[11] For that reason, Howard University Hospital is exempted from the tax portion of the program and DHCF will need to submit a waiver to CMS to approve this exemption.

These subtitles are revenue generators both for the District and the hospitals, with the intention of promoting expanded access for Medicaid beneficiaries. Anticipated FY 2025 revenue as shared by DHCF below (rounded estimates):

Inpatient Directed Payment Fund Revenue	$81 million
Outpatient Directed Payment Fund Revenue	$46.4 million
Total ACR Tax Revenue (*Inpatient + Outpatient Payment Funds)*	$127.5 million
District Retention Fee (*12% deducted from the total ACR tax revenue*)	$13.7 million
Net ACR Tax Revenue	**$113.8 million**
Local Share of Inpatient + Outpatient Funds *(Component of Payments to MCOs)*	$113.8 million
Federal Medicaid Match of Inpatient + Outpatient Funds	$368.8 million
Total Payment to MCOs	$482.6 million
Healthy DC Tax Payment *(MCO tax)*	$9.7 million
Total State Directed Payments to Hospitals	**$472.9 million**

[10] Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.
[11] *Metropolitan Anchor Hospital Case Study: Howard University Hospital*. American Hospital Association. (June 2022). Accessed May 2, 2024 at: https://www.aha.org/system/files/media/file/2022/10/Howard-University-Hospital-MAH-Case-Study.pdf.

The total State Directed Payments ($473 million) will be paid out to each hospital with a formula based on MCO beneficiaries' hospital utilization (see table above for anticipated hospital revenue). The 12% District Retention fee, which generates $13.7 million in FY 2025, is intended to help supplement medical expenditures in the FY 2025 DHCF budget. In future years the District Retention could be used for the General Fund, but that is not reflected across the financial plan.

The Committee recommends increasing the District retention rate by 1.125% total, from 12% to 13.125%. This will generate an additional $1.28 million in revenue, which the Committee proposes using to fund D.C. Law 25-124, the Prior Authorization Reform Amendment Act of 2023, which passed in November 2023. The law establishes prior authorization guidelines and requirements that health insurance utilization review entities must follow and includes four components: Accelerated Prior Authorization Review, Five-Year Determination History, Adverse Determination and Appeals Credentialing Requirements, and Public Facing Determination Statistics. The Committee recommends funding two of the four components of the bill:

- Accelerated Prior Authorization: Currently, MCO contracts stipulate that standard non-urgent prior authorizations must be completed by a utilization review contractor within 14 calendar days of receiving a request with the option of a 14-calendar-day extension by DHCF. Implementing this new law will require a maximum five-day turnaround period for non-urgent authorizations. Likewise, MCO contracts stipulate that urgent care prior authorizations must be completed within 72 hours. The bill requires a turnaround time of 24 hours. To comply with the accelerated turnaround requirements in the bill, MCOs will need to hire additional staff to complete authorization reviews. **The Committee funds the full cost of accelerating prior authorization review estimated by the OCFO in the Fiscal Impact Statement:**

Bill 25-124, Prior Authorization Reform Amendment Act of 2023 Accelerated Prior Authorization Review ($ in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Local	$490	$498	$507	$515	$2,010
Federal	$1,225	$1,246	$1,267	$1,289	$5,026
Total	$1,715	$1,744	$1,774	$1,804	$7,036

- Adverse Determination: The bill requires that all adverse determinations and decisions on appeals of adverse determinations be made by a licensed physician who specializes in managing the medical condition or disease involved in a request and is licensed to practice in the District of Columbia, Maryland, or Virginia. MCOs and the fee-for-service utilization review contactor must hire subcontractors who meet the credentialing requirements required in the bill. These subcontractors bill MCOs and the fee-for service utilization review vendor on a per case basis. **The Committee funds the full cost of enhanced adverse determination and appeals credentialing requirements estimated by the OCFO in the Fiscal Impact Statement:**

Bill 25-124, Prior Authorization Reform Amendment Act of 2023 Adverse Determination and Appeals Credentialing Requirements Cost ($ in thousands)					
	FY 2024	FY 2025	FY 2026	FY 2027	Total
Local	$734	$746	$759	$772	$3,011
Federal	$1,950	$1,983	$2,017	$2,051	$8,001
Total	$2,684	$2,729	$2,776	$2,823	$11,012

The other two components of the bill: the Five-Year Determination History and the Public Facing Determination Statistics are MCO-specific costs for upgrading and maintaining their websites to provide this information. The Committee recommends that MCOs fund these upgrades independently to improve beneficiary service and patient care. In the Committee's BSA Subtitle "Prior Authorization Reform Amendment Act of 2024", the Committee recommends exempting health plans under Medicaid and the HealthCare Alliance from these requirements, thus enabling the Committee to repeal the subject to appropriations clause for the legislation.

The Committee is requiring, through the Committee Prints of the BSA subtitles, that DHCF capitalize on the transformative opportunities provided by the ACR revenue. This program is intended to support hospitals in providing community benefits and the Committee amends the subtitle to require that DHCF directs the hospitals to spend their additional revenue on specific policy goals, including improving maternal and child health outcomes, discharge for long term care and transitions of care plans, substance use treatment, and workforce pipelines. The Committee recommends that DHCF work with the hospitals to ensure existing programs that fit within this framework are supported.

Medicaid Enrollment and Provider Payments

DHCF's budget is split between administrative and provider payment segments with the latter accounting for nearly 90% of the agency's local budget. There are over 50 provider types within the provider payments budget and the increases and decreases per provider types varied significantly. The enhanced budget encompasses increased utilization per beneficiary, despite Medicaid fee-for-service (FFS) enrollment decreasing by nearly 25,000 over the last year, and Medicaid managed care organization (MCO) enrollment decreasing by approximately 50,000 over the last year. DHCF noted that despite decreased enrollment, cost growth and increased utilization per beneficiary accounted for a large portion of the increase in FY 2025, as well as rate increases in the Dual Eligible Special Needs (DSNP) program.

In FY 2025, DHCF reduced their budget for MCO provider payments to $9.8 million, down from $12.8 million in FY 2024. DHCF contracts with an external actuary firm to determine the low, middle, and high bands of payments at which DHCF can reimburse the MCOs that would still be actuarially sound. For FY 2025, a challenging budget year, DHCF chose to reimburse MCOs for providers at the lower band to help relieve spending pressures. In previous years DHCF reimbursed MCOs for provider payments at the middle band, and at the Budget Oversight hearing indicated that they do not expect payments at the lower band to be a permanent decision, and will be reevaluated annually. Director Turnage testified at the Budget Oversight hearing that this is an actuarily sound decision that should have no impact on patient care.

Addressing Workforce Challenges

Certified Nursing Assistants and Nursing Facilities

The Committee was pleased to see a $17.69 million increase in payments to nursing facilities, bring the total amount to $313 million in FY 2025, up from $295 million in FY 2024. This increase occurred because CMS finalized a rule in 2024 that required nursing facilities to meet certain wage requirements in FY 2025. DHCF conducted a study on District nursing facilities and found that they needed to increase their funding to support utilization and workforce in those facilities.[12]

Workforce shortages in the long-term care sector will cause a ripple effect of challenges across the health sector. According to DC Health licensure renewal data, in 2023, the District experienced an approximately 30% reduction in the long-term care workforce, with nearly 4,500 certified nursing assistants (CNAs) and Home Health Aides (HHAs) not renewing their certifications, in large part due to insufficient wages. This significant loss in the long-term care workforce is having direct impact on providing care to residents in need. Providers are reporting severe understaffing at many facilities, causing them to turn away patients. Though this is not a new problem, if the workforce continues to decrease while the aging population continues to increase, the issue will only compound. **The Committee notes that the expectation is that the $17.69 million increase in the budget will be used directly for salary increases for the Certified Nursing Assistants (CNAs) and other direct care staff that work in these nursing facilities and encourages DHCF to study the effects of the increased wages for this segment of the health care workforce.**

Direct Care Professionals

The Direct Care Worker Amendment Act was introduced in November 2023. The bill seeks to accomplish several policy goals: it establishes a new credential type for direct care workers to replace the existing HHA and CNA certifications; lowers the age requirement for direct care workers to 16 years of age; eliminates barriers to certified apprenticeship programs for direct care workers; allows direct care workers certified in Maryland or Virginia to practice in the District; and establishes a minimum wage for direct support services at 120% of the District's living wage.[13] The Committee held a hearing in March 2024, and received feedback from advocates and government officials. The Committee has had a number of conversations with DHCF and the OCFO regarding the costs associated with raising Direct Care Professional's wages and the overall importance. Unfortunately, given this tough budget year, the Committee could not identify the funding to include these wage increases in the FY 2025 budget.

One source of contention around accurately assessing Direct Care Professional's wages is that DHCF had previously requested, but not required, Home Health Agencies to submit cost reports. DHCF could not require this because they received significant pushback from the agencies around this reporting requirement. However, without all cost reports, DHCF is not able to

[12] *(CMS 3442-F) Medicare and Medicaid Programs: Minimum Staffing Standard for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule.* (April 22, 2024). Accessed May 5, 024 at: https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0.

[13] *DC Bill 25-0565 Direct Care Worker Amendment Act of 2023.* (Introduced Nov. 6, 2023). Accessed May 5, 024 at: https://lims.dccouncil.gov/Legislation/B25-0565.

accurately assess needs and make cost adjustments throughout the year, like they do for other payment types. Following the Budget Oversight Hearing, Director Turnage announced that DHCF will now require Home Health agencies to submit cost reports on an annual basis, as a mechanism of assessing for efficiency, economy, and quality of care, and that failure to submit the cost reports within the specified timeframe without an approved extension may result in escalating penalties, up to and including suspension of claims payment.

These costs reports, coupled with the Home Health Rate Study that DHCF is currently working on will be useful tools to determine proper service array, payment methodology, and rates to achieve person centered care and better outcomes. The Committee encourages DHCF to build on initiatives aimed at increasing wages and benefits for direct care professionals to make these positions more attractive compared to other retail or service jobs.

Home Visiting

Home visitors delivers Early Intervention support, including education and coaching, to expecting parents and families with young children with the goal of improving their health outcomes. There are 17 home visiting programs operating in the District, funded with a variety of federal and local grants, as well as private funding; however, not all home visits qualify for Medicaid reimbursement. The Council passed D.C. Law 25-0321, Home Visiting Services Reimbursement Act of 2023, last year, with the intention of authorizing Medicaid, the Alliance, and the Immigrant Children's Program, to cover and reimburse eligible home visiting services.[14] The bill also requires DHCF to consult with home visiting providers to establish criteria and processes for billing and reimbursement, including coverage criteria and a monthly payment reimbursement structure, and to begin reimbursing eligible evidence-based home visiting programs beginning January 1, 2025.

The original fiscal impact statement (FIS) calculated a local cost of $3 million in FY 2025, and a total local cost of $12.8 million over the financial plan. Working with DHCF and advocates, Council staff requested an updated fiscal impact statement to more accurately reflect costs to implement this bill. This updated FIS calculates a local cost of $582,000 for FY2025, and a total local cost of $8.6 million over the course of the financial plan. Several factors affected the updated cost including:

- *Inclusion of Federal Funding*: DHCF will submit a waiver to CMS to allow for "unborn children" to be covered by CHIP starting October 1, 2024. Therefore, pregnant Alliance enrollees will be able to receive home visiting services with their CHIP coverage, and the District will not need to use local dollars for these visits, which reduced cost.
- *Reducing Home Visiting Capacity*: Estimates assumed a lower home visiting capacity in FY2025, originally 1,200, down to 930, which reduced cost.
- *Staggered Program Participant Approach*: In FY2025, the reimbursements will be restricted to programs that meet strict criteria, including: the home visitation model has been in existence for at least 3 years; is research-based; has demonstrated program-determined outcomes; is associated with a national organization; and meets HHS criteria for effectiveness, as determined by a Home Visiting Evidence of Effectiveness review. In the District, only the Nurse Family Partnerships program meets these criteria for FY2025.

[14] *DC Law 25-0321 Home Visiting Services Reimbursement Act of 2023.* (Effective March 23, 2024). Accessed May 5, 024 at: https://lims.dccouncil.gov/Legislation/B25-0321

In subsequent years, subject to available funding, more programs will likely be eligible to participate.

- *Delayed Coverage Start*: DHCF indicated during the budget oversight hearing that the January 1, 2025 start date was unrealistic given the timeline for developing and securing CMS approval of the State Plan Amendment (SPA) needed to implement these reimbursement changes. The Committee will change the start date to July 1, 2025, which is a more realistic time frame and also reduces FY2025 costs.
- *Regional Price Parity:* The original FIS used Virginia as a proxy for the cost of providing home visiting services in DC, which was too low. The updated FIS was increased to more accurately reflect home visiting services costs in the District.

Unfortunately, the Committee was not able to identify funding to implement the Home Visiting Bill, despite the lowered FIS. However, the Committee recommends that the Full Council identify the funds needed to implement D.C. Law 25-0321 and make progress towards improving wages for the District's home visitors, which will improve health outcomes for mothers, families, and children in the District.

Despite not being able to fund L25-0321, the Committee is pleased to accept a transfer from the Committee on Public Works and Operations of $100,000 to fund Nurse Family Partnerships, an integral Home Visiting program in the District.

Whole Person Care - 1115 Waiver Implementation

DHCF is in the midst of gathering public comments and finalizing their priorities ina advance of submitting their 1115 Demonstration Waiver to CMS by May 31, 2024. This waiver has three demonstration goals:

1. Continue to Maximize access to quality behavioral health services;
2. Improve health outcomes during transitions to reduce health disparities and drive sustainable transformation through justice-involved reentry and health-related social needs (HRSN) services; and
3. Develop and maintain infrastructure to support the delivery of reentry and HRSN services.

The Committee accepts a transfer from the Committee on Public Works and Operations of $400,000 to help support increased access to social services under Medicaid through the planning and implementation of the 1115 waiver demonstration. The Committee recommends that DHCF capitalize on these goals and integrate existing programs into the waiver process, to ensure as much continuity of services as possible, especially related to HRSN.

Behavioral Health

The Committee recommends maintaining the $10 million increase for the Behavioral Health Rehabilitation Local Match within the Department of Behavioral Health proposed budget, at $64.8 million, up from $54 million in FY 2024. The Council's Budget Office, after reviewing the FY 2024 spending for this line, concluded that they are spending at a rate to use all resources by the end of the fiscal year. DHCF and DBH collaborated to conduct a comprehensive review of behavioral health services in the District, to ensure District residents received quality behavioral health services by making payment methodologies and rates align with the cost of care. Through

this process the agencies adjusted payment methodologies and rates and added new services. The FY 2025 budget includes implementation of new rate study service recommendations and continued support for service recommendations implemented in FY 2023 and FY 2024.

Behavioral Health Transformation Waiver

In November 2019, DBH and DHCF proposed a multi-year initiative to transform behavioral health in the District. The two agencies began this initiative with a shared vision of establishing a whole-person, population-based, integrated Medicaid behavioral health system. The work was intended to be carried out in three phases: behavioral health service expansion (Phase I), managed care integration (Phase II), and integrated care payment models (Phase III). Phase I began in 2020 with joint collaboration between DBH and DHCF on the Section 1115 Waiver, which was developed to provide a range of behavioral health services and supports for individuals with serious mental illness, substance use disorder, and other behavioral health needs. Ten new benefits were added through the waiver program.

The FY 2025 proposed budget funding for the 1115 Behavioral Health Transformation Waiver was reduced by $21.4 million to $6.6 million. This $6.6 million was included to ensure continuity for two select behavioral health benefits from the original 1115 waiver: reimbursement for services provided in Institutions for Mental Disease (IMD), and removal of the MAT copays.

Phase II of the initiative—managed care integration—was paused in February 2024 when DHCF and DBH notified providers that due to spending pressures, the two agencies were pausing the carve in of behavioral health services into the managed care program, which resulted in a $13 million savings. DHCF testified during the Budget Oversight hearing that despite the current pause, they were open to implementing the carve-in in the future, if there was sufficient budget. Many providers were counting on this behavioral health carve-in to help defray costs and work towards the goal of an integrated care payment model. The Committee recommends continued conversation between DBH and DHCF to determine a plan of how best to execute this model.

Plan Offerings

Continuous Coverage for Children up to 12 Months

The Committee was pleased to see $6.85 million in funding for FY 2025 to comply with provisions included in the federal Consolidated Appropriations Act of 2023, which requires 12 months of continuous eligibility for all children in Medicaid and CHIP for children under the age of 19, regardless of change in circumstances, such as income, household composition, loss of SSI, or obtaining other health insurance.[15] This continuous coverage for children will provide some ease of mind for parents as the Medicaid unwinding and redetermination process ends.

[15] *H.R.2617. Consolidated Appropriations Act, 2023.* Accessed May 5, 024 at: https://www.congress.gov/bill/117th-congress/house-bill/2617

This funding covers a very similar population and policy goals as D.C. Law 25-144, the Childhood Continuous Coverage Act of 2023, which the Council passed last year.[16] The DC law would provide continuous coverage up to age 6, compared to 12-months of coverage up to age 19. DHCF indicated that beneficiaries for both policies would significantly overlap, and there would be minimal benefit to enacting both. The Committee agrees with this assessment, noting the extremely low FIS for L25-144, $90,000, indicating only a small amount of additional coverage. Therefore, the Committee chose not to fund the Continuous Coverage Act of 2023, with the expectation that the 12 months of continuous coverage will provide sufficient coverage for children in the District.

Infertility Diagnosis and Medication

The Council passed D.C. Law 25-34, the Expanding Access to Fertility Treatment Amendment Act of 2023, last year, and funded the Medicaid portions of the legislation in the FY 2024 budget.[17] This law requires, beginning January 1, 2024, that Medicaid and the Alliance provide coverage for the diagnosis of infertility and medically necessary ovulation enhancing drugs and medical services related to the prescribing and monitoring of these drugs, including at least three cycles of ovulation-enhancing medication.

On March 14, 2024, CMS approved DC State Plan Amendment #23-0016, which provided DHCF the authority for the DC Healthcare Alliance program and Medicaid to reimburse for select drugs when used to promote fertility.[18] While the bill was being considered before the Council, the DHCF had estimated that approximately 250 Medicaid and Alliance beneficiaries would use the newly covered drugs during the first year of implementation and approximately 60 beneficiaries would use them in each subsequent year. The larger number in the first year assumed a pent-up demand for services and the smaller number in the later years reflects an assumed lower level of utilization. DHCF projected the local cost at $700,000 in the first year of implementation and $200,000 in the second year. However, as of April 29, 2024, no individuals have yet to use the benefit, and there has been no local cost incurred.

Though the Committee does not believe that DHCF will be able to spend that level of funding on these services particularly in the next five months of FY 2024. However, the Office of the Chief Financial Officer did not certify a revenue reduction of those lines, explaining that because Medicaid is an entitlement program they must guarantee sufficient funds for each service.

Personal Care Aide (PCA) Services

The Mayor's proposed FY 2025 budget includes a $4.3 million reduction in PCA services. PCA Services are available to residents who are elderly or disabled and require assistance with their daily living activities. Program participants can receive assistance with bathing, grooming,

[16] *D.C. Law 25-144. Childhood Continuous Coverage Amendment Act of 2024.* D.C. Law Library (Effective 3/23/24). (https://code.dccouncil.gov/us/dc/council/laws/25-144#:~:text=To%20amend%20the%20Medical%20Assistance,and%20the%20Immigrant%20Children's%20Program). Accessed on 5/2/24.
[17] D.C. Law 25-34. *Expanding Access to Fertility Treatment Amendment Act of 2023.* D.C. Law Library (Effective 9/6/23). (https://code.dccouncil.gov/us/dc/council/laws/25-49). Accessed on 5/5/24.
[18] *District of Columbia's State Plan Amendment (SPA) 23-0016*. Center for Medicaid and CHIP Services. https://www.medicaid.gov/sites/default/files/2024-04/DC-23-0016.pdf. Accessed on 5/2/24.

dressing, toiletry, mobility, meal preparation, and eating. This reduction in PCA funds only reflects a change to the service authorization process; individuals' eligibility for (and the hourly payment rates for) PCA will not be impacted by this change. DHCF indicated that this policy change is being implemented to better align service authorization and delivery with clinical recommendations because their data show that individuals in Long Term Services and Supports (LTSS) programs often use PCA to the exclusion of other services, including day programs and rehabilitative options that may restore function or prevent decline.

DHCF's current authorization methodology allows the maximum possible hours per person based on each person's ability to independently perform activities of daily living (ADL). This change removes the automatic award of maximum hours and instead sets a more standardized set of hours allowable. Through this change, DHCF seeks to ensure PCA services remains an essential part of service plans but does not replace rehabilitative or other supports that also play a key role in maintaining the health and wellness of the LTSS users. The Committee acknowledges this reduction in services but encourages DHCF to allow flexibility and review their beneficiaries' needs on a case-by-case basis as appropriate to ensure they do not lose access to needed services.

The District Access System (DCAS)

DCAS is a technology system that provides the District with an integrated eligibility system for Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance to Needy Families (TANF). DCAS was developed in 2013 as a partnership between DHCF, the Department of Human Services, and the Health Benefit Exchange (HBX), to provide an integrated eligibility and enrollment platform to all District residents for health care and human services programs, including the insurance marketplace, integrated financial and plan management functionality, and case management capabilities.

DCAS consists of hard costs associated with operating of the eligibility system such as software licensing and the technical infrastructure, and oversight administrative costs for resources, support services, and system maintenance.

The FY 2025 DCAS budget is $77.46 million, a small increase from $77.02 million in FY 2024. The DCAS budget is broken into six expense categories, representing the major groupings used to track and monitor operational costs (see table below, shared by DHCF in a response to pre-hearing questions).

Expense Categories	**Total Budget**
Personnel: Contractor	$6,963,890.00
Personnel: FTE	$4,579,501.00
Rent & Facilities	$1,010,431.00
Equipment	$245,833.00
Software	$12,118,830.49
Services Contract	$52,548,834.98
	$77,467,320.47

Software and services contracts are the two largest components of the DCAS budget. The $12 million software expenses in FY2025 represents a $1.3 million increase from FY2024, largely due

to adjustments required to make DCAS cloud compatible. DCAS is also planning to purchase additional software tools to: (1) support user experience for caseworkers and District residents and (2) validate DC residents' personal information. This software to validate personal information is important because starting in 2025, CMS will no longer fully fund critical interfaces on the Federal Data Services Hub, and DCAS requires additional funding to purchase software to perform these validations.

The largest share of DCAS costs falls within the services contract line ($52 million). This category represents a host of service contracts including notice printing and mailing services, the DCAS Call Center, Office of the Chief Technology Officer Infrastructure services, and resource vendor contracts. Notice printing, while a federal requirement, is not a truly effective form of communication to Medicaid beneficiaries, and the Committee recommends communication with CMS about the value of this service relative to costs.

The Committee conducted an oversight hearing on DCAS in December 2023 and identified several problems. One problem: DCAS was the worst performing in the country for case and procedural error rates in FY 2022, which is especially concerning given the extremely high costs to operate the system. Another problem raised was that DCAS, a streamlined system, should eliminate the need for residents to repeatedly submit the same data by collecting that information from existing databases, like tax records. However, federal requirements for data verification processes have limited the extent to which DCAS was able to streamline this process, which makes it challenging and confusing for District residents to navigate.

The Committee recommends maintaining the budget for DCAS due to the need for additional IT/software support but encourages continued conversations between DHCF, the Department of Human Services, HBX, and other agencies that use DCAS, to continue to make improvements, both on the software side, and beneficiary and case manager user experience.

Medicaid Unwinding

Approximately 277,000 beneficiaries had been due to recertify for Medicaid during from May 2023 – March 2024. As of April 2024, DHCF data dashboards show 19,049 applications (6.3% of all applications) are pending. This marks the end of the year-long process to recertify the entire Medicaid population, after the expiration of the COVID-19 federal waiver to pause Medicaid recertifications. However, the Committee is concerned about the backlog of applications as DHCF prepares to enter a second round of recertifications.

DHCF data also showed that as of April 2024, 38,675 people were terminated due to non-response (12.9%). Due to the District's 90-day reinstatement/grace period, these disenrolled figures are likely to be lower when calculated at a future date, because during this grace period beneficiaries can still submit their completed recertification packet and be reconnected to their medical assistance. However, after that 90-day reinstatement period, beneficiaries are required to submit a new application in order to be reconnected to their coverage. The Committee notes that while DHCF is working to process applications, there are cases that slip through the cracks, and encourages diligence in responding to beneficiary concerns. The Committee also notes that increased investment in DCAS improvements should help with processing time and eligibility.

b. FISCAL YEAR 2025 - 2030 CAPITAL BUDGET RECOMMENDATIONS

The Mayor's proposed FY 2025 budget does not include new capital budget projects for DHCF.

3. COMMITTEE POLICY RECOMMENDATIONS

1. Leverage the 1115 Waiver to Enhance Primary Care and Social Service Integration

The Committee recommends that DHCF capitalize on the opportunities presented by the renewal of the 1115 waiver to strengthen the integration of social care into the health care system. The draft waiver includes proposals around:

- Housing, including rent/temporary housing assistance and other housing transition navigations;
- Nutrition, including nutrition counseling and education, produce prescriptions / grocery provisions;
- Case management, including linkages to other state and federal benefit programs;
- Health-related social needs infrastructure, including improvements to technology, development of business and operational practices, workforce development, and other stakeholder convening.

DHCF should consider investing in comprehensive care teams, including peer navigators and community health workers, to facilitate improved health outcomes in these areas.

DHCF has noted that while the current waiver expires on Dec. 31, 2024, CMS has a backlog of approvals, so to anticipate early 2025 for a potential approval of the new waiver. Knowing these time constraints, the Committee recommends DHCF implements parallel planning for the waiver, so programs and changes can be implemented as early and efficiently as possible.

2. Address the Direct Care Workforce Crisis by increasing workforce capacity and wages.

The Mayor's FY 2025 proposed budget does not include any wage increases for Direct Care Professionals, besides the increase for CNAs as detailed above, and wages for Direct Care Professionals in the District are not competitive with other jobs in this labor market.[19] The Committee recommends DHCF continue to develop longer-term plans to address the crisis in the long-term care workforce, including a career ladder enhanced wage for direct care professionals, the home health rate study, and collaboration with other agencies for workforce training.

[19] How States Are Expanding Home Care," AARP Bulletin, December 2023, Vol 54, No. 10, accessed on May 4, 2024 at: https://states.aarp.org/ltss-in-the-mid-atlantic

3. Implement Recommendations from the Behavioral Health Rate Study and Establish a Permanent Rate Setting Process for Behavioral Health Services.

The Committee recommends that DHCF and DBH continue implementation of recommendations from the community behavioral health rate study, specifically addressing the discrepancies in payment rates for Community Support Services, which have not been adequately adjusted for inflation. The Committee also recommends that DHCF and DBH establish a more permanent rate setting process that includes annual inflationary adjustments and periodic rebasing for community behavioral health services to help ensure that payment rates remain fair and adequate over time.

4. Expedite Rate Study for Dental Procedures to Increase Dentists' Wages

Dental services were reduced from $4.7 million in FY 2024 to $4.4 million in FY 2025. This may seem like a relatively small decrease compared to the rest of the budget, but this small decrease is devastating for dentists and dental practices, who are already feeling financial pressures. Dentists testified at the DHCF hearing about the need for increased payments – that the District is one of the most expensive markets to operate for dentists, and DHCF has not increased their Medicaid reimbursement rates for dentists since 2007 when Medicaid first added dentistry to the fee schedule. An ADA dental survey showed that some MCOs in DC pay their dentists between 43%-70% lower than regular FFS rates.[20] At the Budget Oversight hearing on 4/29, Director Turnage was surprised to hear this pay discrepancy and noted the agency's intention to address this. The Committee recommends that DHCF expedite their rate study for dental procedures and increase both FFS and MCO reimbursement rates.

[redacted]

[20] *Medicaid Reimbursement for Dental Care Services – 2022 Update.* Health Policy Institute and American Dental Association. (August 2023). Accessed May 5, 024 at: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/medicaid_reimbursement_dental_care_2022.pdf?rev=16c2f572ec974b01a787949294187ac6&hash=5869A65C6E259FED5733ECFEB5181E34

Office of the Deputy Mayor for Health and Human Services (HG0)

1. AGENCY MISSION AND OVERVIEW

The mission of the Office of the Deputy Mayor for Health and Human Services (DMHHS) is to support the Mayor in coordinating a comprehensive system of benefits, goods, and services across multiple agencies to ensure that children, youth, and adults with and without disabilities can lead healthy, meaningful, and productive lives.

Summary of Services

DMHHS provides leadership for policy and planning; government relations; and communication and community relations for the agencies under its jurisdiction, including:

1. Child and Family Services Agency (CFSA)
2. Department of Behavioral Health (DBH)
3. Department on Disability Services (DDS)
4. Department of Health (DC Health)
5. Department of Health Care Finance (DHCF)
6. Department of Human Services (DHS)
7. Department of Aging and Community Living (DACL)

DMHHS manages two special initiatives: Age-Friendly DC and the Interagency Council on Homelessness. DMHHS also oversees the administration's encampment cleaning and closure efforts.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2025 OPERATING BUDGET RECOMMENDATIONS

The Mayor's proposed FY 2025 operating budget for DMHHS is $2,480,487, which represents a 0.1% increase in operating funds, compared with the approved FY 2024 budget. The funding supports 12.8 FTEs, which is the same as the FY 2024 approved level. The Office also employs 7 Interagency FTEs budgeted in other agencies, 1 from Department of Health Care Finance and 6 from the Department of Human Services.

Encampment Cleaning and Closure

DMHHS leads the Executive's programs to clean and close encampments in the District, where unhoused individuals are living in tents or other non-permanent structures, and to work to connect those individuals with housing, behavioral health resources, and other supports. Although DMHHS leads this program, most of the funding for the program comes from other agencies, including the Department of Human Services, Department of Behavioral Health, and Department of Public Works. DMHHS shared the following table in its responses to the Committee's FY 2023 Performance Oversight pre-hearing questions, showing that the District spent a total of $4.5

million on encampment outreach and clearings in FY 2023, an increase of $576,000 over FY 2022 levels.

DHS	FY21	FY22	FY23
Encampment-Specific Outreach Staff and Equipment	$208,375	$1,252,500	$1,118,819.19
Outreach Staff Equipment (one-time cost)	$15,000	N/A	N/A
Client Related Costs	$14,000	$86,000	1,844,034.93
2 DHS FTEs (Housing Navigator and Encampment Liaison)	$35,333	$212,000	$182,534.32
Outreach/Communications Campaign Supplies	$1,150	$3,500	$1,751.52
DBH			
2 Multidisciplinary Teams (2 teams of 9 staff each)	N/A	$1,560,522	$634,787.53
DPW			
Encampment-Specific Trash Route	$84,049	$336,199	$300,400
Encampment-Specific Cleanup Team (7 staff)	$48,963	$293,780	$239,770
Expanded Biohazard Contract	N/A	$180,000	$180,000
Totals	$406,870	$3,924,501	$4,502,097.49

During this year's performance and budget oversight, the Committee heard concerns from advocates about several aspects of this program. First, advocates testified that DMHHS overuses its authority to conduct Immediate Dispositions, which must be "due to emergency, security risk, health risk, or safety risk" to clear encampments without notice.[21] In contrast, for a Standard Disposition, DMHHS must provide 14-days notice and conduct outreach with residents to notify them and try to connect them with housing prior to the disposition. This leaves outreach workers with inadequate time to work with residents within the encampments to connect them to services. This can also lead to residents' possessions being discarded during the Immediate Disposition, even though the District is required to store them. Advocates also testified that multiple encampment clearings in a single neighborhood, like the 7 encampments that DMHHS and the

[21] Office of the Deputy Mayor for Health and Human Services, District of Columbia Protocol for the Disposition of Property Found on Public Space and Outreach to Displaced Persons. Published Feb. 13, 2019. Accesses on May 3, 2024, at: https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/page_content/attachments/Encampments%20Protocol_12.13.19.pdf.

National Park Service plan to clear in May 2024 in the Penn West area, further disrupts outreach efforts.

The Committee does not make budget recommendations on the encampment cleaning and closure program since most of the budget lies within other agencies. That said, the Committee urges DMHHS to focus its resources on assisting the Department of Human Services with resource to clear the backlog of individuals with vouchers waiting to be matched with permanent housing, and improving its processes to build trust with individuals in encampments so that more will accept services and support.

The Committee recommends the Council adopt the Mayor's proposed DMHHS budget.

b. FISCAL YEAR 2024 - 2029 CAPITAL BUDGET RECOMMENDATIONS

The Mayor's proposed budget for the Office of the Deputy Mayor for Health and Human Services does not include any capital funds.

3. COMMITTEE POLICY RECOMMENDATIONS

The Committee recommends the agency adopt the following policy changes:

1. Take a more proactive, strategic role in leading on key interagency challenges, such as substance abuse, within the Health and Human Services cluster.

In addition to supporting the agencies in its cluster, DMHHS leads 3 specific interagency programs: Age-Friendly DC, the Interagency Council on Homelessness, and the Encampment Response Team. While these three initiatives certainly require an interagency approach, the Committee urges the Deputy Mayor's Office to reconsider its role on other critical cross-sector issues within the cluster, particularly substance abuse.

When asked by Chairperson Henderson at the FY 2025 budget oversight hearing why the Office does not take a more proactive coordinating role on more issues, Deputy Mayor Wayne Turnage testified that while there is an expectation that he would bring key issues to the Office of the City Administration that need interagency coordination, he relies on the agency directors to notify him whether issues require additional attention. Respectfully, DMHHS' role should be to identify interagency priorities and elevate issues where a single agency approach has not led to effective results.

The most glaring example of this is the opioid overdose crisis in the District. Despite the Department of Behavioral Health's efforts and three iterations of the Live. Long. DC (LLDC) Strategy, the District ranks first in the country for opioid-related fatal overdoses. As described in the DBH Chapter of this report, opioid-related fatal overdoses are at an all-time high. In 2023, there were 522 opioid-related fatal overdoses, averaging 43 deaths per month, reflecting a 13% increase. Even though LLDC names other agencies that should play a role in addressing this crisis, DBH has no authority to enforce the recommendations identified in the strategy. Moreover, DBH controls the Opioid Abatement Settlement Funds and leads the Opioid Abatement Commission, but is similarly not in the best position to coordinate what should be a strategic, interagency effort

to effectively distribute these funds. DMHHS would be the more appropriate leader of efforts to address substance abuse across the District, the Committee encourages the Office to embrace that role.

2. Take a more proactive, strategic role in addressing the delays in public benefits processing across the Health and Human Services cluster.

District residents have the right to expect efficient and compassionate public benefit processes, and the District is failing them across multiple programs within the Health and Human Services cluster. At the beginning of Fiscal Year 2024, more than 3,000 residents with housing vouchers have not been connected to housing due to bureaucratic delays and insufficient case managers at the Department of Human Services. The District was also the worst performing state in the country in 2023 for Supplemental Nutrition Assistance Program application processing. As of December 2023, 29% of all pending applications for MAGI Medicaid renewals had been pending for longer than 45 days and 15% for longer than 90 days, even though federal Medicaid regulations require these renewal applications to be processed within 45 days.

Deputy Mayor Turnage has testified multiple times before the Committee that he is not an expert on housing or homelessness, and that he would rather defer to his agency directors. In the FY 2023 performance oversight responses, when asked how DMHHS was assisting DHS in clearing the housing voucher backlog, DMHHS responded "DMHHS does not control the data that DHS has containing the number of individuals matched to a housing voucher." Similarly, at the December 2023 Oversight Roundtable hosted by the Committee on Public Benefit Processing and the DC Access System, Deputy Mayor Turnage testified that the delays in SNAP and Medicaid processing were due to staffing shortages at DHS.

While the Committee agrees that these delays in processing are partially due to insufficient staffing resources at DHS, the Committee urges DMHHS to take a more proactive role in identifying strategies to address these shortages, or invest in other solutions for more timely processing of applications.

3. Provide adequate funding for the Interagency Council on Homelessness to lead the District's strategy on meeting the needs of individuals and families who are homeless or at risk of homelessness.

In the responses to the FY 2025 Budget pre-hearing questions, DMHHS reports that the $173,367 allotted to the Interagency Council on Homelessness (ICH) is under the budget develop by the ICH of $301,000. DMHHS goes on to describe the ICH's proposed uses of those funds in FY 2025, including:

- $220,000 to develop the Homeward DC 3.0 Strategy, including expanding the scope to adequately speak to the needs of Aging Adults, Encampment and Unsheltered Residents, SMI/SUD and co-occurring, Returning Citizens, Young adults, and LGBTQIA;
- $51,000 to host meetings in accessible locations for ICH participants; and
- $30,000 to provide stipends for a robust and comprehensive Lived Experience Advisory Group.

The Committee encourages the Executive to identify full funding for the ICH and to protect the existing funding for the purposes outlined above. Concerningly, in Deputy Mayor Turnage's testimony, he states that DMHHS intends to repurpose the $173,367 from NPS to PS to fund a Community Outreach Specialist. Although the Deputy Mayor responded to a question about this decision by stating that it must have been an error, this seems unlikely given that the specific number for both the ICH NPS budget and the amount allocated for the new Community Engagement Specialist are exactly the same. The Committee urges DMHHS to provide sufficient funding for the ICH to carry out its statutorily required obligations (D.C. Code § 4–752.01 et seq.) and not sweep the funds to cover staffing needs in the Office.

Not-For-Profit Hospital Corporation Subsidy (United Medical Center)(HX0)

1. AGENCY MISSION AND OVERVIEW

The Not-For-Profit Hospital Corporation Subsidy provides a direct payment to the Not-For-Profit Hospital Corporation (NFPHC). The NFPHC is an independent District instrumentality, created by legislation adopted by the Council of the District of Columbia to hold the land, improvements, and equipment of the hospital known as United Medical Center.

NFPHC is governed by a Fiscal Management Board, which serves as a control board, consisting of 9 members, 7 of whom are voting members and 2 of whom are non-voting members. Voting members of the Fiscal Management Board include:

- The Chief Financial Officer of the District of Columbia, or his or her designee, who shall serve as chair of the Fiscal Management Board;
- The Deputy Mayor for Health and Human Services, or his or her designee;
- The Director of the Child and Family Services Agency, or his or her designee;
- One citizen member from either Ward 7 or Ward 8, appointed by the Mayor, who has experience in public health or health care delivery;
- A citizen member, appointed by the Mayor, who has experience serving as the City Administrator of the District of Columbia;
- An individual with expertise in hospital management or finance, appointed by the Mayor; and
- One representative from each of the two unions, selected by each representative union, maintaining the largest collective bargaining units at United Medical Center.

The Chief Executive Officer of the Corporation and the Chief Medical Officer of the Corporation serve as non-voting ex officio members.

COMMITTEE COMMENTS AND ANALYSIS

As the United Medical Center (UMC) prepares to close with the opening of a new hospital in Ward 8 the Cedar Hill Regional Medical Centere in early 2025, the Committee recognizes UMC's role in serving the residents of Southeast Washington, D.C. since 1966. Since this may be the last time UMC appears in the Committee budget report we want to take the opportunity to memorialize the hospital's history.

UMC, initially established as Morris Cafritz Memorial Hospital in 1966, was designed to serve the healthcare needs of Southeast Washington, D.C., and surrounding Maryland communities. The hospital was renamed Greater Southeast Community Hospital in 1974, and over the next decade expanded its facilities, including the addition of a 180-bed nursing home in 1980.[22] The hospital also added a second facility at Fort Washington Medical Center in Fort Washington, MD in 1983. Greater Southeast was renamed United Medical Center in 2008.[23]

[22] United Medical Center. (n.d.). About us. Retrieved from https://unitedmedicaldc.com/about-us/
[23] United Medical Center. (n.d.). About us. Retrieved from https://unitedmedicaldc.com/about-us/

The hospital underwent multiple ownership changes and significant investments in the early 2000s, but continued to struggle with service delivery, prompting the District to intervene.[24] In 2010, the hospital was integrated into the District of Columbia government under the Not-for-Profit Hospital Corporation (NFPHC).[25] According to PR18-1003, the Not-For-Profit Hospital Corporation Establishment Emergency Declaration Resolution of 2010, integration of the hospital into the District of Columbia government under NFPHC was driven by a need to address the hospital's deteriorating condition, safeguard patient safety, and resolve chronic financial and management problems.[26]

UMC's continued financial struggles over the years have been well-documented in various audit reports. One specific report, the "UMC Financial Statements FY 2019 and 2018," outlined several critical issues that contributed to the hospital's financial instability. This includes operational inefficiencies, mismanagement, and challenges related to maintaining an aging infrastructure within a high-need, low-income area.[27] Another report, "Not-For-Profit Hospital Corporation (UMC) Financial Statements and Independent Auditors' Report for Years Ended September 30, 2013, and 2012," highlighted similar long-standing issues, emphasizing the cyclical nature of UMC's financial challenges, which include handling large amounts of uncompensated care and the high costs associated with healthcare services delivery in economically disadvantaged areas.[28] Veritas took over the management of the hospital in 2016 to ensure that the hospital stayed financially feasible[29]. However, there were accusations of mismanagement and improper billing practices under the management of Veritas in 2017[30]. In August 2017, the DC Department of Health issued a 90-day shutdown order for the obstetrics ward after discovering multiple deficiencies in screening, clinical assessment, and delivery protocols at the facility.[31] Moreover,

[24] Council of the District of Columbia. (2009). PR18-1003 - Not-for-Profit Hospital Corporation Emergency Declaration Resolution of 2010. Retrieved from https://lims.dccouncil.gov/Legislation/PR18-1003
[25] United Medical Center. (n.d.). About us. Retrieved from https://unitedmedicaldc.com/about-us/
[26] Council of the District of Columbia. (2009). PR18-1003 - Not-for-Profit Hospital Corporation Emergency Declaration Resolution of 2010. Retrieved from https://lims.dccouncil.gov/Legislation/PR18-1003
[27] Office of the Inspector General. (2020, January 31). UMC financial statements FY 2019 and 2018. Retrieved from https://oig.dc.gov/reports/audit-reports/umc-financial-statements-fy-2019-and-2018
[28] Office of the Inspector General. (2014, April 14). Not-For-Profit Hospital Corporation (UMC) financial statements and independent auditors' report for years ended September 30, 2013, and 2012. Retrieved from https://oig.dc.gov/reports/audit-reports/not-profit-hospital-corporation-umc-financial-statements-and-independent
[29] Gooch, K. (2017, September 5). United Medical Center to evaluate Veritas consulting agreement amid financial troubles. Becker's Hospital Review. Retrieved from https://www.beckershospitalreview.com/finance/united-medical-center-to-evaluate-veritas-consulting-agreement-amid-financial-troubles.html
[30] Jamison, P. (2017, November 21). United Medical Center's top doctor is fired after criticizing hospital consultants. The Washington Post. Retrieved from https://www.washingtonpost.com/local/dc-politics/united-medical-centers-top-doctor-is-fired-after-criticizing-hospital-consultants/2017/11/21/1552f972-ced3-11e7-81bc-c55a220c8cbe_story.html
[31] Paavola, A. (2017, August 10). DC officials order 90-day shutdown of United Medical Center's maternity ward. Becker's Hospital Review. Retrieved from https://www.beckershospitalreview.com/patient-flow/dc-officials-order-90-day-shutdown-of-united-medical-center-s-maternity-ward.html

there were indications that hospital leaders had already been considering the closure of the ward prior to the official shutdown order due to ongoing operational challenges.[32, 33]

In September of 2017, the Mayor announced the release of a site study for the construction of a new hospital east of the Anacostia River, and in August of 2018, the Mayor announced the partnership with The George Washington University Hospital (GW Hospital) to develop a new acute care community hospital and health services complex located on the St. Elizabeths East campus in Ward 8[34],[35] . In 2019, a nine-member Fiscal Management Board for UMC was established through the Fiscal Year 2020 Budget Support Act of 2019, which also required that within four years, the hospital would finally close its doors. Through the Fiscal Year 2020 Budget Support Act of 2019, an annual subsidy cap of $15,000,000 was established to stabilize the hospital's operational budget amidst ongoing financial challenges while ensuring continued service delivery to the community until a new healthcare facility, Cedar Hill, could be established.[36] With this closure underway in a few years, the hospital began to see major changes, such as the transition of their second facility at Fort Washington Medical Center, becoming part of Adventist HealthCare system in 2019.[37] The hospital also closed its 180-bed nursing home in February 2021.[38]

Current Day Operations

Staffing is an on-going challenge for UMC, with fluctuations in workforce numbers impacting hospital operations and patient care. The hospital faced several labor disputes and negotiations over the years, reflecting broader trends in healthcare staffing shortages. During various hearings, hospital leadership acknowledged these challenges, emphasizing their ongoing efforts to address the concerns through strategic staffing solutions and improved labor relations. For instance, during the FY 2023 Performance Oversight Hearing for UMC, Dr. Jacqueline Payne-Borden, Chief Executive Officer, and Angell Jacobs, UMC Board of Directors Chair, testified on the increased usage of staffing agencies, particularly for clinical and administrative roles, to manage the ongoing difficulty in attracting and retaining staff, especially as the hospital approached closure.

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[32] Paavola, A. (2018, January 12). United Medical Center leaders allegedly planned to close obstetrics ward before public health officials ordered shutdown. Becker's Hospital Review. Retrieved from https://www.beckershospitalreview.com/patient-flow/united-medical-center-leaders-allegedly-planned-to-close-obstetrics-ward-before-public-health-officials-ordered-shutdown.html

[33] Nace, C. (2017, October 25). Why the Obstetrics Ward Ordered to be Shutdown at Washington D.C.'s United Medical Center. Paulson & Nace, PLLC. Retrieved from https://www.paulsonandnace.com

[34] Office of the Mayor. (n.d.). Bowser Administration Announces Release of Site Study for New Acute Care Hospital. Retrieved from https://mayor.dc.gov/release/bowser-administration-announces-release-site-study-new-acute-care-hospital

[35] Office of the Mayor. (n.d.). Mayor Bowser Announces Major Milestone in Partnership with George Washington University Hospital for New Hospital. Retrieved from https://mayor.dc.gov/release/mayor-bowser-announces-major-milestone-partnership-george-washington-university-hospital-new

[36] Council of the District of Columbia. (n.d.). B23-0209 - Fiscal Year 2020 Budget Support Act of 2019. Retrieved from https://lims.dccouncil.gov/Legislation/B23-0209

[37] Adventist HealthCare. (n.d.). Fort Washington Medical Center. Retrieved from https://www.adventisthealthcare.com/locations/profile/fort-washington-medical-center/

[38] District of Columbia Health Care Facilities. (2022). Nursing Homes Directory. Retrieved from the directory listing dated March 17, 2022

UMC serves a critical role in providing healthcare to Wards 7 and 8, an area recognized for significant health disparities. The population UMC serves is predominantly low-income, underserved communities that face a high prevalence of chronic diseases and have historically limited access to healthcare services.[39] Despite the myriad challenges it has faced, UMC has steadfastly provided critical healthcare services. UMC currently operates 330 beds, including in-patient psychiatric beds, and has implemented changes aimed at enhancing service quality and operational efficiency, reflecting a commitment to improving patient care despite its financial and administrative obstacles. Its role in delivering essential health services and acting as a health care anchor in the region underscores the importance of sustaining healthcare infrastructure in underserved areas, contributing significantly to public health resilience and community well-being.

Transition to New Hospital

The transition from UMC to the new Cedar Hill Regional Medical Center is a crucial step towards modernizing healthcare infrastructure east of the Anacostia River. The new facility, scheduled to open in early 2025, will offer advanced medical services with a focus on patient-centered care. This transition is anticipated to address previous shortcomings by providing enhanced care capacities, better facilities, and a renewed focus on community health needs.[40] In preparation for the closure, UMC plans to hire a consulting firm with expertise in hospital closures to assist with the development and implementation of a closure plan. The decision to engage external experts underscores the hospital's commitment to maintaining service continuity and safeguarding patient care during the transition period.

This complex history outlines the significant milestones, challenges, and transitions faced by UMC over the years, highlighting its impact on the community and the evolving healthcare landscape in Southeast D.C.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2025 OPERATING BUDGET RECOMMENDATIONS

The Mayor's FY 2025 proposed subsidy for the Not-For-Profit Hospital Corporation reflects a decrease of $15,000,000 in recurring Local Funds, and a one-time increase of $25,200,000. The Mayor transitioned recurring funds to one-time funds with the expectation that FY 2025 will be the last year the hospital incurs operating costs. At the Committee of the Whole Budget Hearing on April 3, 2024, the Mayor testified that the one-time increase of $10.2 million, over the standard $15 million subsidy, is intended to support the hospital's operational needs as it prepares for closure.

The Committee questions the necessity of allocating $10.2 million above the annual subsidy for the hospital, especially considering its impending closure in early 2025. The Committee has provided UMC leadership and the Office of the Chief Financial Officer with three opportunities to submit a detailed spending plan for the one-time $10.2M increase—during the FY 2025 Budget

[39] District of Columbia Department of Health. (2022). *Health Equity Summit Summary*. Washington, D.C.: Author.
[40] Gray, V. C. (2020, July 1). Report on Bill 23-0777, "New Hospital at St. Elizabeths Amendment Act of 2020". Retrieved from https://lims.dccouncil.gov/Legislation/B23-0777

Hearing and through two rounds of written post-hearing questions. Despite these requests, the provided plans have remained insufficiently detailed, leaving significant uncertainties about how the funds would be effectively utilized. For example, UMC provided the following list in response to a "detailed" spend plan:

Related Benefits

Severance Cost	$4,200,000
COLA and Retention Cost	$1,600,000
Related Benefits	$1,400,000
Total	$7,200,000

Record Retrieval and Destruction

Pick, Delivery and Other	$200,000
Destruction	$2,800,000
Total	$3,000,000

Total for Benefits and Record Retrieval and Destruction	$10,200,000

The Committee questions the assumptions that went into calculating $7.2 million for Severance and Related Costs. A critical concern for the Committee is the basis for the severance package calculations for the hospital's 638 full-time employees (FTEs). The assumption that a significant number of these employees will opt for the severance package is questionable, particularly with the anticipated rise in attrition as the closure nears. At the Budget Oversight Hearing, Dr. Payne-Borden noted the expectation of increased staff attrition during this period. Furthermore, UMC's documentation suggests that severance may be provided for nearly all full-time staff, contradicting the predicted attrition rates. Additionally, UMC has indicated that employees transitioning to Cedar Hill Regional Medical Center with *any* employment gap would also receive severance, complicating the financial forecasts. Moreover, the allocation of $2,8 million for record destruction lacks detailed justification. This substantial figure calls for a critical review, especially considering the need to prioritize essential spending during the hospital's winding down period.

Adding further uncertainty to the accuracy of UMC's estimate of severance and operating costs, the hospital appears to be closing down health care services prematurely and without adequate notice to staff or patients. The Committee was notified on April 19, 2024 of the impending closure of UMC's Center for Advanced Wound Care and Hyperbaric Medicine on April 30, 2024. Despite having just had a detailed discussion with UMC leadership about its plans to wind down operations at the Budget Oversight Hearing, the Committee only learned about this closure from an e-mail from the outgoing Director of the Center. UMC appears to have violated the State Health Planning and Development Agency's 90-day notice requirement, and left extremely ill patients with less than a month's notice to find alternative care. In addition to being concerned about the implications of this decision on patient care, the Committee notes that such unplanned closures indicate that the hospital has no firm sense of its operational costs or workforce over the next fiscal year. This reduced operational scope should prompt a critical review of all planned expenditures, ensuring

that the remaining funds are optimally used to support essential services and facilitate a smooth transition during the hospital's closure period.

The Committee also questions the allocation of $2,800,000 for record destruction given the lack of detailed justification provided. This substantial amount earmarked for the process of handling and destroying records demands a thorough review to ensure financial prudence, particularly during a period when the hospital is winding down. Typically, record destruction involves costs associated with secure handling, transportation, and the actual destruction of documents to protect sensitive patient information. However, the figure presented appears unusually high, suggesting a possible overestimation or inefficient allocation of funds.

In light of these considerations, the Committee requested a reduction of $1,250,000 from the $10,200,000 proposed one-time increase, but the Office of the Chief Financial Officer (OCFO) would not certify the reduction. In its first denial of the certification, OCFO stated that the funding level was a "legislative requirement". When the Committee explained that the legislative requirement (the proposed Budget Support Act subtitle) could be amended, the OCFO responded that "to ensure that until UMC's doors close, *[sic]* the OCFO determined that the hospital needed additional funding above the $15 million in FY 2025 and required the Mayor to increase the budget to $25.2 million to address that need. As such, any reductions to the FY 2025 proposed amount would unbalance the budget and plan." Once again, the OCFO provides no rationale for this funding level. The Committee is particularly concerned that the OCFO, which is intended to be a neutral third-party financial auditor, in this case is also leading the hospital's finances. **The Committee therefore urges the full Council to continue requesting a more thorough financial plan, and that funds above what is needed for a successful closure be redistributed to other budget priorities.**

b. FISCAL YEAR 2025 - 2030 CAPITAL BUDGET RECOMMENDATIONS

The Mayor's proposed budgets for the Not-for-Profit Hospital Corporation and the Not-for-Profit Hospital Corporation Subsidy do not include any capital funds.

3. COMMITTEE POLICY RECOMMENDATIONS

1. *Collaborate with the Deputy Mayor for Health and Human Services and community leaders to develop, publish and execute a comprehensive closure plan that emphasizes transparency and public engagement.*

The Committee recommends that the United Medical Center Board of Directors and leadership continue their collaboration with the Deputy Mayor for Health and Human Services, Wayne Turnage, who also sits on the UMC Board, and actively engage with community leaders to refine and execute a comprehensive closure plan. Recognizing that UMC is in the process of hiring a consultant with expertise in hospital closures, the plan should integrate their expert recommendations to ensure a meticulous and transparent closure. This plan should detail strategies for resource management, patient transfers, and staff transitions, with an emphasis on transparency. To bolster public confidence and engagement, UMC should host a series of public meetings to discuss the closure timeline, address community concerns, and gather feedback. The

updated plan should be regularly shared with the public to reflect new data and progress in the closure process.

2. *Work with Cedar Hill Regional Medical Center and Universal Health Services to ensure the safe transfer of patients and the transfer of staff to the new hospital, whenever possible.*

As UMC approaches its closure, the Committee recommends strengthening partnerships with Cedar Hill Regional Medical Center and Universal Health Services, which is essential for ensuring a smooth transition for patients and facilitating potential opportunities for staff. UMC has proactively launched the Voluntary Health Care Professional Training Program, aimed at preparing staff to apply for new positions at Cedar Hill or other healthcare facilities. This program equips them with the necessary training and support but does not guarantee employment. As of March 27, 2024, according to Board meeting minutes, the program has engaged 115 participants, with 51% completing at least one training module. In addition to training, UMC offers career counseling and placement services to help staff effectively navigate their transition to new roles, whether at Cedar Hill or elsewhere. These initiatives are critical in maintaining continuity of care and supporting the workforce as they move to new opportunities in the healthcare field.

3. *Ensure adherence to the State Health Planning and Development Agency (SHPDA) guidelines for facility closures, a crucial part of maintaining transparency, protecting patient rights, and mitigating negative impacts on the community.*

The Committee underscores the importance of full compliance with SHPDA policies as UMC proceeds with closing facilities, including the Center for Advanced Wound Care and Hyperbaric Medicine. As noted earlier in this chapter, the Center was scheduled to close with less than 30 days' notice, contravening SHPDA regulations that mandate a 90-day public notification and a comprehensive impact assessment. Such short notice can lead to abrupt service discontinuation, leaving patients scrambling for essential care and staff uncertain about their employment future. Adherence to these guidelines is vital not only to ensure a structured and humane transition but also to uphold the trust and welfare of the patients and staff who rely on UMC's services. Compliance with SHPDA standards helps ensure that closures are managed in a way that minimizes disruption and maintains continuity of care for patients, which is especially critical in communities already underserved by healthcare infrastructure.

Health Benefit Exchange Authority (H10)

1. AGENCY MISSION AND OVERVIEW

The DC Health Benefit Exchange Authority was established in the District of Columbia to develop and operate the District's online health insurance marketplace in accordance with the Patient Protection and Affordable Care Act, thereby ensuring access to quality and affordable health care to District of Columbia residents and small businesses.

Summary of Services

In March 2010, the Patient Protection and Affordable Care Act was signed into law by President Barack Obama with the central goal of ensuring that all Americans have access to quality, affordable health care. This legislation enabled significant health insurance reforms, including the establishment of Health Benefit Exchanges nationwide.

The DC Health Benefit Exchange Authority is a quasi-governmental agency of the District of Columbia government, charged with implementing and operating the District's Health Benefit Exchange. This Exchange operates DC Health Link, an online insurance marketplace for District residents and small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Through DC Health Link, residents can qualify for lower premiums and cost-sharing reductions and enroll in a health plan that best meets their needs.

As of January 31, 2024, the District of Columbia Health Benefit Exchange Authority is in its twelfth year of operations and has concluded its eleventh open enrollment period for people purchasing individual insurance.

A significant portion of the operations is IT Related Operations that provides development, operations, maintenance, and security for DC Health Link, the District's online health insurance marketplace. This includes operations and maintenance of HBX systems, managing the team of consultants that develop functionality for DC Health Link, and managing the Electronic Data Interchange (EDI) Operations team that oversees information transmitted between carriers and DC Health Link.

Program Structure

The Health Benefit Exchange Authority operates through the following 4 programs:

1. **Consumer Education and Outreach**: Educates and informs District residents, small business owners, and small business employees about quality affordable private health insurance options available through DC Health Link. This program includes Business Partners who educates District small businesses and their employees about DC Health Link private health insurance options through events, webinars, digital and social media.
    - Activities:

- Consumer Education and Outreach Support Services
- Marketing and Communication
- Navigators Certified Application Counselors and In-Person Enrollment Help

2. **Marketplace Innovation Policy and Operations**: Performs functions required of all state-based marketplaces, including enrollment help, eligibility determinations, plan management and certification of qualified health and dental plans.
    - Activities:
        - Contact Center Services
        - Data Analytics and Reporting
        - Eligibility and Enrollment
        - Member Services
        - Planning Management
        - SHOP (Small Group Marketplace)

3. **Agency Management**: Provides for administrative support and the required tools to achieve operational and programmatic results. Standard for all agencies using performance-based budgeting.

4. **Agency Financial Operations**: Provides comprehensive and efficient financial management services to, and on behalf of, District agencies to maintain the financial integrity of the District of Columbia. Standard for all agencies using performance-based budgeting.

2. COMMITTEE BUDGET RECOMMENDATIONS

a. FISCAL YEAR 2025 OPERATING BUDGET RECOMMENDATIONS

The Mayor's FY 2025 proposed operating budget for the DC Health Benefit Exchange Authority (HBX) is $41,752,784 which represents a 11.2% increase in operating funds compared with the approved FY 2024 budget. HBX is funded through Enterprise and Other Funds. The bulk of HBX's budget is funded through an assessment fee on health insurers in the District. The increase in the FY 2025 budget is largely to support an increase of 5.0 FTEs in the Marketplace Innovation Policy Operations program and to fund additional IT operations.

COMMITTEE COMMENTS AND ANALYSIS

HealthCare4ChildCare

The Committee is deeply concerned with the nearly $300 million Pay Equity Fund being stricken from the Mayor's FY 2025 proposed budget and the implications this will have for the HealthCare4ChildCare (HC4CC) program within HBX. The Pay Equity Fund is a first-in-the-nation program aimed at achieving pay parity between early childhood educators and their K-12 counterparts. As part of the Pay Equity Fund, the Office of the State Superintendent for Education (OSSE) provides funds through an interagency transfer to HBX to administer HC4CC, which provides free or low-cost health insurance premiums through DC Health Link for employees and

their dependents who work at participating District-based OSSE-licensed child development centers and homes. The reduction of the Pay Equity Fund will not only affect early child educators' income, but also their access to health insurance.

In both FY 2023 and FY 2024, HBX received $18 million to operate the HC4CC program. HC4CC pays for a large portion of employer premiums; for every $1 HC4CC spends on group coverage, employers contribute 35 cents. These premiums are guaranteed for 12 months once an employee or employer enrolls in the program. One hundred percent of the HC4CC funding goes towards the premiums, and the cost of administering HC4CC is absorbed by HBX. HC4CC coverage allows those who are enrolled comprehensive insurance coverage; about half of people covered by HC4CC are enrolled in a standard plan, meaning all their essential care, like primary care and specialist care visits, generic prescriptions, and urgent care are covered without deductibles.

As of April 2024, 198 businesses in the District have enrolled in HC4CC, representing 55% of eligible District businesses, a 20% increase from 2023. Over half (109 businesses) had not offered health insurance prior to HC4CC due to cost, and HBX spent significant time and resources educating and building trust with the businesses and their employees to share the value of HC4CC. Businesses that enrolled in the HC4CC are located across the District; 86 of those 109 businesses are in Wards 1, 4, 5, 7, and 8. Other demographic information about beneficiaries as of April 2024 include:

- 1,619 people are currently enrolled in HC4CC.
  - 8 of 10 enrollees are women (1,295 women).
  - 1 in 10 enrollees are children (194 children).
  - HC4CC covers workers in all age groups but there has been a growing share of enrollees age 55+.

The Committee commends Director Mila Kofman and the staff at HBX for their collaboration with OSSE to facilitate affordable health insurance coverage for early childhood educators and partnering with the early childhood development facilities through this program since 2023. **The Committee recommends that the Committee of the Whole restore the full funding for the Pay Equity Fund, including the $12 million necessary to maintain the current level of coverage for the HealthCare4ChildCare Program. Restoring the full $18 million for the program would be needed to continue to grow the program to serve more Child Care Centers and employees.**

IVF Coverage

In 2023, the Council unanimously passed D.C. Law 25-49, the Expanding Access to Fertility Treatments Amendment Act. This law requires health insurers offering large group health benefit plans to cover the diagnosis and treatment of infertility, including in vitro fertilization (IVF) and standard fertility preservation services beginning January 1, 2025.[41] Diagnosis and medical treatment of infertility for Medicaid patients went into effect January 2024, and private insurers in

[41] *DC Code § 31–3834.06. Coverage of fertility treatments.* | D.C. Law Library. (Effective Sept. 6, 2023). https://code.dccouncil.gov/us/dc/council/code/sections/31-3834.06#:~:text=(e)%20Coverage%20for%20the%20treatment. Accessed on May 3, 2024

the District are required to cover the services mentioned above in their 2025 plans. The last population that needs to be covered are those with coverage through DC Health Link, whose plans will not include these new services unless the Council pays for defrayal costs as estimated by the Chief Financial Officer and as required by the Centers of Medicare & Medicaid Services (CMS).[42]

On November 15, 2023, CMS issued "Notice of Benefit and Payment Parameters for 2025 Proposed Rule" with new rules about defrayals.[43] Specifically, beginning as early as 2025, a state that had been defraying costs of an Essential Health Benefit (EHB) will be permitted to stop, as long as the benefit has been added to the state's benchmark plan and CMS had been notified. Since HBX and the Department of Insurance, Securities and Banking (DISB) notified CMS about the District's inclusion of IVF and fertility coverage as a new EHB before May 1, 2024, the District will only need to defray costs for these benefits for plan year 2025.[44]

The Committee has been working closely with HBX and DISB to determine the defrayal costs and process of reimbursement. HBX will retroactively reimburse insurers on a case-by-case basis for claims made during plan year 2025. HBX assumes there will be a three-month lag between the conclusion of a plan year and when they receive a request for reimbursement from the insurer. Thus, the first time HBX could issue a defrayal payment for this fertility benefit, for plans that start in January 2025 will be in FY 2026, and HBX will make final defrayal payments for plans that begin at the end of the plan year, December 2025, in FY 2027. HBX and the Office of Revenue Analysis provided the following score for implementing this benefit, which is consistent with the low-range from DISB's actuarial study:

Total Cost by Fiscal Year for PY 2025 Claims	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**	**Total**
Defrayal Costs	$0	$175,000	$245,000	$0	$420,000

Therefore, the Committee recommends an enhancement of $175,000 in FY 2026 and $245,000 in FY 2027 in enterprise and other funds for Program 700065 Member Services, Cost Center 70468 Program Management and Account 7141009 Subsidies to cover defrayal costs for insurers under DC Health Link to implement the Expanding Access to Fertility Treatment Amendment Act of 2023. The Committee understands that HBX submitted their benefit structure to include IVF coverage to CMS and will continue to work with DISB to ensure the plans cover this benefit. The Committee also recommends HBX develop educational and communications materials to share with the Health Plans and beneficiaries to increase education and awareness about this new benefit.

[42] *45 CFR 155.170* | https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-B/section-155.170. Code of Federal Regulations. (Updated April 16, 2024). Accessed on May 5, 2024.
[43] *HHS Notice of Benefit and Payment Parameters for 2025 Final Rule.* (April 2, 2024). https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule. Accessed on May 5, 2024.
[44] *Essential Health Benefits and Selecting a New Benchmark Plan.* | DC Department of Insurance, Securities, and Banking & DC Health Benefit Exchange Authority. (April 26, 2024). https://disb.dc.gov/page/essential-health-benefits-and-selecting-new-benchmark-plan. Accessed on May 6, 2024.

Equity-Based Benefit Design

The Committee also commends HBX for the significant efforts it has made and continues to make to improve plan coverage design to address key areas of health disparities. Coverage design improvements include:

- Type 2 diabetes care coverage: including insulin, lab work, eye and foot exams, prescriptions, and supplies without co-payments, co-insurance, or deductibles, beginning January 1, 2023.
- Pediatric mental and behavioral health coverage: Cost-sharing for these services have been reduced to $5 for office visits, down from $45, including certain lab work, and medication, beginning January 1, 2024.
- Cardiovascular and cerebrovascular disease medical care coverage: no cost sharing, deductible, or co-insurance for office visits with family medicine or internal medicine doctors, or generic prescriptions, lab work, and imaging services including CT scans and ECGs, beginning January 1, 2025.

Each of these programs is an important step to improve health equity in the District, and the Committee supports HBX in these efforts.

Medicaid Unwinding

The Committee commends Director Kofman and the HBX team for their collaboration with the Department of Healthcare Finance (DHCF) in the Medicaid unwinding and renewal process. This collaboration was critical to ensure continuity of coverage for people who were no longer eligible for Medicaid and needed coverage on the individual market. To facilitate this process, DHCF provided monthly reports to HBX on how many individuals were set to lose Medicaid that month who were likely eligible for Health Link. Between May 2023 to March 2024, there were 310 households likely eligible for DC Health Link coverage, and 35% of those households enrolled in health care coverage.

DHCF and HBX also worked to ensure continuity of coverage for the approximately 1,000 Medicaid enrollees that are employees of OSSE-licensed childcare facilities. HBX worked with DHCF to move the Medicaid redetermination for this population to April 2024, the end of the first year of redeterminations. HBX sent communications out to this group in early March 2024 as a reminder for them to complete their renewals and also provided information about how to sign up for HealthCare4ChildCare in case they lost their Medicaid coverage. HBX saw a slight increase in request for appointments due to this outreach.

b. FISCAL YEAR 2025 - 2030 CAPITAL BUDGET RECOMMENDATIONS

The Mayor's proposed budget for HBX does not include any capital funds.

3. COMMITTEE POLICY RECOMMENDATIONS

1. *Continue to monitor the stability of District health insurance rates and explore new and existing partnerships to make health care insurance more accessible.*

The Committee is proud of the near universal insurance coverage in the District: nearly 97% of DC residents have health insurance. Since DC Health Link opened, the uninsurance rate has been cut in half, and DC continues to rank #2 in the US for the lowest uninsured population. The Committee is also proud of the interagency work done between HBX and DHCF in the past year to ensure those who were at risk of losing their health coverage knew about coverage options through the Exchange. The Committee recommends DHCF and HBX continue open lines of communication, especially through the end of the special enrollment period, which CMS extended to November 30, 2024, so those who are no longer eligible for Medicaid can transition to marketplace coverage.

2. *Continue outreach to District Business communities to increase awareness of health insurance options.*

The Committee commends HBX on the work their staff have done to build relationships with various Chambers of commerce in the District, and outreach to individual businesses. For example, the DC Chamber of Commerce sent over 900 marketing and promotional emails to their small business partners, made 383 in-person connections, and referred over 50 businesses. The Committee recommends HBX continue and build upon their outreach to these groups to increase awareness of health insurance options and opportunities.

Fiscal Year 2024 Revised Local Budget Recommendations

Full information about recommended current year budget revisions and related adjustments can be found in Attachment A.

Budget Support Act Recommendations

Recommendations on Mayor's Proposed Subtitles

The Committee provides comments on the following subtitles of the "Fiscal Year 2025 Budget Support Act of 2024":

- Title IV, Subtitle B. Healthy Schools Fund
- Title V, Subtitle A. Direct Care Professional Payment Rates
- Title V, Subtitle B. Health Services Planning Program
- Title V, Subtitle C. Medicaid Inpatient Fund and Directed Payments
- Title V, Subtitle D. Medicaid Outpatient Fund and Directed Payments
- Title V, Subtitle E. Medicaid Hospital Outpatient Supplemental Payment and Hospital Inpatient Rate Supplement Adjustments
- Title V, Subtitle H. Healthy DC Fund
- Title V, Subtitle I. Not-For-Profit Hospital Corporation Subsidy
- Title V, Subtitle M. Birthing Hospital Childcare Grants

The legislative language is included in Attachment F.

TITLE IV, SUBTITLE B. HEALTHY SCHOOLS FUND

Purpose, Effect, and Impact on Existing Law

As introduced in the Mayor's FY 2025 proposed budget, this subtitle proposed to amend the Healthy Schools Act of 2010 to repeal the Healthy Schools Fund (Fund) and its annual sales tax dedication of $5.69 million, replacing it with one-time local funds for Fiscal Year 2025. Additionally, it would eliminate the requirement for the Fund to be used to support the Environmental Literacy Program, grants for school gardens, health education promotion, and nutrition education integration into the school day.

The Committee Print recommends several changes to the subtitle as introduced. The Print recommends rejecting the Mayor's proposed changes that would have eliminated the requirements that the Fund support grants for the Environmental Literacy Program, school gardens, health education promotion, and nutrition education integration into the school day. The Committee recommends keeping the removal of the dedicated tax.

Committee Recommendation and Reasoning

The Committee believes that it is critical that the Fund maintains the funding amount of $5.69 million in FY 2025 and keeps in place the existing required Fund allocations. Retaining initiatives supported by the Healthy Schools Fund is vital to continue programming that substantially improves the health, wellness, and nutrition of public-school students in the District.

The Committee was unable to identify recurring funding throughout the financial plan for the Fund. The Committee would welcome changes that would establish local recurring funding in the Committee of the Whole.

The Committee recommends inclusion of this subtitle, including the changes incorporated in the Committee Print, in the Budget Support Act.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Healthy Schools Act of 2010 to eliminate the Healthy Schools Fund; to establish a local funding amount of $5,690,000 for Fiscal Year 2025; and to repeal the sales dedication tax that previous funded the Fund.

Fiscal Impact

The Mayor's proposed budget allocates $5.69 million in one-time Local funding that will be used to support programs that the Healthy Schools Fund currently supports. Because of the reallocation of the dedicated tax funding to the Healthy Schools Fund, local funds revenue is increased by $5.69 million annually and a total of $22.76 million over the four-year financial plan.

The Office of Revenue Analysis reports that there is no fiscal impact associated with the Committee's recommended changes.

TITLE V, SUBTITLE A. DIRECT CARE PROFESSIONAL PAYMENT RATES

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Direct Support Professional Payment Rate Act of 2020 by delaying the requirement that Department of Health Care Finance (DHCF) reimburse base payments to direct care services providers on average a wage greater than either 117.6% of the minimum, or living wage, whichever is higher, from FY 2025 to FY 2026.

The Committee Print amends the subtitle as introduced by requiring the Mayor to use Home and Community-Based Services American Rescue Plan Act funds to provide the FY 2025 reimbursement for base payments to direct care services providers on average a wage greater than either 117.6% of the minimum, or living wage, whichever is higher. The Committee Print also delays the requirement that direct care providers must demonstrate to the Mayor that they paid their direct care professionals wages on average, the higher of either 117.6% of the minimum wage or living wage, from FY 2025 to FY 2026, to be consistent with the date change requirements across the subtitle.

Committee Recommendation and Reasoning

The Mayor's proposed subtitle, as introduced, delayed DHCF's responsibility to reimburse direct care service providers through Medicaid from FY 2025 to FY2 026. The Fiscal Impact Statement for the subtitle stated that the Executive intended to pay for the FY 2025 wage increase with Home and Community Based (HCBS) American Rescue Plan Act (ARPA) funds, but this commitment was not codified in the legislative language. The Committee's proposed edits codify the requirement for the Mayor to use the HCBS ARPA funds for these wages. The Committee added a new subsection that requires direct care providers who received a supplemental payment through

the HCBS ARPA fund to also demonstrate they paid according to the law's requirements. This change ensures the reporting requirement is consistent across fiscal years, regardless if the payment is from Medicaid FFS or the HCBS ARPA fund.

The HCBS Enhancement Fund was established to collect unspent Local funds from FY 2021 and 2022 equivalent to the amount of federal funds attributable to the Federal Medical Assistance Percentage (FMAP) increase, as authorized by the American Rescue Plan Act of 2021. The federal Centers for Medicare & Medicaid Services (CMS) required that the District use the savings that resulted from the temporary increase to implement activities that enhance, expand, or strengthen Medicaid HCBS, and that DHCF must spend all HCBS Enhancement Funds by March 31, 2025. Therefore, the Committee's edits to the subtitle require DHCF to make a one-time supplemental payment (composed of $20.19 million of local HCBS Funds and $47.10 million of federal Medicaid funding) to fund the wage increases for all of calendar year 2025, which will cover FY 2025 and part of FY 2026.

The Committee recommends inclusion of this subtitle, including the changes incorporated in the Committee Print, in the Budget Support Act.

Section-by-Section Analysis

Sec. XXXX Short title.

Sec. XXXX Amends the Direct Support Professional Payment Rate Act of 2020 by striking the implementation date of FY 2025 and replaces that date with FY 2026 as the new date for the Mayor to determine and pay the reimbursement rate that the District will pay direct care workers through Medicaid FFS; adds a new subsection that requires the Mayor to provide supplement payments to direct care workers through the Home and Community Based Fund in FY 2025; strikes FY 2025 and replaces that date with FY 2026 as the new date that direct care service providers who received Medicaid funding must demonstrate to the Mayor that it paid its direct care workers the appropriate ages, equal to the greater of either 117.6% of the District's minimum or living wage; and adds a new subsection that requires a direct care service provider who received a supplemental payment from the District in FY2025 to demonstrate to the Mayor that it paid its direct care workers the appropriate ages, equal to the greater of either 117.6% of the District's minimum or living wage.

Fiscal Impact

The Mayor's proposed 2025 budget includes $20.19 million of local HCBS Enhancement Fund money and $47.10 million of federal Medicaid funding to pay for wage increases for HCBS professionals. DHCF will make a one-time supplemental payment to fund the wage increase for all of calendar year 2025. Delaying the inclusion of HCBS provider pay increases into fee-for-service base reimbursement rate and instead using a one-time supplemental payment using HCBS Enhancement Funds will result in local savings of $15.14 million in fiscal year 2025 and $5.14 million in fiscal year 2026. Savings in fiscal year 2026 occur because three months of calendar year 2025 fall within fiscal year 2026.

The Office of Revenue Analysis reports that there is no fiscal impact associated with the Committee's recommended changes.

TITLE V, SUBTITLE B. HEALTH SERVICES PLANNING PROGRAM

Purpose, Effect, and Impact on Existing Law

This subtitle proposed to exempt certain health centers and clinics with less than ten full- or part-time staff from applying for a Certificate of Need (CON) from the State Health Planning and Development Agency (SHPDA). Currently, all new health services must obtain a CON from SHPDA that demonstrates a public need for the new health service, facility, or expenditure. Under the subtitle, exempted centers and clinics would still be required to obtain a registration from SHPDA.

Committee Recommendation and Reasoning

The Committee believes this subtitle takes too narrow a view of the need for Certificate of Needs reforms, and bases the exemption on number of employees rather than types of services provided. However, the Committee does agree on the need for a larger conversation about reforming the Certificate of Need process, and plans to work closely with DC Health and stakeholders to develop more strategic improvements.

Therefore, the Committee recommends against moving this subtitle.

TITLE V, SUBTITLE C. MEDICAID INPATIENT FUND AND DIRECTED PAYMENTS

Purpose, Effect, and Impact on Existing Law

This subtitle as introduced creates a new special purpose revenue fund that DHCF will administer, beginning October 1, 2024, that taxes each qualified hospital on their inpatient net revenue at a universal rate, the average commercial rate (ACR). The tax will generate an amount sufficient to fund the Inpatient Hospital Directed Payment Fund, from which the District would deduct a 12% District Retention. The District Retention will be used for Medicaid FFS local funding and will partially fund the salary and benefits of one FTE, but could also be absorbed into the General Fund. MCOs administer the remainder (the local share of the fund), which receives a federal match. The total amount (local share + funds from the federal match) is paid back to the hospitals as the Inpatient Hospital Directed Payment.

Committee Recommendation and Reasoning

The Committee Print increases the District Retention from 12% to 13.125%. This will generate approximately an additional $814,562, which the Committee proposes using to partially fund D.C. Law 25-124, the Prior Authorization Reform Amendment Act of 2023, which passed in November 2023. The law establishes prior authorization guidelines and requirements that health insurance utilization review entities must follow and includes four components: Accelerated Prior Authorization Review, Five-Year Determination History, Adverse Determination and Appeals Credentialing Requirements, and Public Facing Determination Statistics. The Committee

recommends funding two of the four components of the bill: Accelerated Prior Authorization and Adverse Determination.

Second, the Committee proposes amending the subtitle to require that DHCF includes in the preprint, which will be submitted to CMS, directions for the hospitals to spend their additional revenue on specific policy goals, including enhancing care coordination, addressing social determinants of health (with a specific focus on improving nutrition), improving maternal and child health outcomes, discharge for long term care and transitions of care plans, substance use, and workforce pipelines.

The Committee recommends inclusion of this subtitle, including the changes incorporated in the Committee Print, in the Budget Support Act.

Section-by-Section Analysis

Sec. 5021 Short title.

Sec. 5022 Sets definitions, including: Department, District Retention, Fund, Hospital, Hospital System, Medicaid, Inpatient Revenue (and calculations), and State Directed Payment.

Sec. 5023 Establishes the Inpatient Hospital Directed Payment Provider Fee Fund, which is administered by DHCF and includes revenues and fees. Funds can only be used to make payments to MCOs to fund the inpatient hospital directed payments, provide refunds in case of CMS dis-approval, and pay the District retention which will fund: (1) the salary and benefits of one FTE, (2) the local match for Medicaid FFS payments, and (3) payments to fund the Prior Authorization provisions.

Sec. 5024 Establishes the inpatient hospital fee, which taxes each hospital on its inpatient net patient revenue. This section also details how the fee is calculated and adjusted based on hospital needs, and exempts Howard University Hospital and St. Elizabeths hospital from the fee. If CMS does not approve the exemption, then the hospitals will be subject to the fees.

Sec. 5025 Requires the subtitle to take effect as of October 1, 2024, subject to CMS approval, and sets guardrails on returning funds in case CMS does not approve the Medicaid preprint. This section also requires DHCF to include the Committee's policy priorities in the preprint.

Sec. 5026 Requires MCOs to use the Inpatient Hospital Directed Payment Provider Fee Fund to make their inpatient directed payments to hospitals, consistent with the Medicaid preprint.

Sec. 5027 Establishes the cadence for calculating the hospital fees and sets penalties for hospitals who fail to pay their fees.

Sec. 5028 Sets guidance that hospital systems who own, operate, or maintain more than one hospital in the District have to pay the fee for each hospital separately. This section also sets guidance and fees for hospitals that cease operations.

Sec. 5029 Allows the Mayor to issue rules to implement provisions of the subtitle.

Sec. 5030 This subtitle sunsets on September 30, 2029.

Fiscal Impact

The expected local revenue of the Inpatient Hospital Directed Payment Fund is $81 million in FY 2025 and $324.66 million over the financial plan. In FY 2025, the MCO Local Separate Payment totals $72.4 million and the 12% District Retention would have totaled $8.7 million. The District Retention fee was intended to supplement medical expenditures ($8.69 million in FY2025) and fund one FTE plus benefits ($70k in FY2025). In future years the District Retention could be used for the General Fund, but that is not reflected across the financial plan.

The Committee recommends increasing the District retention rate by 1.125% total, from 12% to 13.125%. This will generate an additional $814,562 in revenue, which the Committee proposes using to partially fund D.C. Law 25-124, the Prior Authorization Reform Amendment Act of 2023, which passed in November 2023. To implement the committee's changes to this subtitle $814,562 was reduced from 1011 Dedicated Taxes, Cost Center H3201 Medicaid Provider Payments, Account 714100C Government Grants and Subsidies.

TITLE V, SUBTITLE D. MEDICAID OUTPATIENT FUND AND DIRECTED PAYMENTS

Purpose, Effect, and Impact on Existing Law

This subtitle creates a new special purpose revenue fund that DHCF will administer, beginning October 1, 2024, that taxes each qualified hospital on their outpatient gross revenue at a universal rate, the average commercial rate (ACR). The tax will generate an amount sufficient to fund the Inpatient Hospital Directed Payment Fund, from which DHCF will deduct a 12% District Retention. The District Retention will be used for Medicaid FFS local funding and will partially fund the salary and benefits of one FTE. MCOs administer the remainder (the local share of the fund), which receives a federal match. The total amount (local share + funds from the federal match) is paid back to the hospitals as the Outpatient Hospital Directed Payment.

Committee Recommendation and Reasoning

The Committee recommends increasing the District Retention from 12% to 13.125%. This will generate approximately an additional $466,049, which the Committee proposes using to partially fund D.C. Law 25-124, the Prior Authorization Reform Amendment Act of 2023, which passed in November 2023. The law establishes prior authorization guidelines and requirements that health insurance utilization review entities must follow and includes four components: Accelerated Prior Authorization Review, Five-Year Determination History, Adverse Determination and Appeals Credentialing Requirements, and Public Facing Determination Statistics. The Committee recommends funding two of the four components of the bill: Accelerated Prior Authorization and Adverse Determination.

Second, the Committee proposes amending the subtitle to require that DHCF includes in the preprint directions for the hospitals to spend their additional revenue on specific policy goals, including enhancing care coordination, addressing social determinants of health (with a specific focus on improving nutrition), improving maternal and child health outcomes, discharge for long term care and transitions of care plans, substance use, and workforce pipelines.

The Committee recommends inclusion of this subtitle, including the changes incorporated in the Committee Print, in the Budget Support Act.

Section-by-Section Analysis

Sec. 5031 Short title.

Sec. 5032 Sets definitions, including: Department, District Retention, Fund, Hospital, Hospital System, Medicaid, Outpatient Revenue (and calculations), and State Directed Payment.

Sec. 5033 Establishes the Outpatient Hospital Directed Payment Provider Fee Fund, which is administered by DHCF and includes revenues and fees. Funds can only be used to make payments to MCOs to fund the outpatient hospital directed payments, provide refunds in case of CMS dis-approval, and pay the District retention which will fund: (1) the salary and benefits of one FTE, (2) the local match for Medicaid FFS payments, and (3) payments to fund the Prior Authorization provisions.

Sec. 5034 Establishes the outpatient hospital fee, which taxes each hospital on its outpatient gross patient revenue. This section also details how the fee is calculated and adjusted based on hospital needs, and exempts Howard University Hospital and St. Elizabeths hospital from the fee. If CMS does not approve the exemption, then the hospitals will be subject to the fees.

Sec. 5035 Requires the subtitle to take effect as of October 1, 2024, subject to CMS approval, and sets guardrails on returning funds in case CMS does not approve the Medicaid preprint. This section also requires DHCF to include the Committee's policy priorities in the preprint.

Sec. 5036 Requires MCOs to use the Outpatient Hospital Directed Payment Provider Fee Fund to make their outpatient directed payments to hospitals, consistent with the Medicaid preprint.

Sec. 5037 Establishes the cadence for calculating the hospital fees and sets penalties for hospitals who fail to pay their fees.

Sec. 5038 Sets guidance that hospital systems who own, operate, or maintain more than one hospital in the District have to pay the fee for each hospital separately. This section also sets guidance and fees for hospitals that cease operations.

Sec. 5039 Allows the Mayor to issue rules to implement provisions of the subtitle.

Sec. 5040 This subtitle sunsets on September 30, 2029.

Fiscal Impact

The expected local revenue of the Outpatient Hospital Directed Payment Fund is $46.4 million in FY 2025 and $185.6 million over the financial plan. In FY 2025, the MCO Local Separate Payment totals $41.4 million and the 12% District Retention totals $5 million. In future years the District Retention could be used for the General Fund, but that is not reflected across the financial plan.

The Committee recommends increasing the District retention rate by 1.125% total, from 12% to 13.125%. This will generate an additional $466,049 million in revenue, which the Committee proposes using to fund D.C. Law 25-124, the Prior Authorization Reform Amendment Act of 2023, which passed in November 2023. To implement the Committee's changes to this subtitle $466,049 was reduced from 1011 Dedicated Taxes, Cost Center H3201 Medicaid Provider Payments, Account 714100C Government Grants and Subsidies.

TITLE V, SUBTITLE E. MEDICAID HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT AND HOSPITAL INPATIENT RATE SUPPLEMENT ADJUSTMENTS

Purpose, Effect, and Impact on Existing Law

This section updates the definition of outpatient gross patient revenue and inpatient net patient revenue to conform with the definitions used in Subtitles V(C) and V(D). This Supplemental Subtitle also exempts Howard University Hospital and St. Elizabeths Hospital from the ACR tax as defined in the earlier subtitles.

Committee Recommendation and Reasoning

The Committee recommends including the subtitle in the BSA with technical drafting changes.

Section-by-Section Analysis

Sec. 5041 This section names the subtitle to be cited as the "Medicaid Hospital Outpatient Supplemental Payment and Hospital Inpatient Rate Supplement Adjustments Amendment Act of 2024."

Sec. 5042 This section amends DC Code 44-664 to define "outpatient gross patient revenue" and exempts Howard University and St. Elizabeths from being taxed at the ACR.

Sec. 5043 This section amends DC Code 44-664, to define "inpatient net patient revenue," exempts Howard University Hospital and St. Elizabeths Hospital from being taxed at the ACR, and repeals subsection (C) of the code.

Fiscal Impact

This subtitle does not have a cost, because it only makes confirming changes to make definitions and exemptions consistent.

TITLE V, SUBTITLE H. HEALTHY DC FUND

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Hospital and Medical Services Corporation Regulatory Act of 1996 by requiring a transfer of $5,567,566 from the Healthy DC Fund to Local funds in Fiscal Years 2025-2028.

The Healthy DC Fund is a special purpose revenue fund that collects MCO taxes and DHCF allocates for Managed Care expenditures.

Committee Recommendation and Reasoning

The funds taken from the Healthy DC Fund to the General Fund have already been allocated for other purposes in the Mayor's proposed budget. The Committee cannot take additional funding from the Healthy DC Fund to use for any Committee-related budget purposes, because the entire fund balance has been allocated for FY 2025.

The Committee recommends inclusion of this subtitle in the Budget Support Act without change.

Section-by-Section Analysis

Sec. 5071 Short title.

Sec. 5072 This section amends DC Code 31-3514.02 to add a subsection that transfers $5.57 millions to the General Fund each year of the financial plan.

Fiscal Impact

The FY 2025 budget includes a transfer of $5,567,566 in dedicated taxes from the Healthy DC Fund to Local funds, reducing revenue available to be budgeted in the Healthy DC tax fund and increasing local funds. This transfer will be included in each fiscal year throughout the plan. The Committee did not make any changes to the subtitle.

TITLE V, SUBTITLE I. NOT-FOR-PROFIT HOSPITAL CORPORATION SUBSIDY

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Not-for-Profit Hospital Corporation Establishment Amendment Act of 2011 by modifying the earlier established financial cap of $15,000,000 and increasing it to $22,000,000 for Fiscal Years 2022 and 2024, and up to $26,000,000 for fiscal years thereafter. It also modifies the timelines for subsidies provided to the Not-for-Profit Hospital Corporation.

Committee Recommendation and Reasoning

The Committee generally supports the subtitle's objective to adapt the financial support for the Not-for-Profit Hospital Corporation to meet evolving operational needs. Although the Committee

has remaining questions about the calculations behind the $10.2 million increase (described in detail in the Not-for-Profit Hospital Corporation budget chapter), the Office of the Chief Financial Officer did not certify a reduction to these funds, so there are no changes to this subtitle.

The Committee recommends including the subtitle in the BSA with technical drafting changes.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends to the Not-for-Profit Hospital Corporation Establishment Amendment Act of 2011 to require that, starting after September 30, 2024, the subsidy for the Not-for-Profit Hospital Association may be as much as $26 million annually.

Fiscal Impact

The Mayor's FY 2025 proposed budget includes $25.2 million in subsidy payments to support the operation of inpatient, outpatient, psychiatric, and emergency care services at UMC.

TITLE V, SUBTITLE M. BIRTHING HOSPITAL CHILDCARE GRANTS

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Department of Health Functions Clarification Act of 2001 by creating a new grant in Fiscal Year 2025 totaling $300,000 to be awarded to one or more non-governmental entities to provide childcare to pregnant and birthing parents or legal guardians who are receiving urgent treatment related to pregnancy at a hospital or birthing facility in the District.

Committee Recommendation and Reasoning

The Committee recommends several changes to the subtitle, as introduced. The Committee changes the title of the subtitle from "Birthing Hospital Childcare Grants" to "Childcare for Pregnant and Birthing Parents Grants" to clarify that the grants may go to childcare organizations instead of birthing hospitals. The Committee also adds specific language indicating that the grant is for FY 2025 and that the total must be $300,000, which the Mayor had allocated for this subtitle but was not reflected in the legislative text.

The Committee also expands the language to allow for legal guardians, as well as parents, to be eligible for this service, and expands the language to include birthing facilities, in addition to hospitals, to be eligible locations for the childcare. The Committee also adds a requirement that childcare provided for 5 hours or less must occur on-site at the hospital or facility, and that childcare lasting more that 5 hours may include the transfer of the child to a licensed childcare facility, with notice to the parents or legal guardians. Finally, the subtitle clarifies that these grants are to provide childcare for "urgent treatment related to pregnancy", which includes healthcare treatment outside of standard prenatal care and labor and delivery services.

The Committee recommends inclusion of this subtitle, including the changes incorporated in the Committee Print, in the Budget Support Act.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sex. xxx2 Amends the Department of Health Functions Clarification Act of 2001 by requiring the Department of Health to create a new grant program in Fiscal Year 2025 totaling $300,000 to non-government entities to provide childcare to pregnant and birthing parents and legal guardians who are receiving urgent treatment related to pregnancy at a hospital or birthing facility in the District. The section requires the grantee to provide on-site childcare for childcare lasting 5 hours or less, and allows for off-site childcare at a childcare facilities for childcare lasting more than 5 hours, with notice to DC Health and the parent or legal guardian. The section also defines "on-site childcare" and "urgent treatment related to pregnancy" for purposes of this subtitle.

Fiscal Impact

The Office of Revenue Analysis communicated to the Committee that this subtitle will cost $300,000 in one-time funding, which the Mayor already included in the Fiscal Year 2025 proposed budget.

Recommendations for New Subtitles

The Committee recommends the following new subtitles of the "Fiscal Year 2025 Budget Support Act of 2024":

- Grocery Access Pilot Program
- Mental Health Court Urgent Care Clinic
- Opioid Abatement Directed Funding
- Prior Authorization Reform Amendment
- School-Based Behavioral Health Student Peer Educator Pilot
- Substance Abuse and Behavioral Health Services Targeted Outreach Grant
- Sexual Health Peer Educators Grant
- Tobacco Use Cessation Initiatives
- S2A Repeals

The legislative language is included in Attachment G.

TITLE V, SUBTITLE X. GROCERY ACCESS PILOT PROGRAM

Purpose, Effect, and Impact on Existing Law

This subtitle would amend the Department of Health Functions Clarification Act of 2001 to establish a grocery access grant pilot program for the purpose of providing up to 1,000 eligible District residents with membership to a grocery delivery service at no cost for one year. The subtitle also would give preference to an applicant who lives in a low-food access area and requires that at the conclusion of the one-year pilot program, that the Department of Health incorporate the

data collected in the program in their Supplemental Nutrition Assistance Program Education (SNAP-Ed).

Committee Reasoning

By offering membership to a grocery delivery service at no cost for one year to up to 1,000 eligible residents, the Committee views this pilot program as an innovative approach to addressing food access challenges for vulnerable populations. Despite the District government's longstanding efforts to attract new supermarkets to low food access areas, little progress has been made. Evaluation of various programs aimed at tackling food access issues has revealed that nearly $29 million in foregone District revenues has not resulted in significant impacts on supermarkets' location decisions. Eligibility for this grocery delivery membership is extended to District residents currently enrolled in the District's SNAP-Ed program, which serves individuals of all ages across all eight wards of the city. By prioritizing applicants from low-food access areas the subtitle aims to address the needs of communities disproportionately affected by food insecurity. Furthermore, the data collected during the pilot will be instrumental in informing future efforts to enhance food access across the District.

Section-by-Section Analysis

Section xxx1 Short title.

Section xxx2 Amends the Department of Health Functions Clarification Act of 2001 to establish a grocery access grant pilot program for the purpose of providing up to 500 (or 1,000) eligible District residents with membership to a grocery delivery service at no cost for one year; gives preference to applicants in Wards 5, 7, and 8; requires that at the conclusion of the one-year pilot program, that the Department of Health incorporate the data collected in the program in their Supplemental Nutrition Assistance Program Education (SNAP-Ed).

Fiscal Impact

The Office of Revenue Analysis reports that the cost of this subtitle is $120,000 in one time local funds for Program 700028 Nutrition And Physical Fitness, Cost Center 70057 Nutrition And Physical Fitness Bureau, and Account 7141007 Grants & Gratuities.

TITLE V, SUBTITLE X. MENTAL HEALTH COURT URGENT CARE CLINIC

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Department of Behavioral Health Establishment Act of 2013 to require DBH to contract with a non-governmental organization to establish and manage a mental health urgent care clinic situated within the Moultrie Courthouse at 500 Indiana Avenue, N.W., of the Superior Court of the District of Columbia.

Committee Reasoning

Established in 2008, the Urgent Care Clinic (UCC) caters to individuals engaged with the court system who require mental health or substance use services. Its mission is to enhance access to

care, positively impacting community well-being by providing same-day psychiatric assessments and facilitating connections to community-based treatment providers and essential support services such as housing, clothing, or food. Through crisis intervention, temporary treatment provision, and long-term treatment referrals, the clinic plays a pivotal role in disrupting cycles of untreated mental illness and incarceration. This innovative model effectively addresses the multifaceted needs of court-involved individuals, preempting costly and unnecessary interventions while fostering improved outcomes and community safety.

Since 2012, Pathways to Housing, a District non-profit, has operated the UCC at DC Superior Court. According to testimony from the organization's President and CEO, Christy Respress, presented at the FY 2025 Department of Behavioral Health budget oversight hearing, the clinic has served over 7,100 unique adults and youth, with tens of thousands of follow-up visits. Despite reduced utilization during the pandemic due to virtual court proceedings, the clinic served 132 clients in FY 2022, 189 clients in FY 2023, and as of April 2024, 315 clients in FY 2024. Sustaining the clinic's operation is crucial for ensuring equitable access to mental health services and averting unnecessary crises.

The Committee heard from several agencies and organizations including the Public Defender Service for the District of Columbia (PDS), the United States Attorney's Office (USAO) for the District of Columbia, and the American Federation of Government Employees, AFL-CIO regarding the importance of the UCC. Katerina Semyova, Special Counsel to the Director for Policy, PDS, shared that PDS has "…used the Urgent Care Clinic to get people into same-day treatment, avoiding being stepped back to the jail pending a bed-to-bed transfer…They are able to intervene in mental health crises at the courthouse, and refer to treatment as necessary once the acute crisis has been managed. Without access to this clinic, court-involved individuals with mental illness will be disenfranchised once again, as their access to voluntary services will be severed."

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Department of Behavioral Health Establishment Act of 2013 to require DBH to contract with a non-governmental organization to establish and oversee a mental health urgent care clinic within the Moultrie Courthouse at 500 Indiana Avenue, N.W., of the Superior Court of the District of Columbia; establishes qualifications for organizations eligible to apply for the contract; outlines required activities for the Urgent Care Clinic.

Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $907,000 in recurring funds, which is equal to the cost of the contract. The funding was provided in the Mayor's proposed Fiscal Year 2025 budget for the Department of Behavioral Health.

TITLE V, SUBTITLE X. OPIOID ABATEMENT DIRECTED FUNDING

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Opioid Abatement Fund Establishment Act of 2022 by allocating funds from the Opioid Abatement Fund for several key purposes. First, it directs DBH to utilize these funds for targeted outreach services addressing behavioral health and substance abuse issues in Wards 5 and 6. Second, the funds will support the implementation of the School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2024. Additionally, funds will be allocated to the Office of the Chief Medical Examiner to enable the testing of illicit drug misuse and the development of innovative testing methods for opioids within the agency.

Committee Reasoning

With nearly $50 million in settlement funds expected over 18 years, the District's Opioid Abatement Fund was created in 2022 and is administered by the Office of the Attorney General (OAG). The fund is intended to support programs and initiatives that address the opioid crisis in the District. DBH's proposed FY 2025 budget includes $14,656,000 in the Opioid Abatement Fund. In the District, the use of the opioid settlement funds is governed by the Opioid Litigation Proceeds Amendment Act of 2022[45]. Under this law, DBH was required to establish an Office of Opioid Abatement and work with the Mayor and the DC Council to establish an Opioid Abatement Advisory Commission ("Commission"). The 21-member Commission was seated in October 2023, the first meeting took place on October 25, 2023, and the Committee has met monthly since then. Details on the Commission, including a full list of Commission members, meeting minutes, and the links for meetings can be found on DBH's website.[46]

Monies from the Opioid Abatement Fund are designated for specific purposes outlined in D.C. Code § 7–3221 including funding for the Opioid Abatement Advisory Commission and the Office of Opioid Abatement, conducting needs assessments, granting awards for prevention, recovery, treatment, or harm reduction activities related to opioid use disorder, and evaluating the effectiveness of these initiatives. Additionally, funds may be used for infrastructure development, data tracking, and audits. Expenditures must comply with court orders, and any expenditures must complement existing funds rather than replace them.

Following the Commission's recommendations during the February 2024 meeting, DBH devised a schedule for implementing these suggestions. Within the first 9 months of its inception, DBH has disbursed $2.7 million in grants and contracts using Opioid Abatement Funds, with plans to allocate an additional $2.8 million by June. Moreover, as indicated in post-budget hearing responses, the agency intends to publish a Notice of Funding Availability for up to $7 million on its website by the end of May. Initial grants and contracts encompass funding for a youth prevention media campaign, expansion of youth substance use disorder treatment services, augmentation of existing faith-based prevention programs, enhancements of the FEMS Overdose Response Team, and bolstering housing services for consumers post-SUD treatment.

Through this subtitle, the Committee directs DBH to allocate Opioid Abatement Funds to three initiatives that align with recommendations from the Commission to DBH. These initiatives aim to advance the District's efforts in combating substance abuse, promoting behavioral health services, and enhancing community well-being. The initiatives include:

[45] Opioid Litigation Proceeds Amendment Act of 2022." D.C. Law 24-315.
[46] https://dbh.dc.gov/page/opioid-abatement-advisory-commission-01

4. **$400,000 to expand the Substance Abuse and Behavioral Health Targeted Outreach Grants** to include sites in Wards 5 and 6. This initiative pilots the effectiveness direct support, relationship development, and resource brokering to individuals in need of substance abuse and behavioral health services in the District.

5. **$325,000 to continue the School-Based Behavioral Health Peer to Peer Pilot** for a second year. This program, created by the Council in the FY 2024 budget, provides grants to a Community-Based Organization to train and supervise a team of students who enhance access to behavioral health services and resources while educating their peers on behavioral health topics, including opioid and drug prevention.

6. **$400,000 to restore the funding loss resulting from the expiration of a federal grant for the Office of the Chief Medical Examiner Illicit Drug Surveillance:** This funding sustains the Office of the Medical Examiner's forensic toxicology testing capabilities and supports the development of innovative forensic testing methods. These tests provide important data on suspected opioid-related fatalities, enabling agencies to strategize and respond effectively to the opioid crisis. They involve the analysis of tissue, blood, and other samples from individuals suspected to have died from an opioid overdose. Without this work, a comprehensive understanding of the role of opioids and other toxic substances in District fatalities would be unattainable.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Opioid Abatement Fund Establishment Act of 2022 by requiring DBH to allocate Opioid Abatement Funds for targeted outreach services addressing behavioral health and substance abuse issues in Wards 5 and 6, funding for a second year of the School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2024, and funds to the Office of the Chief Medical Examiner to test illicit drug misuse.

Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $1,125,000 which will be paid from the Mayor's proposed Fiscal Year 2025 budget authority of the Opioid Abatement Fund within the Department of Behavioral Health.

TITLE V, SUBTITLE X. PRIOR AUTHORIZATION REFORM AMENDMENT

Purpose, Effect, and Impact on Existing Law

This subtitle would amend the Prior Authorization Reform Amendment Act of 2023 to exclude health benefits plans provided through Medicaid and the DC HealthCare Alliance from requirements regarding data transparency for prior authorization, including making 5 years of prior authorization requests available on a patient's online portal, and making statistics regarding prior authorization determinations available on the insurer's website.

Committee Reasoning

D.C. Law 25-0100, the Prior Authorization Reform Amendment Act of 2023, improves access to health care by establishing a suite of guidelines and protections to ensure District residents enrolled in health benefit plans can access medications and medically appropriate care without undue burden or delay. This legislation went into effect for private insurance plans on the effective date of the legislation, January 17, 2024. However, because the Department of Health Care Finance estimated a financial impact to implement the legislation for Medicaid and the DC HealthCare Alliance, beneficiaries of these programs do not yet benefit from the prior authorization reforms.

The Fiscal Impact Statement totals $25,405,000 ($7,095,000 local; $18,310,000 federal Medicaid match) over the financial plan for the legislation to apply to Medicaid and Alliance. This FIS includes costs for 4 requirements established by the legislation:

1. $7.036 million for required Accelerated Prior Authorization Review ($2.01 million local; $5.026 million federal Medicaid match);
2. $3.975 million for the requirement that utilization review entities (health insurers) provide 5 years of prior determination history on their patient portal
3. $11.012 million for the requirement of increased credentials for Adverse Determination and Appeals ($3.011 million local; $8.001 federal Medicaid match); and
4. $3.383 million for utilization review entities to include public facing determination statistics on their websites ($931,000 local; $2.452 million federal Medicaid match).

The Committee is please to have identified funds to implement the (1) Accelerated Prior Authorization Review and (3) Increased credentials for Adverse Determination and Appeals in its FY 2025 Budget Report. Implementing these provisions will create creater parity in health care access for beneficiaries of Medicaid and Alliance and individuals on private insurance. The Committee does not allocate funding to implement requirements (2) and (4) because the Committee has reason to believe that the Managed Care Organizations (MCOs) who are the utilization review entities for Medicaid, will develop patient portals over the next few years, at which point the cost of these requirements would significantly decrease.

Therefore, the Committee recommends this subtitle, which carves out health benefits plans provided through Medicaid and the DC HealthCare Alliance from these requirements.

Fiscal Impact

The Office of Revenue Analysis states that there is no impact to this subtitle, however it is related to the budget because this amendment is required for the Committee to repeal the subject to appropriations clause for the Prior Authorization Reform Amendment Act of 2023.

TITLE V, SUBTITLE X. SCHOOL-BASED BEHAVIORAL HEALTH STUDENT PEER EDUCATOR PILOT

Purpose, Effect, and Impact on Existing Law

This subtitle would amend the Early Childhood and School-Based Behavioral Health Infrastructure Act of 2012, effective June 7, 2012 (D.C. Law 19-141, D.C. Official Code § 2-1517.31 *et seq.*) to establish a second year of the school-based behavioral health student peer educator pilot program for at least 100 District public and public charter high school students.

Committee Reasoning

The mental health of youth in the District, like youth across the nation, has been declining steadily for over a decade, and the COVID-19 pandemic exacerbated this crisis. According to the American Psychological Association, more than half of teens reported feeling more stressed, sad, or hopeless, and lonelier because of the pandemic. The Office of the State Superintendent (OSSE) 2021 Youth Risk Behavior Survey (YRBS) revealed that a significant percentage of youth in the District reported feeling sad or hopeless for two consecutive weeks, with an increase from 2017. The data on suicide is alarming, with 25% of females and 10% of males in high school reporting that they thought seriously about suicide; and 21% of females and 10% of males reporting that they had a plan. The survey also found increases in disordered eating behaviors among students, and a concerning percentage (28%) of high school students reporting witnessing physical violence in their neighborhood. Additionally, almost a third of all students reported being in a physical fight in the past year.

Over the past four years, the Committee has heard from students during performance and budget oversight hearings, expressing concerns about the lack of accessible and quality behavioral health services and supports in their high schools. In response, the Committee proposed in the FY 2024 budget the addition of a subtitle, the School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2023, aimed at closing the gap in access to behavioral health services by involving students in the initiative. With an allocation of $325,000, DBH was tasked with awarding funds to one or two community-based organizations to recruit, train, and supervise at least 100 peer educators, with a preference for programs targeting high schools in Wards 5, 7, and 8. This subtitle establishes a second year of this pilot program. During the FY 2025 Department of Behavioral Health budget oversight hearing, Carmen Brito, a Senior at Jackson Reed High School, expressed concern about the lack of mental health education in District schools. She emphasized, “The lack of mental health education is a big problem in schools. When students do not have the time to develop resilience-building skills, they are less able to deal with stress on their own.” Similarly, Nyla Anderson, a Junior at Benjamin Banneker, highlighted the impact of her school’s stressful academic environment on students' mental health. She described instances where students experienced breakdowns and panic attacks due to academic pressure, stating, “There have been students who have broken down due to the grades, having panic attacks in class. The school continues to neglect the competitive nature [of] the school environment. Many students come to school even when they're ill or not in the best mental state just to make sure that their grades don't dwindle from missing the day.”

The involvement of students as behavioral health peer educators within their schools represents a pivotal approach in addressing the mental health needs of adolescents. Classroom presentations conducted by peer educators not only disseminate vital information but also serve as catalysts for destigmatizing mental health issues within school communities. Collaborating with school clinicians further strengthens the continuum of care by ensuring that students receive comprehensive support tailored to their individual needs. Additionally, distributing materials on resilience-building topics empowers students with practical tools to navigate challenges and develop coping skills. Finally, individual education sessions conducted by peer educators offer personalized guidance and support, fostering a culture of mutual aid and promoting overall well-being among students.

In FY 2025, through this pilot program, DBH will establish a second year of the school-based behavioral health student peer educator pilot, by continuing to provide grants to previous grantees previously awarded funds in FY 2024 to recruit, train, and supervise at least 100 peer educators.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Early Childhood and School-Based Behavioral Health Infrastructure Act of 2012, by requiring the Department of Behavioral Health to award grants totaling $325,000, by October 15, 2024, to the non-governmental entities previously awarded grants in FY 2024.

Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $325,000 in one-time funding, which is equal to the cost of the grant, and funded through the Mayor's Proposed Fiscal Year 2025 budget authority of the Opioid Abatement Fund within the Department of Behavioral Health.

TITLE V, SUBTITLE X. SUBSTANCE ABUSE AND BEHAVIORAL HEALTH SERVICES TARGETED OUTREACH GRANT

Purpose, Effect, and Impact on Existing Law

The purpose of this subtitle is to require DBH to provide grant funding to a non-governmental organization by October 31, 2024 to provide direct support, relationship development, and resource brokering to individuals in need of substance abuse and behavioral health services at six sites with high drug activity and substance abuse: (1) the vicinity of the 600 block of T Street, N.W., (2) the vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E., (3) the vicinity of the 3800-4000 blocks of Minnesota Ave. N.E., (4) the vicinity of the 1300-1800 blocks of Marion Barry Avenue, S.E.; (5) the vicinity of King Greenleaf Recreation Center located at 201 N Street, S.W.; and (6) the vicinity of the of the 1300-1700 blocks of North Capitol Street, N.W. Through this subtitle DBH would also provide a grant to an organization responsible for maintaining a Ward 1 Main Street corridor.

Committee Reasoning

According to data from the Office of the Chief Medical Examiner (OCME), opioid-related fatal overdoses are at an all-time high. In 2023, there were 522 opioid-related fatal overdoses, averaging 43 deaths per month, reflecting a 13% increase. Currently in 2024, 20 opioid-related fatalities have been certified by OCME (as of April 17, 2024). Fentanyl, a potent synthetic opioid used primarily for pain management, remains prevalent in nearly all overdose fatalities.

Opioid overdoses continue to disproportionately impact Black residents. OCME reports that in 2023, 83% of those who succumbed to opioid overdoses were Black residents, with the majority being Black men. Wards 7 and 8 experienced the highest number of fatal and non-fatal opioid overdoses in the District in 2023. The map below illustrates overdoses per capita for each ward in.

Opioid-related deaths can be prevented, and opioid dependency is a treatable medical condition. Moreover, opioid use is linked to an increased risk of HIV infection, and implementing strategies to prevent opioid use can also help to curb the spread of HIV. Across the District, there are public spaces where individuals who are using opioids and other narcotics gather and use drugs together. These concentrated drug use locations are dangerous for those using drugs, and cause frustration for neighbors, schools, and local businesses who do not feel safe walking past. This subtitle would fund a second year of the pilot and add three additional outreach locations. The goal is to pilot the effectiveness of an influx of direct support, relationship development, and resource brokering for individuals in need of substance abuse and behavioral health services at the following locations with concentrated outdoor drug use:

1. **The vicinity of the 600 block of T Street, N.W.:** Over the past year, the Office of Ward 1 Councilmember Brianne Nadeau has been coordinating with the Mayor's Office of Neighborhood Engagement, local Advisory Neighborhood Commissions, businesses, residents, Howard University, Cleveland Elementary Schools, and others to address concerns about the T Street Plaza site. The District has tried several deterrents, including fencing off areas and removing furniture, that temporarily address the issue but do not get to the root of the substance abuse and behavioral health issues faced by these individuals.

2. **The vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E.:** The Office of Ward 5 Councilmember Zachary Parker has received several reports of drug use in alleys and abandoned buildings in the vicinity of the intersection of West Virginia Avenue, N.E. and Mount Olivet Road, N.E. Thus far, the District's response has been to increase police presence in the area, but this only provides a temporary solution. There are reports of overdosing in the area and repeated calls for emergency support. Neighbors also report this area is an open drug market for sales.

3. **The vicinity of the 3800-4000 blocks of Minnesota Avenue, N.E.:** The Office of Ward 7 Councilmember Vincent Gray has received numerous concerns from Ward 7 residents about the serious drug use in the 3800-4000 blocks of Minnesota Ave., N.E. Councilmember Gray's office has collaborated with the Department of Behavioral Health (DBH) and community organizations to develop solutions. It is especially concerning that young children and babies are frequently seen in the area with adults who are under the

influence or actively using drugs. This underscores the urgent need for intervention and support in the area.

4. **The vicinity of the 1300-1800 blocks of Marion Barry Avenue, S.E.:** Since 2018, Ward 8 has consistently reported the highest number of fatal and non-fatal overdoses in the District. In 2023 alone, there were 80 fatal overdoses attributed to opioid use. The Office Ward 8 Councilmember Trayon White has received concerns from community residents regarding drug use in the area, as well as concerns regarding a nearby methadone clinic.

5. **The vicinity of King Greenleaf Recreation Center located at 201 N Street, S.W.:** Substance use disorder, particularly involving opioids, has been a significant issue in this area of Ward 6. Ward 6 Councilmember Charles Allen's office has received numerous communications concerning drug use around and within senior living buildings in this vicinity.

6. **The vicinity of the of the 1300-1700 blocks of North Capitol Street, N.W.:** This area has been a hotspot for drug use, with violence connected to drug-related activities. Schools in this vicinity have reported finding syringes on school property, raising serious concerns about student safety and well-being.

Through this pilot, DBH would also be required to award a grant to an organization responsible for maintaining a Main Street corridor in Ward 1 to hire 8 full-time positions to provide direct support, relationship development and resource brokering to individuals at the following locations:

1. Columbia Heights Civic Plaza;
2. The intersection of Mount Pleasant Street, NW and Kenyon Street, NW;
3. Georgia Avenue, NW, between New Hampshire Avenue, NW, and Harvard Street, NW; and
4. U Street, NW, between 14th Street, NW, and Georgia Avenue, NW.

Each of these areas would greatly benefit from consistent and intensive outreach and support to connect individuals with the necessary services and resources, and help them enter treatment and recovery. A targeted outreach team could improve access to treatment, provide harm reduction services, and address the root causes of drug use in the area.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Requires the Department of Behavioral Health to award one or more grants in the amount of $1,2000,000 to a 501(c)(3) organization to provide direct support, relationship development, and resource brokering to individuals in need of substance abuse and behavioral health services in the (1) the vicinity of the 600 b lock of T Street, N.W., (2) the vicinity of the 1100-1300 blocks of Mount Olivet Road, N.E., (3) the vicinity of the 3800-4000 blocks of Minnesota Ave. N.E., (4) the vicinity of the 1300-1800 blocks of Marion Barry Avenue, S.E.; (5) the vicinity of King Greenleaf Recreation Center located at 201 N Street, S.W.; and (6) the

vicinity of the of the 1300-1700 blocks of North Capitol Street, N.W. Additionally, this section stipulates that DBH will allocate funds to an organization tasked with maintaining a Ward 1 Main Street corridor. DBH is also required to awards grants in FY 2025 to the same organizations that were awarded grants for locations 1-3 in FY 2024. Lastly, this section requires that grantees submit annual reports to DBH, which must then relay them to the Council within 30 days of receipt.

Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $1,200,000 in one-time funding, which is equal to the cost of the grant. The Mayor's proposed FY 2025 budget included $600,000 in one time local funding for this pilot, and the Committee on Recreation Libraries and Youth Affairs transferred $200,000 in one time local funds for the additional site in Ward 8. This total of $800,000 is located in Program 700286 Adult Behavioral Health Services Mh/Sud, Cost Center 70424 Sud Prevention Office and Account 7141007 Grants & Gratuities within the Department of Behavioral Health. The remaining $400,000 is funded through the Mayor's Proposed FY 2025 budget authority of the Opioid Abatement Fund within the Department of Behavioral Health.

TITLE V, SUBTITLE X. SEXUAL HEALTH PEER EDUCATORS

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Department of Health Functions Clarification Act of 2001 by creating a Sexual Health Peer Educators Grant program, that would provide $150,000 to non-governmental entities to train, compensate, and supervise at least 50 high school students to work in public and public charter high schools as sexual health educators.

Committee Reasoning

This subtitle is intended to restart the evidence-based peer-to-peer sexual health and tobacco cessation grant that DC Health used to administer, but that was cut during the COVID-19 public health emergency when schools moved to virtual learning. A number of high school student representatives from the Young Women's Project advocated at the Budget Oversight Hearing for this grant program as a way to better reach them and their peers. DC Health testified that peer-based sexual health programs have strong evidence to support their effectiveness, and that the District should invest in such programs. As middle school and high school youth have returned to in-person learning and extracurricular activities, the need for peer-led sexual education once again has become increasingly crucial. According to a 2022 Young Women's Project Sexual Health Survey of 600 students from 22 schools, 84% of high school students in the District received less than one hour of sex education in 2022.[47] Further, of the 24% of teens who reported being sexually active, only 46% reported using a condom in their last encounter (down from 57% in 2019). Although DC Health is supporting a Sexual Health Youth Advisory Board through an MOU with OSSE, that group currently includes only 8 active students representing 5 schools.

[47] Young Women's Project. "YWP Sexual Health & Wellness Survey: Preliminary Results." (Dec. 26, 2022) *available at*: https://docs.google.com/document/d/1MOuwMBVfKRLt1V3ToH8dKiNHONwQhL_jMQ7XyHKWzNg/edit (accessed May 6, 2024)

The Committee was able to provide $150,000 to fund this grant in FY 2025, but recognizes that full restoration of this grant would necessitate $213,000. The Committee hopes to further expand the grant program in future fiscal years.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Department of Health Functions Clarification Act of 2001 by creating a new Sexual Health Peer Educators Grant program, under which DC Health would be required to provide $150,000 in grant funding to non-governmental entities to train, compensate, and supervise at least 125 high school students to work in public and public charter schools as sexual health educators; Establishes criteria for grant applications, including that the applicant must list at least 3 public or public charter high schools, with a preference for Wards 5, 7, and 8, state the number of student health educators they plan to hire; state the types of interventions the applicant will train the student health educators to perform; state that the applicant is based in the District; demonstrate experience providing programming to high school students related to sexual and reproductive health; and commit to quarterly reports to DC Health.

Fiscal Impact

The Office of Revenue Analysis estimates that the Financial Impact of this subtitle is $150,000 in recurring local funding, which is equal to the cost of the grant. This funding is located in the Department of Health, Program 700041 Prevention And Intervention Services, Cost Center 70079 Prevention & Intervention Services and Account 7141007 Grants & Gratuities.

TITLE V, SUBTITLE X. TOBACCO USE CESSATION INITIATIVES

Purpose, Effect, and Impact on Existing Law

This subtitle amends the Department of Health Functions Clarification Act of 2001 by creating a new special non-lapsing fund, the Tobacco Use Cessation Fund. This Fund will be administered by DC Health and will include any appropriated funds, as well as 50% of the amounts received by the District in the settlement of *District of Columbia v. JUUL Labs Inc.*, Superior Court of the District of Columbia Case No. 2019 CA 007795 B ("Settlement Funds").

The subtitle requires DC Health to spend the funds on tobacco use prevention, education, and cessation programs, including: Investigators, including youth associates, to attempt vaping purchases; Social media countermarking campaign featuring District youth; and Developing and conducting a bi-annual survey on District youth use of vaping products; and Developing a bi-annual report detailing how the Settlement Funds allocated to the DC Health have been spent and providing updated data from the survey described above.

Committee Reasoning

The DC Office of the Attorney General (OAG) reached a legal settlement with JUUL Labs, Inc. in April 2023, resolving allegations of violating consumer protection laws related to youth

marketing and sales practices. Through the settlement, the District will receive a total of $13.67 million over eight years, or $1.7 million per year. There are currently two years' worth of Settlement Funds available in FY 2025, totaling $3.42 million, because the FY 2024 funds were loaded after the budget was finalized. The Settlement Agreement mandates that at least 50% of the funds, totaling $7.56M over eight years, be used for vaping remediation efforts, including cessation, education, and prevention initiatives. OAG has proposed keeping 25% of the funds within its Litigation Support Fund (LSF) and allocating the remaining 75% to the General Fund.

The Committee on the Judiciary has agreed to transfer 50% of the Settlement Funds to the new Tobacco Use Cessation Fund. The Committee developed the specific uses described in the subtitle based on DC Health's original application to OAG for the Settlement Funds, which proposed using all $13.67M of the Settlement Funds on the purposes named in this subtitle.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Amends the Department of Health Functions Clarification Act of 2001 by creating a new, special, non-lapsing fund entitle the Tobacco Use Cessation Fund to be administered by DC Health and to be spend on the following categories: Investigators, including youth associates, to attempt vaping purchases; Social media counter marketing campaign featuring District youth; Developing and conducting a bi-annual survey on District youth use of vaping products; and Developing a bi-annual report detailing how the Settlement Funds have been allocated and providing updated data on youth use of vaping products.

Sec. xxx3 Repeals the Smoking Cessation Fund in D.C. Code Section 47-2402(l).

Fiscal Impact

The fiscal impact of this subtitle is $1,624,945 in FY 2025 and $853,785 annually throughout the financial plan. This funding will be transferred from the OAG Litigation Support Fund.

TITLE V, SUBTITLE X. S2A REPEALS

Purpose, Effect, and Impact on Existing Law

The subtitle repeals the subject to appropriations clauses for the following pieces of legislation passed by the Council during Council Period 25:

- Prior Authorization Reform Amendment Act of 2023, effective January 17, 2024 (D.C. Law 25-100; D.C. Official Code § 31-3875.01 *et seq.*);
- Access to Emergency Medications Amendment Act of 2023, effective February 23, 2024 (D.C. Law 25-0124; 70 DCR 16578); and
- Expanding Access to Fertility Treatment Amendment Act of 2023, effective September 22, 2023 (D.C. Law 25-0049; 70 DCR 10351).

Committee Reasoning

The Committee is pleased to fully fund several critical pieces of legislation considered and approved by the Committee during this Council Period.

Section-by-Section Analysis

Sec. xxx1 Short title.

Sec. xxx2 Repeals section 301, the subject to appropriations clause, of D.C. Law 25-100, the Prior Authorization Reform Amendment Act of 2023.

Sec. xxx3 Repeals section 3 of D.C. Law 25-0124, the Access to Emergency Medications Amendment Act of 2023.

Sec. xxx4 Repeals section 3 of D.C. Law 25-0049, the Expanding Access to Fertility Treatment Amendment Act of 2023.

Fiscal Impact

The Committee has allocated funds to pay for the estimated financial impact of each of these laws, as provided by the Office of Revenue Analysis:

1. Prior Authorization Reform Amendment Act of 2023, effective January 17, 2024 (D.C. Law 25-100; D.C. Official Code § 31-3875.01 *et seq.*)
    - As described in the Committee reasoning for Subtitle X, Prior Authorization Reform Amendment, the Committee has amended this legislation by exempting health plans under Medicaid and the Alliance from the data transparency provisions in the original bill that had associated financial impacts. The Committee fully funds the FIS for the other two requirements with associated financial impacts and is therefore able to repeal the subject to approrpriations clause. The FIS for this legislation can be found on LIMS.[48]
    - Within the Department of Health Care Finance, this legislation was funded as follows:
        - $60,480 in FY25 in recurring local funds for Program 100190 Clinicians, Rx And Acute Care, Cost Center 70161 Division Of Clinicians, Pharmacy, & Acute Provider Services and Account 7132001 Contractual Services - Other to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
        - $181,441 in FY25 in recurring Federal Medicaid Payments for Program 100190 Clinicians, Rx And Acute Care, Cost Center 70161 Division Of Clinicians, Pharmacy, & Acute Provider Services and Account 7132001

[48] Office of the Chief Financial Officer, Fiscal Impact Statement- Prior Authorization Reform Amendment Act of 2023 (issued September 26, 2023). Accessed on May 8, 2024 at: https://lims.dccouncil.gov/downloads/LIMS/52301/Other/B25-0124-FIS_-_Prior_Authorization_Reform.pdf?Id=176398

Contractual Services - Other to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.

- $206,700 in FY25 in recurring local funds for Program 700105 MCO - Medicaid, Cost Center 70202 Cassip and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $482,300 in FY25 in recurring Federal Medicaid Payments for Program 700105 MCO - Medicaid, Cost Center 70202 Cassip and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $85,002 in FY25 in recurring local funds for Program 700105 MCO - Medicaid, Cost Center 70200 Managed Care Organizations (MCO) and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $198,338 in FY25 in recurring Federal Medicaid Payments for Program 700105 MCO - Medicaid, Cost Center 70200 Managed Care Organizations (MCO) and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $23,913 in FY25 in recurring local funds for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70231 MCO-Newly Eligible and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $215,218 in FY25 in recurring Federal Medicaid Payments for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70231 MCO-Newly Eligible and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $624 in FY25 in recurring local funds for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70236 MCO- Expansion Poplulation and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $5,615 in FY25 in recurring Federal Medicaid Payments for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70236 MCO-Expansion Poplulation and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $8,388 in FY25 in recurring local funds for Program 700103 MCO - Chip, Cost Center 70201 Managed Care Organizations (MCO) - Chip and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-

124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.

- $31,555 in FY25 in recurring Federal Medicaid Payments for Program 700103 MCO - Chip, Cost Center 70201 Managed Care Organizations (MCO) - Chip and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $47,376 in FY25 in recurring local funds for Program 700105 MCO - Medicaid, Cost Center 70500 MCO-Abd and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $110,545 in FY25 in recurring Federal Medicaid Payments for Program 700105 MCO - Medicaid, Cost Center 70500 MCO-Abd and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $4,629 in FY25 in recurring local funds for Program 700104 MCO - Immigrant Children, Cost Center 70224 Immigrant Kids and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $52,638 in FY25 in recurring local funds for Program 700101 MCO - Alliance, Cost Center 70259 MCO Alliance and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Accellerated Prior Authorization Review.
- $240,000 in FY25 in recurring local funds for Program 100190 Clinicians, Rx And Acute Care, Cost Center 70161 Division Of Clinicians, Pharmacy, & Acute Provider Services and Account 7132001 Contractual Services - Other to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $720,000 in FY25 in recurring Federal Medicaid Payments for Program 100190 Clinicians, Rx And Acute Care, Cost Center 70161 Division Of Clinicians, Pharmacy, & Acute Provider Services and Account 7132001 Contractual Services - Other to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $81,000 in FY25 in recurring local funds for Program 700105 MCO - Medicaid, Cost Center 70202 Cassip and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $189,000 in FY25 in recurring Federal Medicaid Payments for Program 700105 MCO - Medicaid, Cost Center 70202 Cassip and Account 7141003

Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.

- $157,642 in FY25 in recurring local funds for Program 700105 MCO - Medicaid, Cost Center 70200 Managed Care Organizations (MCO) and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $367,831 in FY25 in recurring Federal Medicaid Payments for Program 700105 MCO - Medicaid, Cost Center 70200 Managed Care Organizations (MCO) and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $44,348 in FY25 in recurring local funds for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70231 MCO-Newly Eligible and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $399,135 in FY25 in recurring Federal Medicaid Payments for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70231 MCO-Newly Eligible and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $1,157 in FY25 in recurring local funds for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70236 MCO- Expansion Poplulation and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $10,413 in FY25 in recurring Federal Medicaid Payments for Program 700102 MCO - Childless Adults (Group 8), Cost Center 70236 MCO-Expansion Poplulation and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $15,556 in FY25 in recurring local funds for Program 700103 MCO - Chip, Cost Center 70201 Managed Care Organizations (MCO) - Chip and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $58,520 in FY25 in recurring Federal Medicaid Payments for Program 700103 MCO - Chip, Cost Center 70201 Managed Care Organizations (MCO) - Chip and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $87,863 in FY25 in recurring local funds for Program 700105 MCO - Medicaid, Cost Center 70500 MCO-Abd and Account 7141003 Medical

Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.

- $205,013 in FY25 in recurring Federal Medicaid Payments for Program 700105 MCO - Medicaid, Cost Center 70500 MCO-Abd and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $8,586 in FY25 in recurring local funds for Program 700104 MCO - Immigrant Children, Cost Center 70224 Immigrant Kids and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.
- $97,621 in FY25 in recurring local funds for Program 700101 MCO - Alliance, Cost Center 70259 MCO Alliance and Account 7141003 Medical Vendor Services to satisfy the FIS for B25-124/L25/100 Prior Authorization Reform Amendment Act of 2023 - Adverse Determination and Appeals Credentialing Requirements.

2. Access to Emergency Medications Amendment Act of 2023, effective February 23, 2024 (D.C. Law 25-0124; 70 DCR 16578)
   - The Committee requested an updated Financial Impact Statement from ORA during the FY 2025 budget formulation process. The update FIS is included below and the funds are allocated as follows:
   - Within the Department of Health:
     - $164,431 in FY25 in recurring local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7011001 Continuing Full Time to fund FTE requirements for B25-226 Access to Emergency Medications Amendment Act for one Grade 12, Step 1 Nurse Consultant and one Grade 9, Step 5 Program Support Specialist.
     - $36,175 in FY25 in recurring local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7014008 Misc Fringe Benefits to fund FTE fringe requirement for B25-226 Access to Emergency Medications Amendment Act .
     - $46,000 in FY25 in one time local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7132001 Contractual Services - Other to fund medication storage for B25-226 Access to Emergency Medications Amendment Act .
     - $22,000 in FY25 in one time local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7132001 Contractual Services - Other to fund training for B25-226 Access to Emergency Medications Amendment Act .
     - $376,000 in FY25 in recurring local funds for Program 700026 Family Health, Cost Center 70058 Family Health Bureau and Account 7132001 Contractual Services - Other to fund Medication Procurement and

Distribution for B25-226 Access to Emergency Medications Amendment Act .

- Via a transfer to the Committee of the Whole directed to the Office of the State Superintendent of Education:
  - $90,805 in FY25 recurring local funds for Program 400365, Cost Center 40230, Account 7011001 for salary for one Grade 12 Step 5 FTE.
  - $21,975 in FY25 recurring local funds for Program 400365, Cost Center 40230, Account 7014008, for fringe for one Grade 12 Step 5 FTE.

Bill 25-226, Access to Emergency Medications Amendment act of 2023 Total DC Health Cost					
	FY2025	**FY2026**	**FY2027**	**FY2028**	**TOTAL**
Salary (a)	$164,431	$167,555	$170,739	$173,983	$676,708
Fringe	$36,175	$37,728	$39,349	$41,039	$154,291
Medication Storage (b)	$46,000	$0	$0	$0	$46,000
Training Update	$22,000	$0	$0	$0	$22,000
Medication Procurement and Distribution (c)	$376,000	$383,144	$390,424	$397,842	$1,547,410
TOTAL	**$644,606**	**$588,428**	**$600,511**	**$612,863**	**$2,446,408**

(a) Assumes salary for one Grade 12, Step 1 Nurse Consultant ($98,335) and one Grade 9, Step 5 Program Support Specialist.($66,078) Assumes fringe rate of 22.0 percent, cost growth of 1.9 percent, and fringe growth of 2.35 percent. Assumes October 1, 2024 start date.
(b) Assumes one-time costs of $650 for procure and install 71 locking medication cabinets.
(c) Includes annual procurement and distribution of albuterol and glucagon to 252 schools.

Bill 25-226, Access to Emergency Medications Amendment act of 2023 Total OSSE Cost					
	FY2025	**FY2026**	**FY2027**	**FY2028**	**TOTAL**
Salary	$90,805	$92,349	$93,919	$95,515	$372,588
Fringe	$21,975	$22,874	$23,809	$24,783	$93,440
TOTAL	**$112,780**	**$115,222**	**$117,728**	**$120,298**	**$466,028**

(a) Assumes salary for one Grade 12, Step 5 Management Analyst. ($90,805) Assumes fringe rate of 24.2 percent, cost growth of 1.9 percent, and fringe growth of 2.35 percent. Assumes October 1, 2024 start date.

Bill 25-226, Access to Emergency Medications Amendment Act of 2023 Total Cost					
	FY2025	**FY2026**	**FY2027**	**FY2028**	**TOTAL**

DC HEALTH	$644,606	$588,428	$600,511	$612,863	$2,446,408
OSSE	$112,780	$115,222	$117,728	$120,298	$466,028
TOTAL	**$757,386**	**$703,650**	**$718,239**	**$733,161**	**$2,912,436**

3. Expanding Access to Fertility Treatment Amendment Act of 2023, effective September 22, 2023 (D.C. Law 25-0049; 70 DCR 10351)

- The Committee funded the Medicaid portion of this legislation in the Fiscal Year 2024 budget, and therefore the last remaining portion of the legislation subject to appropriations is the requirement for DC Health Link plans to provide the services covered by the legislation. To implement this provision, the Council must fund the defrayal costs for these plans in Plan Year 2025, until the new CMS regulations go into effect (see HBX chapter for further explanation). The Committee worked closed with ORA, HBX, and DISB to revise the FIS, which the Committee fully funds:
  - $175,000 in FY26 and $245,000 in FY27 in enterprise and other funds for Program 700065 Member Services, Cost Center 70468 Program Management and Account 7141009 Subsidies to cover defrayal costs for Insurers to implement the Expanding Access to Fertility Treatment Amendment Act of 2023.

Total Cost by Fiscal Year for PY 2025 Claims	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**	**Total**
Defrayal Costs	$0	$175,000	$245,000	$0	$420,000

Committee Action and Vote

On Thursday, May 9, 2024, the Committee on Health held a hybrid meeting in Room 500 of the John A. Wilson Building and over the Zoom online platform to consider and vote on the Mayor's proposed FY 2025 budget for the agencies under its jurisdiction, the provisions of the FY 2025 Budget Support Act of 2024 referred to the Committee for comment, the Committee's budget report, and the ledger of Committee actions. Chairperson Christina Henderson determined the existence of a quorum with the presence of Councilmembers XXX. Chairperson Henderson provided an overview of the draft report, the ledger of committee actions, and the changes recommended to the Mayor's proposed budget, and then invited other members to provide comments on the Committee's report and recommendations.

[Committee Member Comments]

Chairperson Henderson then moved for approval of the Committee's Fiscal Year 2025 Local Budget Act recommendations, the Committee's Fiscal Year 2025 Budget Support Act of 2024 recommendations, the Committee's budget report, and the ledger of committee actions, with leave for staff to make technical and conforming changes to reflect the Committee's actions. The Members voted X-X to X the recommendations, voting as follows:

Members in favor:
Members opposed:
Members voting present:
Members absent:

Chairperson Henderson then thanked the members of the Committee for all of their work and support during the budget process. She thanked her staff, including Chief of Staff Michael Shaffer, Deputy Chief of Staff Heather Edelman, Committee Director Ona Balkus, Legislative Director Gabrielle Rogoff, Communications Director Sierra Wallace, Constituent Services Director Ana S. Berríos-Vázquez, Senior Policy Advisor Marcia Huff, Policy Advisor Rebecca Cooper, Legislative Assistants Ashley Strange and Nico Pcholkin, and Staff Assistant Taylor Coleman. She also thanked Errol Spence-Sutherland, Anne Phelps, and Jen Budoff of the Council Budget Office and Assistant General Counsel David Guo for their invaluable assistance. Chairperson Henderson adjourned the meeting at XX p.m.

Attachments

Attachment A: Consolidated Entry Report of Recommended Changes to Agency Budgets and Revenues for Agencies under the Committee's Purview

Attachment B: Recommended Agency Budgets and Full-Time Equivalents by Cost Center for Agencies under the Committee's Purview

Attachment C: Recommended Agency Budgets and Full-Time Equivalents by Program for Agencies under the Committee's Purview

Attachment D: Recommended Agency Budgets by Fund for Agencies under the Committee's Purview

Attachment E: Explanation of District Integrated Financial System Budget Attributes and Crosswalk

Attachment F: Recommended Legislative Language for the Mayor's Proposed Budget Support Act Subtitles under the Committee's Purview

Attachment G: Recommended Legislative Language for the Committee Proposed Budget Support Act Subtitles under the Committee's Purview

Attachment H: Witness List and Testimony Submitted for the April 8, 2024, Fiscal Year 2025 Budget Oversight Hearing on the DC Health Benefit Exchange Authority and the Not-for-Profit Hospital Corporation (United Medical Center)

Attachment I: Witness List and Testimony Submitted for the April 10, 2024 (public witnesses) and April 11, 2024 (government witness), Fiscal Year 2025 Budget Oversight Hearing for the Department of Behavioral Health

Attachment J: Witness List and Testimony Submitted for the April 10, 2024 (public witnesses) and April 11, 2024 (government witness), Fiscal Year 2025 Budget Oversight Hearing for the Department of Health

Attachment K: Witness List and Testimony Submitted for the April 29, 2024, Fiscal Year 2025 Budget Oversight Hearing on the Office of the Deputy Mayor for Health and Human Services and the Department of Health Care Finance

Agency	Scenario	Committee	Cluster	Agency Code	DIFS Appr. Fund	DIFS Fund	DIFS Program Parent L1	DIFS Program	DIFS Cost Ctr. Parent L1	DIFS Cost Center	DIFS Account Parent L1	DIFS Account	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY24	FY25	FY26	FY27	FY28	Comments	Legislation
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1203 - OFFICE OF THE DIRECTOR	70462 - EXECUTIVE OFFICE - HC0	7111100C - SUPPLIES & MATERIALS	7111020 - IT SUPPLIES		Budget	Reduction	Recurring		($3,556)	($3,624)	($3,693)	($3,763)	Reduce by $3,556.48 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1203 - OFFICE OF THE DIRECTOR	70462 - EXECUTIVE OFFICE - HC0	7111100C - SUPPLIES & MATERIALS	7111020 - IT SUPPLIES		Budget	Reduction	One Time	($3,556)					Reduce by $3,556.48 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H004003 - COMMUNITY OF HEALTH SUPPORT SERVICES	700329 - COMMUNITY OF HEALTH SUPPORT SERVICES	H0702 - COMMUNITY HEALTH ADMINISTRATION	70056 - DEPUTY DIRECTOR FOR OPERATIONS - CHA	7131100C - OTHER SERVICES & CHARGES	7131011 - OFFICE SUPPORT		Budget	Reduction	Recurring		($13,374)	($13,828)	($13,887)	($14,151)	Reduce by $13,374.35 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H004003 - COMMUNITY OF HEALTH SUPPORT SERVICES	700329 - COMMUNITY OF HEALTH SUPPORT SERVICES	H0702 - COMMUNITY HEALTH ADMINISTRATION	70056 - DEPUTY DIRECTOR FOR OPERATIONS - CHA	7131100C - OTHER SERVICES & CHARGES	7131020 - TUITION FOR EMPLOYEE TRAINING		Budget	Reduction	Recurring		($4,346)	($4,429)	($4,513)	($4,598)	Reduce by $6,956.24 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H005001 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE	700331 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE	H0901 - HEALTH REGULATION AND LICENSING ADMINISTRATION	70073 - OFFICE OF FOOD, DRUG, RADIATION AND COMMUNITY HYGIENE	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($25,550)	($26,035)	($26,530)	($27,034)	Vendor name and contract number are both TBD, unclear why the contract title refers to a 2022 enhancement, but this is a new contract. Contract: FY22 Mayor Enhancement: Support Psychological Jurisdictional Impact.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04201 - ACCOUNTABILITY ADMINISTRATIVE SERVICES	700271 - ACCOUNTABILITY ADMINISTRATIVE SERVICES	H6401 - DIVISION OF DATA, QUALITY and COMPLIANCE	70430 - OFFICE OF ACCOUNTABILITY	7131100C - OTHER SERVICES & CHARGES	7131099 - PROF SERVICE FEES & CONTR		Budget	Reduction	Recurring		($46,227)	($47,106)	($48,001)	($48,913)	TBD is listed for vendor name, contract/grant purpose, competitive/sole source, & contract type . Attachment 1, Tab 3, Line 117.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7131100C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($12,095)	($12,325)	($12,559)	($12,797)	Reduce by $12,094.72 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP040 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	100183 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	H8100 - DATA ANALYTICS AND RESEARCH ADMINISTRATION (DARA)	70536 - ANALYTIC REPORTING DIVISION	7131100C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($2,313)	($2,357)	($2,401)	($2,447)	Reduce by $2,312.63 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP043 - HEALTH CARE DELIVERY MGT SUPPORT SVCS	100186 - HEALTH CARE DELIVERY MGT SUPPORT SVCS	H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION	70159 - HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION	7131100C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($2,351)	($2,395)	($2,441)	($2,487)	Reduce by $2,350.82 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP041 - PROGRAM INTEGRITY	100184 - PROGRAM INTEGRITY	H3001 - PROGRAM INTEGRITY ADMINISTRATION	70158 - PROGRAM INTEGRITY SUPPORT DIVISION	7131100C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($3,200)	($3,260)	($3,322)	($3,386)	Reduce by $3,199.69 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP038 - SENIOR DEPUTY DIRECTOR/FINANCE	100181 - SENIOR DEPUTY DIRECTOR/FINANCE	H8200 - OFFICE OF DDS FINANCE	70538 - SENIOR DEPUTY DIRECTOR FINANCE ADMINISTRATIVE FUNCTIONS	7131100C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($5,453)	($5,556)	($5,662)	($5,769)	Reduce by $5,452.82 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP037 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	100180 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	H3701 - OFFICE OF THE OSMD	70530 - SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMISTRATIVE FUNCTIONS	7131100C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($3,439)	($3,504)	($3,571)	($3,638)	Reduce by $3,438.72 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7131100C - OTHER SERVICES & CHARGES	7131005 - MAINTENANCE & REPAIRS - AUTO		Budget	Reduction	Recurring		($14,409)	($14,683)	($14,962)	($15,246)	Reduce by $14,408.77 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP040 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	100183 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	H8100 - DATA ANALYTICS AND RESEARCH ADMINISTRATION (DARA)	70536 - ANALYTIC REPORTING DIVISION	7131100C - OTHER SERVICES & CHARGES	7131015 - ADVERTISING		Budget	Reduction	Recurring		($7,838)	($7,986)	($8,138)	($8,293)	Reduce by $7,837.52 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7131100C - OTHER SERVICES & CHARGES	7131017 - POSTAGE		Budget	Reduction	Recurring		($9,348)	($9,526)	($9,707)	($9,891)	Reduce by $9,348.25 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP050 - DCAS INFORMATION TECHNOLOGY	100202 - DCAS INFORMATION TECHNOLOGY	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	7131100C - OTHER SERVICES & CHARGES	7131020 - TUITION FOR EMPLOYEE TRAINING		Budget	Reduction	Recurring		($10,336)	($10,532)	($10,733)	($10,936)	Reduce by $10,336.04 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP050 - DCAS INFORMATION TECHNOLOGY	100202 - DCAS INFORMATION TECHNOLOGY	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	7131100C - OTHER SERVICES & CHARGES	7131025 - PAYMENT OF MEMBERSHIP DUES		Budget	Reduction	Recurring		($4,535)	($4,621)	($4,709)	($4,798)	Reduce by $4,534.69 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP048 - LONG TERM CARE SUPPORT SERVICES	100191 - LONG TERM CARE SUPPORT SERVICES	H3601 - LONG TERM CARE ADMINISTRATION	70270 - LONG TERM CARE SUPPORT SERVICES DIVISION	7131100C - OTHER SERVICES & CHARGES	7131025 - PAYMENT OF MEMBERSHIP DUES		Budget	Reduction	Recurring		($4,180)	($4,260)	($4,341)	($4,423)	Reduce by $4,180.47 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP037 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	100180 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	H3701 - OFFICE OF THE OSMD	70530 - SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMISTRATIVE FUNCTIONS	7131100C - OTHER SERVICES & CHARGES	7131025 - PAYMENT OF MEMBERSHIP DUES		Budget	Reduction	Recurring		($7,255)	($7,393)	($7,533)	($7,677)	Reduce by $7,255.08 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP056 - DCAS PROJECT MANAGEMENT	100199 - DCAS PROJECT MANAGEMENT	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70153 - PROJECT MANAGEMENT DIVISION	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171002 - PURCHASES FURNITURE & FIXTURES		Budget	Reduction	Recurring		($15,158)	($15,446)	($15,739)	($16,038)	Reduce by $15,157.55 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP012 - INFORMATION TECHNOLOGY SERVICES	100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70280 - INFORMATION TECHNOLOGY DIVISION - HT0	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171002 - PURCHASES FURNITURE & FIXTURES		Budget	Reduction	Recurring		($6,352)	($6,472)	($6,595)	($6,721)	Reduce by $6,351.74 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP048 - LONG TERM CARE SUPPORT SERVICES	100191 - LONG TERM CARE SUPPORT SERVICES	H3601 - LONG TERM CARE ADMINISTRATION	70270 - LONG TERM CARE SUPPORT SERVICES DIVISION	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171007 - TEXT BOOKS		Budget	Reduction	Recurring		($2,480)	($2,527)	($2,575)	($2,624)	Reduce by $2,479.83 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171008 - IT HARDWARE ACQUISITIONS		Budget	Reduction	Recurring		($603)	($615)	($626)	($638)	Reduce by $603.20 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP056 - DCAS PROJECT MANAGEMENT	100199 - DCAS PROJECT MANAGEMENT	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70153 - PROJECT MANAGEMENT DIVISION	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171008 - IT HARDWARE ACQUISITIONS		Budget	Reduction	Recurring		($7,124)	($7,259)	($7,397)	($7,537)	Reduce by $7,123.60 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP012 - INFORMATION TECHNOLOGY SERVICES	100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70280 - INFORMATION TECHNOLOGY DIVISION - HT0	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171008 - IT HARDWARE ACQUISITIONS		Budget	Reduction	Recurring		($11,130)	($11,341)	($11,557)	($11,777)	Reduce by $11,130.02 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP013 - INFORMATION TECHNOLOGY SERVICES	100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70280 - INFORMATION TECHNOLOGY DIVISION - HT0	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171009 - IT SOFTWARE ACQUISITIONS		Budget	Reduction	Recurring		($289,561)	($295,063)	($300,669)	($306,382)	Reduce by $289,561.30 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP012 - INFORMATION TECHNOLOGY SERVICES	100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70280 - INFORMATION TECHNOLOGY DIVISION - HT0	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($300,000)	($305,700)	($311,508)	($317,427)	TBD on vendor, contract number, contract purpose, contract term begin and end... Contracts HTO_FY25_Attachement1 - Tab 1, Lines 48 (Local Funds) .	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP012 - INFORMATION TECHNOLOGY SERVICES	100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70280 - INFORMATION TECHNOLOGY DIVISION - HT0	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($150,000)	($152,850)	($155,754)	($158,713)	TBD on vendor, contract number, contract term begin and end. Contracts HTO_FY25_Attachement1 - Tab 1, Line 78 : MDW- Medication Therapy Management.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP037 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	100180 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	H3701 - OFFICE OF THE OSMD	70530 - SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMISTRATIVE FUNCTIONS	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($300,000)	($305,700)	($311,508)	($317,427)	TBD on vendor, contract number, contract purpose, contract term begin and end. Contracts HTO_FY25_Attachement1 - Tab 1, Line 96 (TBD, TBD).	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP044 - MANAGED CARE MGT	100187 - MANAGED CARE MGT	H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION	70160 - DIVISION OF MANAGED CARE	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($300,000)	($305,700)	($311,508)	($317,427)	There's been no vendor listed on this contract for the past 2 years, also TBD for contract number, contract term begin and end. Contracts HTO_FY25_Attachement1 - Tab 1, Line 148, MCO Quality Monitoring Contract, Contract TBD.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP050 - OPERATIONS	100193 - OPERATIONS	H3601 - LONG TERM CARE ADMINISTRATION	70272 - LONG TERM CARE OPERATIONS DIVISION	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($135,000)	($137,565)	($140,179)	($142,842)	TBD on vendor, contract number, contract purpose, contract term begin and end. Contracts HTO_FY25_Attachement1 - Tab 1, Line 200 (TBD, TBD).	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP053 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES	100196 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES	H3401 - HEALTH CARE POLICY & RESEARCH ADMINISTRATION	70263 - HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($352,415)	($359,111)	($365,934)	($372,887)	TBD on vendor, contract number, contract purpose, contract term begin and end. Contracts HTO_FY25_Attachement1 - Tab 1, Line 218 (TBD, TBD).	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP055 - DCAS PROGRAM MANAGEMENT	100198 - DCAS PROGRAM MANAGEMENT	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70152 - DCAS - PROGRAM MANAGEMENT DIVISION	7132000C - CONTRACTUAL SERVICES - OTHER	7132002 - IT CONSULTANT CONTRACTS		Budget	Reduction	Recurring		($209,776)	($213,762)	($217,823)	($221,962)	This is one of four contracts for this DCAS type - and this one does not have a vendor or a contract.. Contracts HTO_FY25_Attachement1 - Tab 1, Line 223 (TBD, TBD) DCAS - R1/R2/R3 Staff Augs - 1.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT	100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERAL	H6401 - OFFICE OF THE CHIEF OPERATING OFFICER	70447 - FISCAL SERVICES AND MONITORING OFFICE	7131100C - OTHER SERVICES & CHARGES	7131099 - PROF SERVICE FEES & CONTR		Budget	Reduction	Recurring		($242,247)	($246,850)	($251,540)	($256,319)	Reduce by $242,247.05 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP023 - RESOURCE MANAGEMENT	100127 - RESOURCE MANAGEMENT - GENERAL	H6401 - OFFICE OF THE CHIEF OPERATING OFFICER	70447 - FISCAL SERVICES AND MONITORING OFFICE	7131100C - OTHER SERVICES & CHARGES	7131036 - IT SOFTWARE MAINTENANCE		Budget	Reduction	Recurring		($74,167)	($75,576)	($77,012)	($78,475)	Reduce by $74,167.12 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04505 - EARLY CHILDHOOD SERVICES	700302 - EARLY CHILDHOOD SERVICES	H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES	70425 - OFFICE OF PREVENTION AND EARLY INTERVENTION	7131100C - OTHER SERVICES & CHARGES	7131011 - OFFICE SUPPORT		Budget	Reduction	Recurring		($75,968)	($77,412)	($78,882)	($80,381)	Reduce by $75,968.28 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04603 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	700310 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	H8300 - DIVISION OF CRISIS SERVICES	70413 - OFFICE OF COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	7111100C - SUPPLIES & MATERIALS	7111004 - MEDICAL SURGICAL & LAB		Budget	Reduction	Recurring		($515)	($524)	($534)	($544)	Reduce by $514.56 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04603 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	700310 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	H8300 - DIVISION OF CRISIS SERVICES	70413 - OFFICE OF COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	7111100C - SUPPLIES & MATERIALS	7111010 - FOOD PROVISIONS		Budget	Reduction	Recurring		($18,333)	($18,882)	($19,037)	($19,398)	Reduce by $18,333.35 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04801 - CLINICAL ADMINISTRATIVE SERVICES	700317 - CLINICAL ADMINISTRATIVE SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70439 - OFFICE OF THE CHIEF CLINICAL OFFICER (SEH)	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171003 - PURCHASES EQUIPMENT & MACHINERY		Budget	Reduction	Recurring		($9,044)	($9,216)	($9,391)	($9,570)	Reduce by $9,044.48 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04802 - CLINICAL AND MEDICAL SERVICES	700318 - CLINICAL AND MEDICAL SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70439 - OFFICE OF THE CHIEF CLINICAL OFFICER (SEH)	7131100C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($22,716)	($23,148)	($23,588)	($24,036)	Reduce by $22,716.40 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04802 - CLINICAL AND MEDICAL SERVICES	700318 - CLINICAL AND MEDICAL SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70439 - OFFICE OF THE CHIEF CLINICAL OFFICER (SEH)	7171100C - PURCHASES EQUIPMENT & MACHINERY	7171003 - PURCHASES EQUIPMENT & MACHINERY		Budget	Reduction	Recurring		($4,452)	($4,536)	($4,623)	($4,710)	Reduce by $4,451.73 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04803 - ENGINEERING AND MAINTENANCE SERVICES	700319 - ENGINEERING AND MAINTENANCE SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70440 - OFFICE OF THE CHIEF OPERATING OFFICER (SEH)	7131100C - OTHER SERVICES & CHARGES	7131006 - MAINTENANCE & REPAIRS - M&H		Budget	Reduction	Recurring		($29,093)	($29,646)	($30,209)	($30,783)	Reduce by $29,093.22 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04805 - HOSPITAL ADMINISTRATIVE SERVICES	700321 - HOSPITAL ADMINISTRATIVE SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70440 - OFFICE OF THE CHIEF OPERATING OFFICER (SEH)	7131100C - OTHER SERVICES & CHARGES	7131099 - PROF SERVICE FEES & CONTR		Budget	Reduction	Recurring		($46,175)	($47,053)	($47,947)	($48,858)	Reduce by $46,175.32 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04807 - MATERIAL MANAGEMENT SERVICES	700323 - MATERIAL MANAGEMENT SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70440 - OFFICE OF THE CHIEF OPERATING OFFICER (SEH)	7131100C - OTHER SERVICES & CHARGES	7131029 - PROFESSIONAL SERVICES		Budget	Reduction	Recurring		($4,562)	($4,649)	($4,737)	($4,827)	Reduce by $4,562.14 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04810 - QUALITY AND DATA MANAGEMENT SERVICES	700326 - QUALITY AND DATA MANAGEMENT SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70437 - OFFICE OF CHIEF QUALITY DATA TRAINING & PERFORMANCE MANAGEMENT (SEH)	7131100C - OTHER SERVICES & CHARGES	7131099 - PROF SERVICE FEES & CONTR		Budget	Reduction	Recurring		($11,275)	($11,489)	($11,708)	($11,930)	Reduce by $11,275.07 to align with FY23 actual spending plus 20% for growth and inflation.	

Agency	Scenario	Committee	Cluster	Agency Code	DIFS Appr. Fund	DIFS Fund	DIFS Program Parent L1	DIFS Program	DIFS Cost Ctr. Parent L1	DIFS Cost Center	DIFS Account Parent L1	DIFS Account	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY24	FY25	FY26	FY27	FY28	Comments	Legislation
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04811 - SECURITY AND SAFETY SERVICES	700327 - SECURITY AND SAFETY SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70440 - OFFICE OF THE CHIEF OPERATING OFFICER (SEH)	711100C - SUPPLIES & MATERIALS	7111008 - CLOTHING & UNIFORMS		Budget	Reduction	Recurring		($744)	($758)	($773)	($787)	Reduce by $744.14 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04812 - TRANSPORATION AND GROUNDS SERVICES	700328 - TRANSPORATION AND GROUNDS SERVICES	H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL	70440 - OFFICE OF THE CHIEF OPERATING OFFICER (SEH)	713100C - OTHER SERVICES & CHARGES	7131009 - PROF SERVICE FEES & CONTR		Budget	Reduction	Recurring		($11,226)	($11,439)	($11,656)	($11,878)	Reduce by $11,225.70 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04508 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES	700305 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES	H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES	70425 - OFFICE OF PREVENTION AND EARLY INTERVENTION	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($593,780)	($605,062)	($616,558)	($628,273)	DBH intends to end contract for the School-Based Behavioral Health Program grant that is currently held by George Washington University, yet the contract is listed in the FY25 spreadsheet. Attachment I, Tab 1, Line 62 .	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	Human Support Services	HG0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS	70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DMHHS	701100C - CONTINUING FULL TIME	7011001 - CONTINUING FULL TIME		Budget	Reduction	One Time		($23,597)				Reduction to increase vacancy savings to 1%	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	Human Support Services	HG0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS	70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DMHHS	701200C - CONTINUING FULL TIME - OTHERS	7012003 - CONTINUING PART TIME		Budget	Reduction	One Time		($1,439)	$0	$0	$0	Reduction to increase vacancy savings to 1%	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	Human Support Services	HG0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS	70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DMHHS	701400C - FRINGE BENERFITS - CURR PERSONNEL	7014008 - MISC FRINGE BENEFITS		Budget	Reduction	One Time		($4,331)	$0	$0	$0	Reduction to increase vacancy savings to 1%	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	Human Support Services	HG0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS	70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DMHHS	701100C - CONTINUING FULL TIME	7011001 - CONTINUING FULL TIME		Budget	Reduction	One Time	($24,007)					Reduction to increase vacancy savings to 1%	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	Human Support Services	HG0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS	70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DMHHS	701200C - CONTINUING FULL TIME - OTHERS	7012003 - CONTINUING PART TIME		Budget	Reduction	One Time	($1,511)					Reduction to increase vacancy savings to 1%	
Office of the Deputy Mayor for Health and Human Services	Committee Recommendation	Committee on Health	Human Support Services	HG0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP030 - EXECUTIVE ADMINISTRATION	100151 - EXECUTIVE ADMINISTRATION	H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS	70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DMHHS	701400C - FRINGE BENERFITS - CURR PERSONNEL	7014008 - MISC FRINGE BENEFITS		Budget	Reduction	One Time	($3,849)					Reduction to increase vacancy savings to 1%	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04308 - HOUSING SUPPORT SERVICES	700283 - HOUSING SUPPORT SERVICES	H5701 - DIVISION OF ADULT SERVICES	70420 - HOUSING DEVELOPMENT OFFICE	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Reduction	Recurring		($292,980)	($298,547)	($304,219)	($309,999)	Adjustment to reduce contractual services budget	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP047 - CLINICIANS, RX AND ACUTE CARE	100190 - CLINICIANS, RX AND ACUTE CARE	H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION	70161 - DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	Recurring		$60,480	$61,629	$62,800	$63,993	Accellarated Prior Authorization Review - Fee for Service	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	AMP047 - CLINICIANS, RX AND ACUTE CARE	100190 - CLINICIANS, RX AND ACUTE CARE	H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION	70161 - DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	Recurring		$181,441	$184,888	$188,401	$191,981	Accellarated Prior Authorization Review - Fee for Service	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$206,700	$210,827	$214,629	$218,707	Accellarated Prior Authorization Review - HBCSN	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$482,300	$491,464	$500,802	$510,317	Accellarated Prior Authorization Review - HBCSN	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$85,002	$86,617	$88,263	$89,940	Accellarated Prior Authorization Review - Base MCO	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$198,338	$202,106	$205,946	$209,859	Accellarated Prior Authorization Review - Base MCO	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70231 - MCO-NEWLY ELIGIBLE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$23,913	$24,367	$24,830	$25,302	Accellarated Prior Authorization Review - Newly Eligible	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70231 - MCO-NEWLY ELIGIBLE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$212,118	$219,307	$223,474	$227,720	Accellarated Prior Authorization Review - Newly Eligible	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70236 - MCO- EXPANSION POPULATION	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$624	$636	$648	$660	Accellarated Prior Authorization Review - Expansion	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70236 - MCO- EXPANSION POPULATION	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$5,615	$5,722	$5,830	$5,941	Accellarated Prior Authorization Review - Expansion	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70500 - MCO-ABD	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$47,376	$48,276	$49,193	$50,128	Accellarated Prior Authorization Review - MCO ABD	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70500 - MCO-ABD	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$110,545	$112,645	$114,786	$116,967	Accellarated Prior Authorization Review - MCO ABD	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02710 - MCO - IMMIGRANT CHILDREN	700104 - MCO - IMMIGRANT CHILDREN	H3201 - MEDICAID PROVIDER PAYMENTS	70224 - IMMIGRANT KIDS	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$4,629	$4,717	$4,807	$4,898	Accellarated Prior Authorization Review - ICP	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02707 - MCO - ALLIANCE	700101 - MCO - ALLIANCE	H3203 - ALLIANCE PROVIDER PAYMENT	70259 - MCO ALLIANCE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$52,638	$53,638	$54,657	$55,696	Accellarated Prior Authorization Review - Alliance	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP047 - CLINICIANS, RX AND ACUTE CARE	100190 - CLINICIANS, RX AND ACUTE CARE	H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION	70161 - DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	Recurring		$240,000	$244,560	$249,207	$253,942	Adverse Determination and Appeals Credentialing Requirements - Fee for Service	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	AMP047 - CLINICIANS, RX AND ACUTE CARE	100190 - CLINICIANS, RX AND ACUTE CARE	H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION	70161 - DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	Recurring		$720,000	$733,680	$747,620	$761,825	Adverse Determination and Appeals Credentialing Requirements - Fee for Service	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$81,000	$82,539	$84,107	$85,705	Adverse Determination and Appeals Credentialing Requirements - HSCSN	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$189,000	$192,591	$196,250	$199,979	Adverse Determination and Appeals Credentialing Requirements - HSCSN	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$157,642	$160,637	$163,689	$166,799	Adverse Determination and Appeals Credentialing Requirements - Base MCO	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$367,831	$374,820	$381,941	$389,198	Adverse Determination and Appeals Credentialing Requirements - Base MCO	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70231 - MCO-NEWLY ELIGIBLE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$44,348	$45,191	$46,049	$46,924	Adverse Determination and Appeals Credentialing Requirements - Newly Eligible	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70231 - MCO-NEWLY ELIGIBLE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$399,135	$406,719	$414,446	$422,321	Adverse Determination and Appeals Credentialing Requirements - Newly Eligible	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70236 - MCO- EXPANSION POPULATION	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$1,157	$1,179	$1,201	$1,224	Adverse Determination and Appeals Credentialing Requirements - Expansion	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02708 - MCO - CHILDLESS ADULTS (GROUP 8)	700102 - MCO - CHILDLESS ADULTS (GROUP 8)	H3201 - MEDICAID PROVIDER PAYMENTS	70236 - MCO- EXPANSION POPULATION	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$10,413	$10,611	$10,812	$11,018	Adverse Determination and Appeals Credentialing Requirements - Expansion	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70500 - MCO-ABD	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$87,863	$89,532	$91,234	$92,967	Adverse Determination and Appeals Credentialing Requirements - MCO ABD	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70500 - MCO-ABD	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$205,013	$208,908	$212,878	$216,922	Adverse Determination and Appeals Credentialing Requirements - MCO ABD	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02710 - MCO - IMMIGRANT CHILDREN	700104 - MCO - IMMIGRANT CHILDREN	H3201 - MEDICAID PROVIDER PAYMENTS	70224 - IMMIGRANT KIDS	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$8,586	$8,749	$8,915	$9,085	Adverse Determination and Appeals Credentialing Requirements - ICP	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02707 - MCO - ALLIANCE	700101 - MCO - ALLIANCE	H3203 - ALLIANCE PROVIDER PAYMENT	70259 - MCO ALLIANCE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$97,621	$99,476	$101,366	$103,292	Adverse Determination and Appeals Credentialing Requirements - Alliance	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	701100C - CONTINUING FULL TIME	7011001 - CONTINUING FULL TIME	2.00	Budget	Enhance	Recurring		$164,431	$167,555	$170,739	$173,983	FTE Requirement for B25-226 Access to Emergency Medications Amendment Act (Salary for one Grade 12, Step 1 Nurse Consultant ($98,335) and one Grade 9, Step 5 Program Support Specialist ($66,078))	B25-226/L25-124
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	701400C - FRINGE BENERFITS - CURR PERSONNEL	7014008 - MISC FRINGE BENEFITS		Budget	Enhance	Recurring		$36,175	$37,025	$37,895	$38,786	FTE Fringe Requirement for B25-226 Access to Emergency Medications Amendment Act	B25-226/L25-124
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	One Time		$46,000				Medication Storage for B25-226 Access to Emergency Medications Amendment Act	B25-226/L25-124
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	One Time		$22,000				Training Update for B25-226 Access to Emergency Medications Amendment Act	B25-226/L25-124
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	713200C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	Recurring		$376,000	$383,144	$390,424	$397,842	Medication Procurement and Distribution for B25-226 Access to Emergency Medications Amendment Act	B25-226/L25-124
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00407 - NUTRITION AND PHYSICAL FITNESS	700028 - NUTRITION AND PHYSICAL FITNESS	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70057 - NUTRITION AND PHYSICAL FITNESS BUREAU	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	Recurring		$600,000	$611,400	$623,017	$634,854	Enhancement for Produce Plus program to decrease waitlist	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$700,000				Increase grant to Children's National for School Health Suite Staffing to maintain current services	

Agency	Scenario	Committee	Cluster	Agency Code	DIFS Appr. Fund	DIFS Fund	DIFS Program Parent L1	DIFS Program	DIFS Cost Ctr. Parent L1	DIFS Cost Center	DIFS Account Parent L1	DIFS Account	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY24	FY25	FY26	FY27	FY28	Comments	Legislation
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$711,000				Increase grant to Children's National for Administration of Medication Training	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$74,600				PQC Grant for "Count the Kicks" Stillbirth Reduction Initiative	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00808 - PREVENTION AND INTERVENTION SERVICES	700041 - PREVENTION AND INTERVENTION SERVICES	H1001 - HIV/AIDS, HEPATITIS, STD, AND TB ADMINISTRATION	70079 - PREVENTION & INTERVENTION SERVICES	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	Recurring		$150,000	$152,850	$155,754	$158,713	Implementation of the Peer-Based Sexual Health and Risky Behavior Education Grant Program	BSA Subtitle: "Sexual Health Peer Educators Amendment Act of 2024"
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00401 - CANCER AND CHRONIC DISEASE PREVENTION	700023 - CANCER AND CHRONIC DISEASE PREVENTION	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70059 - CANCER & CHRONIC DISEASE BUREAU	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$771,160				Vaping Prevention and Cessation Program with proceeds from Juul Litigation Funding	BSA Subtitle:
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00407 - NUTRITION AND PHYSICAL FITNESS	700028 - NUTRITION AND PHYSICAL FITNESS	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70057 - NUTRITION AND PHYSICAL FITNESS BUREAU	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$120,000				To Implement the "Grocery Access Pilot Program"	BSA Subtitle: "Grocery Access Pilot Program Establishment Amendment Act of 2024
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00405 - FAMILY HEALTH	700026 - FAMILY HEALTH	H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY	70058 - FAMILY HEALTH BUREAU	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	Recurring		$25,000	$25,475	$25,959	$26,452	MAP Program - training to help staff who work with at risk families identify indicators of domestic violence, provide resources, and improve patient outcomes.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP064 - GRANTS ADMINISTRATION FUNCTION	100207 - GRANTS ADMINISTRATION FUNCTION	H3501 - HEALTH CARE REFORM AND INNOVATION ADMINISTRATION	70267 - AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$100,000				Transfer in from PWO for either Nurse Family Partnership or Home Visiting	BSA Subtitle
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP059 - DCAS INFORMATION TECHNOLOGY	100202 - DCAS INFORMATION TECHNOLOGY	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	7171000C - PURCHASES EQUIPMENT & MACHINERY	7171009 - IT SOFTWARE ACQUISITIONS		Budget	Enhance	One Time		$400,000	$0	$0	$0	Transfer in from PWO for either Nurse Family Partnership or Home Visiting	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H01301 - EMERGENCY MEDICAL SERVICES REGULATION	700050 - EMERGENCY MEDICAL SERVICES REGULATION	H0801 - HEALTH EMERGENCY PREPAREDNESS AND RESPONSE ADMINISTRATION	70067 - EMERGENCY MEDICAL MANAGEMENT DIVISION	7011000C - CONTINUING FULL TIME	7011001 - CONTINUING FULL TIME	1.00	Budget	Enhance	Recurring		$137,329	$139,938	$142,597	$145,306	Transfer in from T&E for Data Analyst for HEPRA Trauma Registry FTE	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011018 - INPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($587,167)	($598,323)	($609,691)	($621,275)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011018 - INPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02708 - MCO - CHILDLESS ADULTS (GROUP B)	700102 - MCO - CHILDLESS ADULTS (GROUP B)	H3201 - MEDICAID PROVIDER PAYMENTS	70231 - MCO-NEWLY ELIGIBLE	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($122,899)	($125,234)	($127,614)	($130,038)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011018 - INPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02708 - MCO - CHILDLESS ADULTS (GROUP B)	700102 - MCO - CHILDLESS ADULTS (GROUP B)	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($10,556)	($10,757)	($10,961)	($11,169)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011018 - INPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02710 - MCO - IMMIGRANT CHILDREN	700104 - MCO - IMMIGRANT CHILDREN	H3201 - MEDICAID PROVIDER PAYMENTS	70224 - IMMIGRANT KIDS	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($24,881)	($25,354)	($25,835)	($26,326)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011018 - INPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($69,060)	($70,372)	($71,709)	($73,072)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES	Budget	Reduction	Recurring		($1,370,056)	($1,396,087)	($1,422,612)	($1,449,642)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02708 - MCO - CHILDLESS ADULTS (GROUP B)	700102 - MCO - CHILDLESS ADULTS (GROUP B)	H3201 - MEDICAID PROVIDER PAYMENTS	70231 - MCO-NEWLY ELIGIBLE	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES	Budget	Reduction	Recurring		($1,106,088)	($1,127,104)	($1,148,519)	($1,170,340)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES	Budget	Reduction	Recurring		($161,140)	($164,202)	($167,322)	($170,501)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011019 - OUTPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($331,137)	($337,429)	($343,840)	($350,373)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011019 - OUTPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02708 - MCO - CHILDLESS ADULTS (GROUP B)	700102 - MCO - CHILDLESS ADULTS (GROUP B)	H3902 - INFORMATION SYSTEMS DIVISION	70321 - DCAS UNIT	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($60,195)	($61,339)	($62,504)	($63,692)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011019 - OUTPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02709 - MCO - CHIP	700103 - MCO - CHIP	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($16,400)	($16,712)	($17,029)	($17,353)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011019 - OUTPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02710 - MCO - IMMIGRANT CHILDREN	700104 - MCO - IMMIGRANT CHILDREN	H3201 - MEDICAID PROVIDER PAYMENTS	70224 - IMMIGRANT KIDS	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($17,455)	($17,786)	($18,124)	($18,469)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	1011019 - OUTPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($40,862)	($41,839)	($42,430)	($43,236)	Adjustment to Dedicated Tax Budget to increase the district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70200 - MANAGED CARE ORGANIZATIONS (MCO)	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES	Budget	Reduction	Recurring		($772,654)	($787,334)	($802,294)	($817,537)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02708 - MCO - CHILDLESS ADULTS (GROUP B)	700102 - MCO - CHILDLESS ADULTS (GROUP B)	H3201 - MEDICAID PROVIDER PAYMENTS	70231 - MCO-NEWLY ELIGIBLE	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES	Budget	Reduction	Recurring		($541,756)	($552,049)	($562,538)	($573,226)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1011 - DEDICATED TAXES	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02711 - MCO - MEDICAID	700105 - MCO - MEDICAID	H3201 - MEDICAID PROVIDER PAYMENTS	70202 - CASSIP	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES	Budget	Reduction	Recurring		($95,345)	($97,157)	($99,003)	($100,884)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP059 - DCAS INFORMATION TECHNOLOGY	100202 - DCAS INFORMATION TECHNOLOGY	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	7171000C - PURCHASES EQUIPMENT & MACHINERY	7171009 - IT SOFTWARE ACQUISITIONS		Budget	Enhance	Recurring		$844,599	$2,092,133	$2,131,616	$2,171,843	Committee balance	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP059 - DCAS INFORMATION TECHNOLOGY	100202 - DCAS INFORMATION TECHNOLOGY	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	7171000C - PURCHASES EQUIPMENT & MACHINERY	7171009 - IT SOFTWARE ACQUISITIONS		Budget	Enhance	One Time	$31,875					Committee balance	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AF0003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES	150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES	A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT	10070 - BUDGET DIVISION - HSSC	7111000C - SUPPLIES & MATERIALS	7111002 - OFFICE SUPPLIES		Budget	Reduction	Recurring		($1,000)	($1,019)	($1,038)	($1,058)	Reduce by $999.82 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AF0003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES	150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES	A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT	10070 - BUDGET DIVISION - HSSC	7111000C - SUPPLIES & MATERIALS	7111002 - OFFICE SUPPLIES		Budget	Reduction	One Time		($1,000)				Reduce by $999.82 to align with FY23 actual spending plus 20% for growth and inflation.	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H00808 - PREVENTION AND INTERVENTION SERVICES	700041 - PREVENTION AND INTERVENTION SERVICES	H1001 - HIV/AIDS, HEPATITIS, STD, AND TB ADMINISTRATION	70079 - PREVENTION & INTERVENTION SERVICES	7132000C - CONTRACTUAL SERVICES - OTHER	7132001 - CONTRACTUAL SERVICES - OTHER		Budget	Enhance	Recurring		$350,000	$356,650	$363,426	$370,331	To restore at home HIV and STI self-testing within HAHSTA, which would be eliminated in the proposed FY25 budget due to the loss of federal funding. The federal funding loss is due to the District's progress toward lowering the rate of new HIV infections	
Department of Health	Committee Recommendation	Committee on Health	Human Support Services	HC0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H01301 - EMERGENCY MEDICAL SERVICES REGULATION	700050 - EMERGENCY MEDICAL SERVICES REGULATION	H0801 - HEALTH EMERGENCY PREPAREDNESS AND RESPONSE ADMINISTRATION	70067 - EMERGENCY MEDICAL MANAGEMENT DIVISION	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7014008 - MISC FRINGE BENEFITS		Budget	Enhance	Recurring		$30,212	$30,786	$31,371	$31,967	Transfer in from T&E for Data Analyst for HEPRA Trauma Registry; growth rates match fin plan amounts, not the FR	
Health Benefit Exchange Authority	Committee Recommendation	Committee on Health	Enterprise and Other Funds	HI0	8362 - ENTERPRISE AND OTHER FUNDS - HBX	8362003 - HEALTH BENEFIT EXCHANGE AUTHORITY FUND	H02004 - MEMBER SERVICES	700065 - MEMBER SERVICES	H2201 - PROGRAM DEPARTMENT	70468 - PROGRAM MANAGEMENT	7141000C - GOVERNMENT SUBSIDIES & GRANTS	7141009 - SUBSIDIES		Budget	Enhance	Recurring			$175,000	$245,000		Non-standard enhancement to fund Defrayal Costs in FY26 and FY27 for Insurers to implement the Expanding Access to Fertility Treatment Amendment Act of 2023	B25-34/L25-49 Expanding Access to Fertility Treatment Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP059 - DCAS INFORMATION TECHNOLOGY	100202 - DCAS INFORMATION TECHNOLOGY	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	7131000C - OTHER SERVICES & CHARGES	7131003 - TRAVEL - OUT OF CITY		Budget	Reduction	Recurring		($3,450)	($3,516)	($3,582)	($3,651)	Reduce by $3,450.13 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7131000C - OTHER SERVICES & CHARGES	7131015 - ADVERTISING		Budget	Reduction	Recurring		($23,750)	($24,201)	($24,661)	($25,130)	Reduce by $23,750.06 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7131000C - OTHER SERVICES & CHARGES	7131020 - TUITION FOR EMPLOYEE TRAINING		Budget	Reduction	Recurring		($46,056)	($46,931)	($47,823)	($48,731)	Reduce by $46,055.97 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7131000C - OTHER SERVICES & CHARGES	7131024 - CONFERENCE FEES		Budget	Reduction	Recurring		($8,593)	($8,757)	($8,923)	($9,093)	Reduce by $8,593.35 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP059 - DCAS INFORMATION TECHNOLOGY	100202 - DCAS INFORMATION TECHNOLOGY	H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION	70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	7131000C - OTHER SERVICES & CHARGES	7131024 - CONFERENCE FEES		Budget	Reduction	Recurring		($6,762)	($6,890)	($7,021)	($7,155)	Reduce by $6,761.86 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP041 - PROGRAM INTEGRITY	100184 - PROGRAM INTEGRITY	H3001 - PROGRAM INTEGRITY ADMINISTRATION	70156 - PROGRAM INTEGRITY SUPPORT DIVISION	7131000C - OTHER SERVICES & CHARGES	7131024 - CONFERENCE FEES		Budget	Reduction	Recurring		($13,167)	($13,418)	($13,673)	($13,932)	Reduce by $13,167.46 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP038 - SENIOR DEPUTY DIRECTOR/FINANCE	100181 - SENIOR DEPUTY DIRECTOR/FINANCE	H8200 - OFFICE OF DDS FINANCE	70538 - SENIOR DEPUTY DIRECTOR FINANCE ADMINISTRATIVE FUNCTIONS	7131000C - OTHER SERVICES & CHARGES	7131024 - CONFERENCE FEES		Budget	Reduction	Recurring		($5,100)	($5,197)	($5,296)	($5,397)	Reduce by $5,100.37 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7131000C - OTHER SERVICES & CHARGES	7131025 - PAYMENT OF MEMBERSHIP DUES		Budget	Reduction	Recurring		($3,536)	($3,603)	($3,672)	($3,741)	Reduce by $3,536.03 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7171000C - PURCHASES EQUIPMENT & MACHINERY	7171009 - IT SOFTWARE ACQUISITIONS		Budget	Reduction	Recurring		($2,582)	($2,631)	($2,681)	($2,732)	Reduce by $2,581.63 to align with the FY23 Account actual spending amount plus 20% for growth and inflation.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	7171000C - PURCHASES EQUIPMENT & MACHINERY	7171009 - IT SOFTWARE ACQUISITIONS		Budget	Reduction	One Time	($135,451)					PLACEHOLDER REDUCTION to increase vacancy savings to 6%. Will replace with appropriate attributes.	

Agency	Scenario	Committee	Cluster	Agency Code	DIFS Appr. Fund	DIFS Fund	DIFS Program Parent L1	DIFS Program	DIFS Cost Ctr. Parent L1	DIFS Cost Center	DIFS Account Parent L1	DIFS Account	Proposed Change in FTEs	Resources/ Budget	Adjustment	Recurring or One-Time Change	FY24	FY25	FY26	FY27	FY28	Comments	Legislation
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	AMP039 - CHIEF OPERATING OFFICE	100182 - CHIEF OPERATING OFFICE	H3702 - OFFICE OF THE CHIEF OPERATING OFFICER	70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	717100C - PURCHASES EQUIPMENT & MACHINERY	7171009 - IT SOFTWARE ACQUISITIONS		Budget	Reduction	One Time		($135,451)				PLACEHOLDER REDUCTION to increase vacancy savings to 6%. Will replace with appropriate attributes.	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02709 - MCO - CHIP	700103 - MCO - CHIP	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$8,388	$8,547	$8,710	$8,875	Accelerated Prior Authorization Review - CHIP	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H02709 - MCO - CHIP	700103 - MCO - CHIP	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$15,556	$15,852	$16,153	$16,460	Adverse Determination and Appeals Credentialing Requirements - CHIP	
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02709 - MCO - CHIP	700103 - MCO - CHIP	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$31,555	$32,155	$32,765	$33,388	Accelerated Prior Authorization Review - CHIP	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02709 - MCO - CHIP	700103 - MCO - CHIP	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Enhance	Recurring		$58,520	$59,632	$60,765	$61,919	Adverse Determination and Appeals Credentialing Requirements - CHIP	B25-0124/L25-100 "Prior Authorization Reform Amendment Act of 2023
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02709 - MCO - CHIP	700103 - MCO - CHIP	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($39,709)	($40,463)	($41,232)	($42,016)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Inpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Inpatient Hospital Directed Payment Act of 2024
Department of Health Care Finance	Committee Recommendation	Committee on Health	Human Support Services	HT0	4025 - FEDERAL MEDICAID PAYMENTS	4025002 - FEDERAL MEDICIAD PAYMENTS	H02709 - MCO - CHIP	700103 - MCO - CHIP	H3201 - MEDICAID PROVIDER PAYMENTS	70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141003 - MEDICAL VENDOR SERVICES		Budget	Reduction	Recurring		($61,695)	($62,868)	($64,062)	($65,279)	Adjustment to Medicaid Budget due to increased district retention provided for in the Medicaid Outpatient Hospital Directed Payment subtitle	BSA Subtitle: Medicaid Outpatient Hospital Directed Payment Act of 2024
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04311 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	700286 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES	70424 - SUD PREVENTION OFFICE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$750,000				Transfer in from PWO for Substance Abuse and Behavioral Health Services Targeted outreach	BSA Subtitle: "Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2024"
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04311 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	700286 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES	70424 - SUD PREVENTION OFFICE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	Recurring		$300,000	$305,700	$311,508	$317,427	Transfer in from BED for Gambling Addiction	
Department of Behavioral Health	Committee Recommendation	Committee on Health	Human Support Services	RM0	1010 - LOCAL FUND	1010001 - LOCAL FUNDS	H04311 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	700286 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES	70424 - SUD PREVENTION OFFICE	714100C - GOVERNMENT SUBSIDIES & GRANTS	7141007 - GRANTS & GRATUITIES		Budget	Enhance	One Time		$200,000				Transfer in from RTLA for Ward 8 Targeted Outreach Site	BSA Subtitle: "Substance Abuse and Behavioral Health Services Targeted Outreach Pilot Act of 2024"

Agency Operating Budget by Cost Center Parent L1 and Cost Center					
Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	$671,144	$0	$0	$0	$0
10002 - ACCOUNTING DIVISION	$898,745	$0	$0	$0	$0
10003 - ACFO DIVISION	$222,377	$0	$0	$0	$0
10070 - BUDGET DIVISION - HSSC	$292	$1,395,339	$810,235	$0	$810,235
10071 - ACCOUNTING DIVISION - HSSC	$0	$787,171	$890,306	$0	$890,306
10072 - ACFO DIVISION - HSSC	$0	$312,564	$577,230	$0	$577,230
10086 - P-CARD CLEARING	$37,998	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$1,830,556**	**$2,495,073**	**$2,277,771**	**$0**	**$2,277,771**
C0100 - NO COST CENTER					
00000 - NO COST CENTER	($201,670)	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**($201,670)**	**$0**	**$0**	**$0**	**$0**
H5701 - DIVISION OF ADULT SERVICES					
70411 - FORENSIC SERVICES OFFICE	$4,371,424	$4,734,130	$4,102,385	$0	$4,102,385
70414 - ASSESSMENTS AND REFERRALS OFFICE	$1,765,180	$2,273,267	$2,393,309	$0	$2,393,309
70417 - SPECIALTY CARE OFFICE	$7,971,873	$7,416,635	$5,514,618	$0	$5,514,618
70418 - SOR GRANT OFFICE	$25,405,859	$29,847,071	$36,014,647	$0	$36,014,647
70419 - OFFICE OF RESIDENTIAL SUPPORT AND CONTINULTY SERVIC	$614,491	$582,907	$599,614	$0	$599,614
70420 - HOUSING DEVELOPMENT OFFICE	$27,419,358	$29,637,309	$28,987,309	($292,980)	$28,694,329
70567 - LOCAL BEHAVIORAL HEALTH REHABILITATION OFFICE	$0	$0	$44,638,076	$0	$44,638,076
TOTAL COST CENTER PARENT L1 FUNDS	**$67,548,186**	**$74,491,317**	**$122,249,958**	**($292,980)**	**$121,956,978**
H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES					
70416 - OFFICE OF BEHAVIORAL HEALTH SERVICES	$7,395,059	$7,791,734	$7,682,553	$0	$7,682,553
70424 - SUD PREVENTION OFFICE	$12,248,501	$13,171,675	$11,752,089	$1,250,000	$13,002,089
70425 - OFFICE OF PREVENTION AND EARLY INTERVENTION	$31,318,051	$42,236,343	$31,864,077	($669,748)	$31,194,329
70426 - OFFICE OF LINKAGE AND ASSESSMENTS	$4,343,647	$4,453,466	$2,396,602	$0	$2,396,602
70427 - OFFICE OF COMMUNITY BASED SERVICES	$64,545,506	$66,731,236	$26,122,571	$0	$26,122,571
TOTAL COST CENTER PARENT L1 FUNDS	**$119,850,765**	**$134,384,453**	**$79,817,893**	**$580,252**	**$80,398,144**
H5901 - EXECUTIVE OFFICE OF THE DIRECTOR					
70428 - EXECUTIVE ADMINISTRATIVE OFFICE - RM0	$2,991,784	$3,960,306	$3,761,979	$0	$3,761,979
70429 - OFFICE OF THE GENERAL COUNSEL - RM0	$1,049,390	$1,040,560	$1,046,625	$0	$1,046,625
TOTAL COST CENTER PARENT L1 FUNDS	**$4,041,174**	**$5,000,866**	**$4,808,604**	**$0**	**$4,808,604**
H6001 - OFFICE OF POLICY ADVISOR					
70432 - OFFICE OF SYSTEMS TRANSFORMATION	$6,091,311	$6,292,334	$5,821,094	$0	$5,821,094
TOTAL COST CENTER PARENT L1 FUNDS	**$6,091,311**	**$6,292,334**	**$5,821,094**	**$0**	**$5,821,094**
H6101 - OFFICE OF THE CHIEF CLINICAL OFFICER					
70433 - OFFICE OF CLINICAL SERVICES AND SUPPORT	$1,490,638	$202,510	$202,510	$0	$202,510
70434 - OFFICE OF DISASTER BEHAVIORAL HEALTH AND SUPPORT SI	$302,495	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$1,793,132**	**$202,510**	**$202,510**	**$0**	**$202,510**
H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL					
70435 - OFFICE OF CHIEF NURSING EXECUTIVE (SEH)	$53,997,718	$46,290,762	$50,248,168	$0	$50,248,168
70437 - OFFICE OF CHIEF QUALITY DATA TRAINING & PERFORMANCE	$1,454,629	$1,571,602	$1,505,308	($11,275)	$1,494,032
70438 - OFFICE OF THE CHIEF OF STAFF (SEH)	$7,619	$110,067	$74,093	$0	$74,093
70439 - OFFICE OF THE CHIEF CLINICAL OFFICER (SEH)	$33,641,410	$33,758,757	$35,771,151	($36,213)	$35,734,939
70440 - OFFICE OF THE CHIEF OPERATING OFFICER (SEH)	$20,028,937	$21,035,340	$20,106,594	($91,801)	$20,014,794
TOTAL COST CENTER PARENT L1 FUNDS	**$109,130,313**	**$102,766,528**	**$107,705,313**	**($139,288)**	**$107,566,025**
H6301 - OFFICE OF THE CHIEF OF STAFF					
70441 - LEGISLATIVE & PUBLIC AFFAIRS OFFICE	$932,635	$963,828	$917,518	$0	$917,518
70443 - CONSUMER AND FAMILY AFFAIRS OFFICE	$1,996,907	$993,354	$1,018,515	$0	$1,018,515
70444 - OFFICE OF OMBUDSMAN	$293,560	$302,307	$401,154	$0	$401,154
70445 - HUMAN RESOURCES OFFICE - RM0	$2,369,028	$3,043,988	$2,790,285	$0	$2,790,285
TOTAL COST CENTER PARENT L1 FUNDS	**$5,592,130**	**$5,303,478**	**$5,127,471**	**$0**	**$5,127,471**
H6401 - OFFICE OF THE CHIEF OPERATING OFFICER					
70446 - CLAIMS AND BILLING OFFICE	$2,157,390	$818,323	$844,135	$0	$844,135
70447 - FISCAL SERVICES AND MONITORING OFFICE	$15,262,142	$18,215,402	$11,572,116	($316,414)	$11,255,702
70448 - INFORMATION TECHNOLOGY OFFICE - RM0	$5,671,105	$6,548,434	$5,066,119	$0	$5,066,119
70450 - RECORDS MANAGEMENT OFFICE	$686,471	$815,427	$807,991	$0	$807,991
TOTAL COST CENTER PARENT L1 FUNDS	**$23,777,108**	**$26,397,586**	**$18,290,360**	**($316,414)**	**$17,973,946**
H8001 - OFFICE OF OPIOID ABATEMENT					
70508 - OFFICE OF OPIOID ABATEMENT	$0	$548,000	$14,655,500	$0	$14,655,500
TOTAL COST CENTER PARENT L1 FUNDS	**$0**	**$548,000**	**$14,655,500**	**$0**	**$14,655,500**
H8300 - DIVISION OF CRISIS SERVICES					
70412 - COMMUNITY RESPONSE OFFICE	$8,110,980	$10,644,554	$9,982,467	$0	$9,982,467
70413 - OFFICE OF COMPREHENSIVE PSYCHIATRIC EMERGENCY SEF	$5,098,748	$5,174,478	$7,756,394	($18,848)	$7,737,546
70415 - ACCESS HELPLINE OFFICE	$1,729,525	$2,987,375	$2,630,514	$0	$2,630,514
70555 - CHILD/YOUTH CRISIS & COMMUNITY TRAUMA RESPONSE OF	$0	$0	$1,366,544	$0	$1,366,544
TOTAL COST CENTER PARENT L1 FUNDS	**$14,939,253**	**$18,806,407**	**$21,735,920**	**($18,848)**	**$21,717,072**
H8401 - DIVISION OF DATA, QUALITY and COMPLIANCE					
70430 - OFFICE OF ACCOUNTABILITY	$3,784,555	$3,411,485	$2,843,846	($46,227)	$2,797,619
TOTAL COST CENTER PARENT L1 FUNDS	**$3,784,555**	**$3,411,485**	**$2,843,846**	**($46,227)**	**$2,797,619**
TOTAL AGENCY FUNDS	**$358,176,811**	**$380,100,036**	**$385,536,240**	**($233,506)**	**$385,302,734**
Department of Health					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	$1,124,210	$1,272,746	$0	$0	$0
10002 - ACCOUNTING DIVISION	$1,054,412	$1,329,845	$0	$0	$0
10003 - ACFO DIVISION	$751,491	$869,005	$0	$0	$0
10070 - BUDGET DIVISION - HSSC	$0	$0	$1,315,053	($2,000)	$1,313,053

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
10071 - ACCOUNTING DIVISION - HSSC	$0	$0	$1,383,475	$0	$1,383,475
10072 - ACFO DIVISION - HSSC	$0	$0	$857,559	$0	$857,559
TOTAL COST CENTER PARENT L1 FUNDS	**$2,930,113**	**$3,471,596**	**$3,556,087**	**($2,000)**	**$3,554,087**
C0100 - NO COST CENTER					
00000 - NO COST CENTER	$7,366	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$7,366**	**$0**	**$0**	**$0**	**$0**
H0601 - CENTER FOR POLICY, PLANNING, AND EVALUATION					
70049 - COMMUNITY PROGRAMS DIVISION - HC0	$8,708,071	$20,767,882	$32,719,890	$0	$32,719,890
70050 - COMMUNITY PROGRAMS - OPERATIONS DIVISION - HC0	$4,129,968	$5,074,580	$4,991,528	$0	$4,991,528
70054 - HEALTHY PEOPLE OFFICE	$1,687,855	$2,593,612	$3,314,419	$0	$3,314,419
TOTAL COST CENTER PARENT L1 FUNDS	**$14,525,894**	**$28,436,074**	**$41,025,838**	**$0**	**$41,025,838**
H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY					
70057 - NUTRITION AND PHYSICAL FITNESS BUREAU	$22,255,563	$22,474,173	$22,523,173	$720,000	$23,243,173
70058 - FAMILY HEALTH BUREAU	$57,978,662	$46,126,495	$40,057,552	$2,155,206	$42,212,758
70059 - CANCER & CHRONIC DISEASE BUREAU	$11,384,446	$9,710,496	$10,702,362	$771,160	$11,473,522
70060 - HEALTHCARE ACCESS BUREAU	$3,912,198	$3,657,070	$10,278,374	$0	$10,278,374
TOTAL COST CENTER PARENT L1 FUNDS	**$95,530,869**	**$81,968,234**	**$83,561,460**	**$3,646,366**	**$87,207,826**
H0702 - COMMUNITY HEALTH ADMINISTRATION					
70056 - DEPUTY DIRECTOR FOR OPERATIONS - CHA	$7,490,920	$9,481,382	$9,136,206	($17,720)	$9,118,486
TOTAL COST CENTER PARENT L1 FUNDS	**$7,490,920**	**$9,481,382**	**$9,136,206**	**($17,720)**	**$9,118,486**
H0801 - HEALTH EMERGENCY PREPAREDNESS AND RESPONSE ADMINISTRATION					
70062 - SENIOR DEPUTY DIRECTOR'S OFFICE - HEPRA	$7,232,199	$3,919,363	$4,799,908	$0	$4,799,908
70066 - PLANNING, OPERATIONS AND TRAINING DIVISION	$340,581	$462,117	$0	$0	$0
70067 - EMERGENCY MEDICAL MANAGEMENT DIVISION	$106,421	$201,301	$135,479	$167,541	$303,020
70068 - PUBLIC HEALTH PREPAREDNESS DIVISION	$2,023,169	$1,502,138	$1,481,355	$0	$1,481,355
TOTAL COST CENTER PARENT L1 FUNDS	**$9,702,370**	**$6,084,920**	**$6,416,742**	**$167,541**	**$6,584,283**
H0901 - HEALTH REGULATION AND LICENSING ADMINISTRATION					
70070 - OFFICE OF HEALTH PROFESSIONAL LICENSING BOARDS	$13,805,433	$11,853,378	$12,599,294	$0	$12,599,294
70071 - OFFICE OF HEALTH FACILITIES	$6,217,104	$8,215,422	$7,372,921	$0	$7,372,921
70073 - OFFICE OF FOOD, DRUG, RADIATION AND COMMUNITY HYG	$14,551,012	$14,128,003	$14,015,136	($25,550)	$13,989,586
TOTAL COST CENTER PARENT L1 FUNDS	**$34,573,549**	**$34,196,803**	**$33,987,351**	**($25,550)**	**$33,961,801**
H1001 - HIV/AIDS, HEPATITIS, STD, AND TB ADMINISTRATION					
70076 - SENIOR DEPUTY DIRECTOR'S OFFICE - HAHSTA	$2,872,557	$2,840,154	$4,164,014	$0	$4,164,014
70077 - DEPUTY DIRECTOR FOR OPERATIONS - HAHSTA	$2,204,107	$3,430,210	$3,289,794	$0	$3,289,794
70078 - CARE AND TREATMENT DIVISION	$36,937,310	$39,975,052	$38,172,448	$0	$38,172,448
70079 - PREVENTION & INTERVENTION SERVICES	$23,362,071	$20,180,370	$22,606,467	$500,000	$23,106,467
70080 - STRATEGIC INFORMATION DIVISION	$2,037,954	$4,165,821	$3,991,618	$0	$3,991,618
70081 - HOUSING CAPACITY BUILDING AND COMMUNITY OUTREACH	$11,863,045	$13,664,395	$13,980,418	$0	$13,980,418
70082 - STD/TB CONTROL DIVISION	$6,067,254	$6,068,445	$5,545,260	$0	$5,545,260
TOTAL COST CENTER PARENT L1 FUNDS	**$85,344,298**	**$90,324,448**	**$91,750,019**	**$500,000**	**$92,250,019**
H1101 - OFFICE OF HEALTH EQUITY					
70083 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLICY I	$5,224,655	$5,375,863	$254,888	$0	$254,888
70084 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATION	$125,182	$102,390	$12,333	$0	$12,333
70085 - MULTI SECTOR COLLABORATION OFFICE	$478,091	$567,539	$695,024	$0	$695,024
TOTAL COST CENTER PARENT L1 FUNDS	**$5,827,928**	**$6,045,793**	**$962,245**	**$0**	**$962,245**
H1201 - OFFICE OF THE CHIEF OPERATING OFFICER					
70086 - INFORMATION TECHNOLOGY OFFICE - HC0	$6,405,450	$4,165,806	$8,090,145	$0	$8,090,145
70087 - HUMAN RESOURCES OFFICE - HC0	$1,626,902	$2,055,249	$2,363,641	$0	$2,363,641
70089 - CONTRACTS AND PROCUREMENT OFFICE - HC0	$870,607	$785,676	$1,241,399	$0	$1,241,399
70090 - FACILITIES MANAGEMENT & SUPPORT OFFICE - HC0	$16,396,265	$19,639,133	$16,991,359	$0	$16,991,359
70463 - LEGAL OFFICE - HC0	$2,293,932	$2,716,132	$2,702,454	$0	$2,702,454
TOTAL COST CENTER PARENT L1 FUNDS	**$27,593,155**	**$29,361,996**	**$31,388,997**	**$0**	**$31,388,997**
H1202 - OFFICE OF THE CHIEF OF STAFF					
70091 - COMMUNITY RELATIONS OFFICE - HC0	$822,057	$1,056,599	$1,335,580	$0	$1,335,580
TOTAL COST CENTER PARENT L1 FUNDS	**$822,057**	**$1,056,599**	**$1,335,580**	**$0**	**$1,335,580**
H1203 - OFFICE OF THE DIRECTOR					
70462 - EXECUTIVE OFFICE - HC0	$4,249,839	$1,700,763	$1,708,472	($3,556)	$1,704,916
TOTAL COST CENTER PARENT L1 FUNDS	**$4,249,839**	**$1,700,763**	**$1,708,472**	**($3,556)**	**$1,704,916**
H7401 - COMMUNITY HEALTH ADMINISTRATION					
70465 - PRIMARY CARE AND PREVENTION ADMINISTRATION	$98,187	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$98,187**	**$0**	**$0**	**$0**	**$0**
TOTAL AGENCY FUNDS	**$288,696,544**	**$292,128,607**	**$304,828,997**	**$4,265,081**	**$309,094,078**
Department of Health Care Finance					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	$650,653	$740,233	$835,970	$0	$835,970
10002 - ACCOUNTING DIVISION	$3,354,462	$7,133,253	$7,249,272	$0	$7,249,272
10003 - ACFO DIVISION	$335,813	$356,386	$368,559	$0	$368,559
10071 - ACCOUNTING DIVISION - HSSC	$1,784	$0	$0	$0	$0
10086 - P-CARD CLEARING	$637	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$4,343,349**	**$8,229,872**	**$8,453,801**	**$0**	**$8,453,801**
H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION					
70152 - DCAS - PROGRAM MANAGEMENT DIVISION	$2,842,253	$2,397,305	$2,020,398	($209,776)	$1,810,622
70153 - PROJECT MANAGEMENT DIVISION	$3,707,477	$8,626,369	$4,350,037	($22,281)	$4,327,756
70154 - ORGANIZATIONAL CHANGE DIVISION	$5,708,486	$13,477,387	$12,989,521	$0	$12,989,521
70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	$38,939,783	$51,743,876	$57,293,250	$1,219,517	$58,512,767
70535 - DCAS HHS FUNCTIONAL DIVISION	$0	$0	$814,115	$0	$814,115
TOTAL COST CENTER PARENT L1 FUNDS	**$51,197,999**	**$76,244,937**	**$77,467,320**	**$987,460**	**$78,454,780**

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H2902 - HEALTH AND HUMAN SERVICES FUNCTIONAL DIVISION					
70507 - HEALTH AND HUMAN SERVICES FUNCTIONAL DIVISION	$0	$708,779	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$0**	**$708,779**	**$0**	**$0**	**$0**
H3001 - PROGRAM INTEGRITY ADMINISTRATION					
70156 - INVESTIGATION AND COMPLIANCE DIVISION	$0	$0	$1,082,601	$0	$1,082,601
70157 - SURVEILLANCE AND UTILIZATION DIVISION	$0	$0	$1,991,561	$0	$1,991,561
70158 - PROGRAM INTEGRITY SUPPORT DIVISION	$3,510,956	$3,986,654	$1,696,494	($16,367)	$1,680,127
TOTAL COST CENTER PARENT L1 FUNDS	**$3,510,956**	**$3,986,654**	**$4,770,656**	**($16,367)**	**$4,754,289**
H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION					
70159 - HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION	$1,031,103	$1,486,607	$1,445,848	($2,351)	$1,443,498
70160 - DIVISION OF MANAGED CARE	$7,597,436	$12,819,010	$9,885,450	($300,000)	$9,585,450
70161 - DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SE	$7,604,805	$9,861,474	$8,363,600	$1,201,921	$9,565,521
70162 - DIVISON OF QUALITY AND HEALTH OUTCOMES	$2,225,827	$3,166,714	$2,948,407	$0	$2,948,407
70163 - DIVISION OF CHILDREN'S HEALTH SERVICES	$937,423	$1,564,887	$1,792,502	$0	$1,792,502
TOTAL COST CENTER PARENT L1 FUNDS	**$19,396,593**	**$28,898,692**	**$24,435,808**	**$899,570**	**$25,335,378**
H3201 - MEDICAID PROVIDER PAYMENTS					
70164 - INPATIENT IN STATE	$104,023,763	$108,872,966	$119,614,406	$0	$119,614,406
70165 - INPATIENT CHIP	$306,716	$184,814	$203,048	$0	$203,048
70166 - INPATIENT - DSH PAYMENTS	$57,213,799	$76,011,793	$0	$0	$0
70167 - INPATIENT - GME PAYMENTS	$26,026,717	$28,256,762	$28,545,255	$0	$28,545,255
70168 - MENTAL HEALTH FACILITY SERVICES	$574,372	$2,417,349	$2,456,478	$0	$2,456,478
70170 - PSYCHIATRIC RESIDENTIAL TREATMENT FACIL.	$961,997	$1,042,011	$1,939,358	$0	$1,939,358
70171 - NURSING FACILITY IN STATE	$324,068,727	$295,327,295	$313,024,453	$0	$313,024,453
70172 - NURSING HOME QUALITY OF CARE SERVICES	$156,669	$88,507	$200,000	$0	$200,000
70173 - ICF PRIVATE	$102,854,775	$90,585,166	$111,860,655	$0	$111,860,655
70174 - PHYSICIAN SERVICES-MEDICAID	$10,727,658	$21,974,711	$21,139,111	$0	$21,139,111
70175 - PHYSICIAN SERVICES CHIP	$147,844	$53,765	$51,720	$0	$51,720
70176 - OUTPATIENT HOSPITAL IN STATE	$15,467,360	$18,956,112	$15,423,162	$0	$15,423,162
70177 - OUTPATIENT HOSPITAL CHIP	$79,347	$73,264	$59,609	$0	$59,609
70178 - PRESCRIBED DRUGS	$44,239,477	$40,622,456	$50,351,460	$0	$50,351,460
70179 - PRESCRIBED DRUGS - CHIP	$208,679	$1,647,568	$2,111,998	$0	$2,111,998
70180 - DENTAL SERVICES	$4,645,381	$4,743,932	$4,441,819	$0	$4,441,819
70181 - DENTAL SERVICES - CHIP	$17,370	$33,464	$31,333	$0	$31,333
70182 - OTHER PRACTITIONERS' SERVICES	$774,472	$810,599	$807,736	$0	$807,736
70183 - OTHER PRACTITIONERS' SERVICES CHIP	$27,288	$2,755	$2,745	$0	$2,745
70184 - CLINIC SERVICES - PRIVATE	$5,605,924	$6,114,822	$4,355,280	$0	$4,355,280
70185 - CLINIC SERVICES - PRIVATE CHIP	$4,191	$1,147	$817	$0	$817
70186 - CLINIC SERVICES - MENTAL HEALTH	$337,026	$463,136	$23,470,947	$0	$23,470,947
70187 - CLINIC SERVICES - MENTAL HEALTH CHIP	$3,458	$113	$0	$0	$0
70188 - CLINIC SERVICES - MHRS	$163,693,063	$142,205,963	$46,915,248	$0	$46,915,248
70189 - CLINIC SERVICES - MHRS CHIP	$2,359,523	$2,154,118	$0	$0	$0
70190 - LABORATORY & RADIOLOGICAL SERVICES	$4,887,035	$5,168,391	$4,981,877	$0	$4,981,877
70191 - LABORATORY & RADIOLOGICAL SERVICES -CHIP	$30,684	$17,840	$17,196	$0	$17,196
70192 - HOME HEALTH SERVICES	$12,229,214	$11,911,749	$13,308,136	$0	$13,308,136
70193 - HOME HEALTH SERVICES - CHIP	$0	$57,398	$51,570	$0	$51,570
70194 - STERILIZATIONS	$14,012	$6,675	$6,644	$0	$6,644
70195 - EPSDT-MEDICAID	$365,858	$394,127	$519,367	$0	$519,367
70196 - EPSDT SCREENING SERVICES - CHIP	$6,276	$15,820	$20,847	$0	$20,847
70197 - MEDICAID PART A	$14,234,134	$16,974,220	$16,643,612	$0	$16,643,612
70198 - MEDICAID PART B	$73,304,212	$77,288,111	$84,249,232	$0	$84,249,232
70199 - MEDICAID PART B - NON FFP	$4,976,813	$1,595,903	$6,067,553	$0	$6,067,553
70200 - MANAGED CARE ORGANIZATIONS (MCO)	$640,492,539	$940,323,976	$860,635,284	($2,252,201)	$858,383,083
70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	$48,891,676	$89,400,563	$67,439,236	($14,341)	$67,424,895
70202 - CASSIP	$185,992,791	$188,530,387	$228,755,225	$592,592	$229,347,817
70203 - PERSONAL CARE SERVICES	$93,281,138	$113,898,085	$101,271,156	$0	$101,271,156
70205 - HOSPICE BENEFITS	$2,061,926	$2,799,137	$2,756,132	$0	$2,756,132
70206 - FEDERALLY-QUALIFIED HEALTH CENTER	$8,328,751	$9,638,944	$10,555,508	$0	$10,555,508
70207 - FEDERALLY-QUALIFIED HEALTH CENTER - CHIP	$18,171	$836,638	$916,193	$0	$916,193
70208 - NON-EMERGENCY MEDICAL TRANSPORTATION	$19,631,470	$26,242,202	$26,040,228	$0	$26,040,228
70209 - NON-EMERGENCY MEDICAL TRANSPORT. - CHIP	$87,570	$137,669	$138,154	$0	$138,154
70210 - PHYSICAL THERAPY	$60,477	$107,456	$75,002	$0	$75,002
70211 - PHYSICAL THERAPY - CHIP	$217	$1,806	$1,260	$0	$1,260
70212 - PROSTHETIC DEVICES, DENTURES, EYEGLASSES	$1,686,908	$2,205,815	$1,533,608	$0	$1,533,608
70213 - PROSTHETC DVCS,DENTURES,EYEGLASSES-CHIP	$746	$2,237	$1,555	$0	$1,555
70214 - NURSE MID-WIFE	$44,293	$91,907	$67,382	$0	$67,382
70215 - EMERGENCY HOSPITAL SERVICES	$4,747,175	$5,023,224	$5,259,228	$0	$5,259,228
70216 - EMERGENCY HOSPITAL SERVICES - CHIP	$36,212	$47,851	$43,653	$0	$43,653
70217 - NURSE PRACTITIONER SERVICES	$3,623,234	$3,188,398	$4,315,393	$0	$4,315,393
70218 - NURSE PRACTITIONER SERVICES - CHIP	$5,794	$7,592	$10,275	$0	$10,275
70219 - PRIVATE DUTY NURSING	$11,285,914	$8,119,161	$17,624,133	$0	$17,624,133
70221 - DURABLE MED EQUIP (DME)-MEDICAID	$19,490,424	$19,062,147	$11,588,263	$0	$11,588,263
70222 - DURABLE MED EQUIP (DME)-MEDICAID - CHIP	$1,434	$4,878	$2,965	$0	$2,965
70223 - COBRA/RECIPIENT OOP	$40,753	$945,000	$42,587	$0	$42,587
70224 - IMMIGRANT KIDS	$15,118,596	$10,491,795	$18,270,916	($29,121)	$18,241,795
70225 - OPTIONAL STATE SUPPLEMENT PAYMENTS	$4,971,098	$5,594,124	$5,403,324	$0	$5,403,324
70226 - PART-D CLAWBACK	$23,420,152	$24,725,239	$30,201,502	$0	$30,201,502
70228 - IDD WAIVER	$326,958,411	$241,997,891	$258,474,146	$0	$258,474,146
70229 - EPD WAIVER	$192,147,253	$147,249,069	$172,611,919	$0	$172,611,919
70230 - ADULT DAY HEALTH	$3,469,455	$6,412,659	$4,871,727	$0	$4,871,727
70231 - MCO-NEWLY ELIGIBLE	$750,707,580	$651,147,235	$898,292,085	($1,088,129)	$897,203,957
70232 - EMERGENCY MEDICAID (NON MEDICAID POP.)	$31,476,885	$35,829,677	$16,731,102	$0	$16,731,102
70233 - ICF SUPPLEMENTAL PAYMENTS	$107,610	$2,600,000	$2,600,000	$0	$2,600,000
70234 - APRA ASARS: ADULT SUBSTANCE ABUSE	$15,446,767	$2,391,205	$2,322,871	$0	$2,322,871
70235 - APRA ASTEP: CHILD SUBSTANCE ABUSE	$903	$2,962	$5,558	$0	$5,558
70236 - MCO- EXPANSION POPLULATION	$20,213,992	$17,398,494	$27,538,684	$17,809	$27,556,493
70237 - DHCF - HEALTH HOMES I	$193,079	$328,168	$227,885	$0	$227,885
70238 - HEALTH HOMES II	$2,815,727	$2,952,016	$1,843,402	$0	$1,843,402
70239 - PROGRAM OF ALL-INCLUSIVE CARE (PACE)	$932,279	$17,643,899	$14,920,146	$0	$14,920,146
70241 - MENTAL HEALTH FACILITY - CHIP	$14,121	$80,501	$81,804	$0	$81,804
70242 - CASSIP - CHIP	$3,882,395	$4,978,728	$6,034,085	$0	$6,034,085

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
70243 - IFS WAIVER	$405,348	$5,619,814	$1,568,756	$0	$1,568,756
70451 - BEHAVIORAL HEALTH TRANSFORMATION WAIVER - MEDICAID	$2,844,155	$27,614,249	$6,602,248	$0	$6,602,248
70456 - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY - CHIP	$104,349	$10,315	$19,198	$0	$19,198
70479 - HOSPITAL SUPPORT	$9,035,000	$0	$0	$0	$0
70481 - PERMANENT SUPPORTIVE HOUSING	$17,254,710	$24,832,599	$20,961,752	$0	$20,961,752
70482 - PERMANENT SUPPORTIVE HOUSING-GROUP V111	$0	$33,030,854	$28,469,778	$0	$28,469,778
70487 - DUAL CHOICE	$228,524,461	$216,382,667	$305,065,955	$0	$305,065,955
70494 - HCBS OVERSIGHT & IMPLEMENTATION	$475,094	$491,050	$0	$0	$0
70499 - EMERGENCY MEDICAID GROUP VIII	$462,825	$0	$14,780,086	$0	$14,780,086
70500 - MCO-ABD	$339,649,735	$0	$319,741,038	$450,797	$320,191,835
70501 - DOULA SERVICES	$0	$0	$744,409	$0	$744,409
70503 - DDS HCBS ADMINISTRATIVE	$1,390,822	$0	$0	$0	$0
70504 - HCBS ARPA HCRIA INITIATIVES	$1,149,500	$0	$0	$0	$0
70505 - HCBS ARPA LTC IMPROVEMENTS	$204,807	$0	$224,775	$0	$224,775
TOTAL COST CENTER PARENT L1 FUNDS	**$4,007,760,552**	**$3,846,495,100**	**$4,370,554,243**	**($2,322,593)**	**$4,368,231,650**
H3202 - PUBLIC PROVIDER PAYMENTS					
70244 - DC PUBLIC SCHOOLS	$15,252,030	$8,000,000	$8,000,000	$0	$8,000,000
70245 - DC PUBLIC SCHOOLS - CHIP	$0	$2,500,000	$2,500,000	$0	$2,500,000
70246 - DC CHARTER SCHOOLS	$5,058,134	$4,000,000	$4,000,000	$0	$4,000,000
70247 - DC CHARTER SCHOOLS - CHIP	$89,052	$300,000	$300,000	$0	$300,000
70248 - OSSE-CHILDREN W/SPCL NEEDS TRNSPT	$22,950,359	$12,000,000	$12,000,000	$0	$12,000,000
70249 - OSSE-CHILDREN W/SPCL NEEDS TRNSPT - CHIP	$2,146,321	$2,000,000	$2,000,000	$0	$2,000,000
70250 - DBH - REHAB OPTION	$4,740,555	$2,000,000	$2,000,000	$0	$2,000,000
70251 - DBH - REHAB OPTION - CHIP	$26,447	$0	$0	$0	$0
70252 - SAINT ELIZABETHS HOSPITAL	$3,694,227	$1,300,000	$1,300,000	$0	$1,300,000
70253 - ST ELIZBETHS HSPTL DSH (M.H. FCLTY DSH)	$4,987,394	$4,581,595	$4,987,394	$0	$4,987,394
70254 - CHILD & FAMILY SERVICES (CFSA)	$325,525	$500,000	$500,000	$0	$500,000
70255 - FIRE & EMS SVS. (AMBULANCE)	$74,645,417	$38,000,000	$38,000,000	$0	$38,000,000
70256 - FIRE & EMS SVS. (AMBULANCE) - CHIP	$489,714	$0	$0	$0	$0
70258 - DBH - DENTAL OPTION	$0	$30,000	$30,000	$0	$30,000
TOTAL COST CENTER PARENT L1 FUNDS	**$134,405,174**	**$75,211,595**	**$75,617,394**	**$0**	**$75,617,394**
H3203 - ALLIANCE PROVIDER PAYMENT					
70259 - MCO ALLIANCE	$109,878,177	$116,730,982	$132,493,843	$150,259	$132,644,102
70480 - ALLIANCE EMERGENCY MEDICAL TRANSPORT	$1,316,093	$1,596,871	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$111,194,270**	**$118,327,853**	**$132,493,843**	**$150,259**	**$132,644,102**
H3301 - HEALTH CARE OPERATIONS ADMINISTRATION					
70260 - HEALTH CARE OPERATIONS SUPPORT OFFICE	$270,899	$444,909	$454,445	$0	$454,445
70261 - DIVISION OF CLAIMS MANAGEMENT	$43,572,464	$51,036,289	$59,722,222	$0	$59,722,222
70262 - DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES	$3,017,340	$3,221,722	$3,664,604	$0	$3,664,604
TOTAL COST CENTER PARENT L1 FUNDS	**$46,860,703**	**$54,702,920**	**$63,841,271**	**$0**	**$63,841,271**
H3401 - HEALTH CARE POLICY AND RESEARCH ADMINISTRATION					
70263 - HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVI	$2,103,662	$4,556,582	$1,957,327	($352,415)	$1,604,912
70264 - DIVISION OF REGULATIONS & POLICY MANAGEMENT	$678,181	$899,139	$1,004,024	$0	$1,004,024
70265 - DIVISION OF ANALYTICS AND POLICY RESEARCH	$0	$215,100	$0	$0	$0
70266 - DIVISION OF ELIGIBILITY POLICY	$788,970	$1,301,808	$2,092,607	$0	$2,092,607
70534 - ELIGIBILITY DETERMINATION	$0	$0	$1,886,021	$0	$1,886,021
TOTAL COST CENTER PARENT L1 FUNDS	**$3,570,814**	**$6,972,630**	**$6,939,980**	**($352,415)**	**$6,587,565**
H3501 - HEALTH CARE REFORM AND INNOVATION ADMINISTRATION					
70267 - AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT D	$2,825,281	$1,857,541	$5,921,060	$100,000	$6,021,060
70268 - HIT/HIE PROJECT MANAGEMENT DIVISION	$1,600,315	$1,204,863	$11,321,423	$0	$11,321,423
70269 - HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES	$7,956,371	$8,654,733	$454,012	$0	$454,012
TOTAL COST CENTER PARENT L1 FUNDS	**$12,381,968**	**$11,717,137**	**$17,696,495**	**$100,000**	**$17,796,495**
H3601 - LONG TERM CARE ADMINISTRATION					
70270 - LONG TERM CARE SUPPORT SERVICES DIVISION	$16,064,330	$20,934,246	$2,991,068	($6,660)	$2,984,408
70271 - LONG TERM CARE OVERSIGHT DIVISION	$1,623,804	$1,807,223	$2,243,721	$0	$2,243,721
70272 - LONG TERM CARE OPERATIONS DIVISION	$1,891,105	$1,816,335	$12,414,241	($135,000)	$12,279,241
70273 - INTAKE AND ASSESSMENT DIVISION	$971,454	$1,133,956	$9,775,936	$0	$9,775,936
TOTAL COST CENTER PARENT L1 FUNDS	**$20,550,694**	**$25,691,760**	**$27,424,966**	**($141,660)**	**$27,283,306**
H3701 - OFFICE OF THE OSMD					
70277 - COMPLIANCE DIVISION - HT0	$0	$636,000	$36,000	$0	$36,000
70488 - ANALYTICS AND RESEARCH	$1,168,431	$2,135,427	$0	$0	$0
70528 - OFFICE OF CHIEF MEDICAL OFFICER	$0	$0	$1,415,668	$0	$1,415,668
70530 - SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMI	$0	$0	$3,003,217	($310,694)	$2,692,523
TOTAL COST CENTER PARENT L1 FUNDS	**$1,168,431**	**$2,771,428**	**$4,454,885**	**($310,694)**	**$4,144,191**
H3702 - OFFICE OF THE CHIEF OPERATING OFFICER					
70278 - SUPPORT SERVICES DIVISION - HT0	$3,943,356	$13,943,311	$4,024,851	$0	$4,024,851
70279 - HUMAN RESOURCES DIVISION - HT0	$1,027,716	$2,047,874	$1,514,471	$0	$1,514,471
70280 - INFORMATION TECHNOLOGY DIVISION - HT0	$9,595,595	$12,173,922	$13,096,074	($757,043)	$12,339,031
70281 - CONTRACTS DIVISION	$1,956,113	$1,875,735	$2,076,000	$0	$2,076,000
70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	$1,228,760	$1,409,438	$2,615,172	($256,423)	$2,358,750
TOTAL COST CENTER PARENT L1 FUNDS	**$17,751,540**	**$31,450,280**	**$23,326,568**	**($1,013,466)**	**$22,313,102**
H3703 - OFFICE OF THE DIRECTOR					
70274 - OFFICE OF THE OMBUDSMAN - HT0	$3,157,948	$4,700,046	$4,957,285	$0	$4,957,285
70275 - OFFICE OF THE DIRECTOR'S ADMINISTRATIVE OFFICE	$656,465	$1,236,360	$1,445,209	$0	$1,445,209
70282 - OFFICE OF THE GENERAL COUNSEL - HT0	$1,231,384	$1,633,025	$1,470,759	$0	$1,470,759
70283 - OFFICE OF THE DEPUTY DIRECTOR, FINANCE	$3,419,127	$5,084,658	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$8,464,923**	**$12,654,090**	**$7,873,253**	**$0**	**$7,873,253**
H3902 - INFORMATION SYSTEMS DIVISION					
70321 - DCAS UNIT	$0	$0	$5,350,673	($60,195)	$5,290,477
TOTAL COST CENTER PARENT L1 FUNDS	**$0**	**$0**	**$5,350,673**	**($60,195)**	**$5,290,477**
H3903 - PROGRAM REVIEW MONITORING AND INVESTIGATIONS DIVISION					
70323 - QUALITY CONTROL UNIT	$0	$0	$4,470,555	$0	$4,470,555

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
TOTAL COST CENTER PARENT L1 FUNDS	**$0**	**$0**	**$4,470,555**	**$0**	**$4,470,555**
H8100 - DATA ANALYTICS AND RESEARCH ADMINSTRATION (DARA)					
70536 - ANALYTIC REPORTING DIVISION	$0	$0	$1,330,774	($10,150)	$1,320,624
70537 - RESEARCH AND DEVELOPMENT DIVISION	$0	$0	$758,671	$0	$758,671
TOTAL COST CENTER PARENT L1 FUNDS	**$0**	**$0**	**$2,089,445**	**($10,150)**	**$2,079,295**
H8200 - OFFICE OF DDS FINANCE					
70538 - SENIOR DEPUTY DIRECTOR FINANCE ADMINSTRATIVE FUNCTI	$0	$0	$4,433,737	($10,553)	$4,423,184
70539 - OFFICE OF RATES REIMBURSEMENT AND FINANCIAL ANALYS	$0	$0	$1,971,658	$0	$1,971,658
TOTAL COST CENTER PARENT L1 FUNDS	**$0**	**$0**	**$6,405,395**	**($10,553)**	**$6,394,842**
TOTAL AGENCY FUNDS	**$4,442,557,965**	**$4,304,063,725**	**$4,863,666,552**	**($2,100,804)**	**$4,861,565,747**
Health Benefit Exchange Authority					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	$208,124	$207,584	$206,407	$0	$206,407
10002 - ACCOUNTING DIVISION	$136,302	$207,584	$161,150	$0	$161,150
10003 - ACFO DIVISION	$349,439	$413,879	$412,483	$0	$412,483
10072 - ACFO DIVISION - HSSC	$800	$0	$0	$0	$0
10086 - P-CARD CLEARING	$3,806	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$698,471**	**$829,047**	**$780,040**	**$0**	**$780,040**
C0100 - NO COST CENTER					
00000 - NO COST CENTER	($3,806)	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**($3,806)**	**$0**	**$0**	**$0**	**$0**
H1901 - DIRECTOR'S OFFICE					
70117 - DIRECTOR'S ADMINISTRATIVE OFFICE - HI0	$5,648,657	$2,392,033	$2,573,589	$0	$2,573,589
70118 - GENERAL COUNSEL'S OFFICE - HI0	$1,071,716	$1,278,375	$1,303,422	$0	$1,303,422
TOTAL COST CENTER PARENT L1 FUNDS	**$6,720,373**	**$3,670,408**	**$3,877,010**	**$0**	**$3,877,010**
H2001 - OPERATIONS DEPARTMENT					
70120 - HUMAN RESOURCES OFFICE - HI0	$353,898	$377,369	$386,089	$0	$386,089
70121 - CONTRACTS AND PROCUREMENT OFFICE - HI0	$691,214	$651,920	$678,608	$0	$678,608
70122 - FACILITIES, INVOICING AND ADMINISTRATIVE SUPPORT OFFIC	$1,315,943	$1,506,499	$1,492,410	$0	$1,492,410
TOTAL COST CENTER PARENT L1 FUNDS	**$2,361,056**	**$2,535,787**	**$2,557,107**	**$0**	**$2,557,107**
H2201 - PROGRAM DEPARTMENT					
70125 - ASSISTER GRANT PROGRAM OFFICE	$962,820	$1,050,000	$1,050,000	$0	$1,050,000
70468 - PROGRAM MANAGEMENT	$17,110,841	$13,768,917	$17,030,242	$0	$17,030,242
TOTAL COST CENTER PARENT L1 FUNDS	**$18,073,661**	**$14,818,917**	**$18,080,242**	**$0**	**$18,080,242**
H6601 - COMMUNICATIONS AND CIVIC ENGAGEMENT DEPARTMENT					
70116 - COMMUNICATIONS AND CIVIC ENGAGEMENT DEPARTMENT	$2,071,797	$2,313,705	$2,316,786	$0	$2,316,786
TOTAL COST CENTER PARENT L1 FUNDS	**$2,071,797**	**$2,313,705**	**$2,316,786**	**$0**	**$2,316,786**
H6701 - INFORMATION TECHNOLOGY DEPARTMENT					
70119 - INFORMATION TECHNOLOGY DEPARTMENT	$17,636,357	$13,384,283	$14,141,599	$0	$14,141,599
TOTAL COST CENTER PARENT L1 FUNDS	**$17,636,357**	**$13,384,283**	**$14,141,599**	**$0**	**$14,141,599**
TOTAL AGENCY FUNDS	**$47,557,909**	**$37,552,148**	**$41,752,784**	**$0**	**$41,752,784**
Not-for-Profit Hospital Corporation					
C0100 - NO COST CENTER					
00000 - NO COST CENTER	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL COST CENTER PARENT L1 FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
TOTAL AGENCY FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy					
C0100 - NO COST CENTER					
00000 - NO COST CENTER	$22,000,000	$15,000,000	$25,200,000	$0	$25,200,000
TOTAL COST CENTER PARENT L1 FUNDS	**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**
TOTAL AGENCY FUNDS	**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**
Office of the Deputy Mayor for Health and Human Services					
H1301 - CHIEF OF STAFF ADMINISTRATIVE OFFICE					
70094 - DEPUTY CHIEF OF STAFF OFFICE	$117,020	$405,671	$304,583	$0	$304,583
TOTAL COST CENTER PARENT L1 FUNDS	**$117,020**	**$405,671**	**$304,583**	**$0**	**$304,583**
H1501 - OFFICE OF THE CHIEF OF STAFF					
70107 - THRIVE BY FIVE OFFICE	$71,577	$0	$0	$0	$0
TOTAL COST CENTER PARENT L1 FUNDS	**$71,577**	**$0**	**$0**	**$0**	**$0**
H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS					
70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DI	$1,856,314	$2,071,890	$2,175,904	($29,368)	$2,146,536
TOTAL COST CENTER PARENT L1 FUNDS	**$1,856,314**	**$2,071,890**	**$2,175,904**	**($29,368)**	**$2,146,536**
TOTAL AGENCY FUNDS	**$2,044,911**	**$2,477,561**	**$2,480,487**	**($29,368)**	**$2,451,119**
GRAND TOTAL	**$5,161,034,141**	**$5,186,322,077**	**$5,778,465,060**	**$1,901,402**	**$5,780,366,462**

Agency FT Equivalent by Cost Center Parent L1 and Cost Center

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	4.39	0.00	0.00	0.00	0.00
10002 - ACCOUNTING DIVISION	7.89	0.00	0.00	0.00	0.00
10003 - ACFO DIVISION	1.75	0.00	0.00	0.00	0.00
10070 - BUDGET DIVISION - HSSC	0.00	6.00	6.00	0.00	6.00

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
10071 - ACCOUNTING DIVISION - HSSC	0.00	8.00	8.00	0.00	8.00
10072 - ACFO DIVISION - HSSC	0.00	2.00	2.00	0.00	2.00
10086 - P-CARD CLEARING	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**14.03**	**16.00**	**16.00**	**0.00**	**16.00**
C0100 - NO COST CENTER					
00000 - NO COST CENTER	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H5701 - DIVISION OF ADULT SERVICES					
70411 - FORENSIC SERVICES OFFICE	20.97	24.00	26.00	0.00	26.00
70414 - ASSESSMENTS AND REFERRALS OFFICE	17.74	21.00	21.00	0.00	21.00
70417 - SPECIALTY CARE OFFICE	12.72	20.50	16.50	0.00	16.50
70418 - SOR GRANT OFFICE	11.82	20.50	20.50	0.00	20.50
70419 - OFFICE OF RESIDENTIAL SUPPORT AND CONTINULTY SERVIC	3.47	4.00	4.00	0.00	4.00
70420 - HOUSING DEVELOPMENT OFFICE	3.47	0.00	0.00	0.00	0.00
70567 - LOCAL BEHAVIORAL HEALTH REHABILITATION OFFICE	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**70.19**	**90.00**	**88.00**	**0.00**	**88.00**
H5801 - DIVISION OF CHILD/ADOLESCENT/FAMILY SERVICES					
70416 - OFFICE OF BEHAVIORAL HEALTH SERVICES	45.57	49.00	36.00	0.00	36.00
70424 - SUD PREVENTION OFFICE	10.19	9.00	9.00	0.00	9.00
70425 - OFFICE OF PREVENTION AND EARLY INTERVENTION	90.13	99.67	88.37	0.00	88.37
70426 - OFFICE OF LINKAGE AND ASSESSMENTS	14.91	17.00	14.00	0.00	14.00
70427 - OFFICE OF COMMUNITY BASED SERVICES	6.12	7.00	7.00	0.00	7.00
TOTAL COST CENTER PARENT L1 FUNDS	**166.92**	**181.67**	**154.37**	**0.00**	**154.37**
H5901 - EXECUTIVE OFFICE OF THE DIRECTOR					
70428 - EXECUTIVE ADMINISTRATIVE OFFICE - RM0	18.32	20.65	19.65	0.00	19.65
70429 - OFFICE OF THE GENERAL COUNSEL - RM0	4.82	5.50	5.50	0.00	5.50
TOTAL COST CENTER PARENT L1 FUNDS	**23.14**	**26.15**	**25.15**	**0.00**	**25.15**
H6001 - OFFICE OF POLICY ADVISOR					
70432 - OFFICE OF SYSTEMS TRANSFORMATION	22.77	26.17	28.00	0.00	28.00
TOTAL COST CENTER PARENT L1 FUNDS	**22.77**	**26.17**	**28.00**	**0.00**	**28.00**
H6101 - OFFICE OF THE CHIEF CLINICAL OFFICER					
70433 - OFFICE OF CLINICAL SERVICES AND SUPPORT	0.00	0.00	0.00	0.00	0.00
70434 - OFFICE OF DISASTER BEHAVIORAL HEALTH AND SUPPORT SI	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H6201 - OFFICE OF THE CHIEF OF EXECUTIVE ST ELIZABETHS HOSPITAL					
70435 - OFFICE OF CHIEF NURSING EXECUTIVE (SEH)	380.49	431.00	428.00	0.00	428.00
70437 - OFFICE OF CHIEF QUALITY DATA TRAINING & PERFORMANCE	9.65	11.00	11.00	0.00	11.00
70438 - OFFICE OF THE CHIEF OF STAFF (SEH)	0.00	0.00	0.00	0.00	0.00
70439 - OFFICE OF THE CHIEF CLINICAL OFFICER (SEH)	194.66	223.05	230.05	0.00	230.05
70440 - OFFICE OF THE CHIEF OPERATING OFFICER (SEH)	134.70	151.03	146.02	0.00	146.02
TOTAL COST CENTER PARENT L1 FUNDS	**719.50**	**816.08**	**815.07**	**0.00**	**815.07**
H6301 - OFFICE OF THE CHIEF OF STAFF					
70441 - LEGISLATIVE & PUBLIC AFFAIRS OFFICE	8.72	8.35	7.52	0.00	7.52
70443 - CONSUMER AND FAMILY AFFAIRS OFFICE	7.84	9.00	9.00	0.00	9.00
70444 - OFFICE OF OMBUDSMAN	2.02	2.00	3.00	0.00	3.00
70445 - HUMAN RESOURCES OFFICE - RM0	19.29	22.00	21.00	0.00	21.00
TOTAL COST CENTER PARENT L1 FUNDS	**37.87**	**41.35**	**40.52**	**0.00**	**40.52**
H6401 - OFFICE OF THE CHIEF OPERATING OFFICER					
70446 - CLAIMS AND BILLING OFFICE	5.23	6.00	6.00	0.00	6.00
70447 - FISCAL SERVICES AND MONITORING OFFICE	24.54	31.83	32.83	0.00	32.83
70448 - INFORMATION TECHNOLOGY OFFICE - RM0	20.47	22.00	21.00	0.00	21.00
70450 - RECORDS MANAGEMENT OFFICE	7.86	9.00	9.00	0.00	9.00
TOTAL COST CENTER PARENT L1 FUNDS	**58.10**	**68.83**	**68.83**	**0.00**	**68.83**
H8001 - OFFICE OF OPIOID ABATEMENT					
70508 - OFFICE OF OPIOID ABATEMENT	0.00	4.00	4.00	0.00	4.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**4.00**	**4.00**	**0.00**	**4.00**
H8300 - DIVISION OF CRISIS SERVICES					
70412 - COMMUNITY RESPONSE OFFICE	60.79	72.00	73.00	0.00	73.00
70413 - OFFICE OF COMPREHENSIVE PSYCHIATRIC EMERGENCY SEF	35.63	41.25	52.00	0.00	52.00
70415 - ACCESS HELPLINE OFFICE	19.37	31.00	27.00	0.00	27.00
70555 - CHILD/YOUTH CRISIS & COMMUNITY TRAUMA RESPONSE OF	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**115.79**	**144.25**	**152.00**	**0.00**	**152.00**
H8401 - DIVISION OF DATA, QUALITY and COMPLIANCE					
70430 - OFFICE OF ACCOUNTABILITY	23.08	25.00	20.00	0.00	20.00
TOTAL COST CENTER PARENT L1 FUNDS	**23.08**	**25.00**	**20.00**	**0.00**	**20.00**
TOTAL AGENCY FUNDS	**1,251.39**	**1,439.50**	**1,411.94**	**0.00**	**1,411.94**
Department of Health					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	5.86	8.00	0.00	0.00	0.00
10002 - ACCOUNTING DIVISION	8.12	11.00	0.00	0.00	0.00
10003 - ACFO DIVISION	3.98	5.00	0.00	0.00	0.00
10070 - BUDGET DIVISION - HSSC	0.00	0.00	8.00	0.00	8.00
10071 - ACCOUNTING DIVISION - HSSC	0.00	0.00	11.00	0.00	11.00
10072 - ACFO DIVISION - HSSC	0.00	0.00	5.00	0.00	5.00
TOTAL COST CENTER PARENT L1 FUNDS	**17.96**	**24.00**	**24.00**	**0.00**	**24.00**
C0100 - NO COST CENTER					
00000 - NO COST CENTER	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H0601 - CENTER FOR POLICY, PLANNING, AND EVALUATION					
70049 - COMMUNITY PROGRAMS DIVISION - HC0	10.92	78.50	88.50	0.00	88.50
70050 - COMMUNITY PROGRAMS - OPERATIONS DIVISION - HC0	35.62	36.12	36.68	0.00	36.68
70054 - HEALTHY PEOPLE OFFICE	1.71	9.78	12.38	0.00	12.38
TOTAL COST CENTER PARENT L1 FUNDS	**48.25**	**124.40**	**137.56**	**0.00**	**137.56**
H0701 - DEPUTY DIRECTOR FOR PROGRAMS AND POLICY					
70057 - NUTRITION AND PHYSICAL FITNESS BUREAU	13.11	19.00	20.00	0.00	20.00
70058 - FAMILY HEALTH BUREAU	58.95	69.50	32.93	2.00	34.93
70059 - CANCER & CHRONIC DISEASE BUREAU	25.45	28.50	34.50	0.00	34.50
70060 - HEALTHCARE ACCESS BUREAU	0.00	15.50	52.37	0.00	52.37
TOTAL COST CENTER PARENT L1 FUNDS	**97.51**	**132.50**	**139.80**	**2.00**	**141.80**
H0702 - COMMUNITY HEALTH ADMINISTRATION					
70056 - DEPUTY DIRECTOR FOR OPERATIONS - CHA	18.07	23.50	28.05	0.00	28.05
TOTAL COST CENTER PARENT L1 FUNDS	**18.07**	**23.50**	**28.05**	**0.00**	**28.05**
H0801 - HEALTH EMERGENCY PREPAREDNESS AND RESPONSE ADMINISTRATION					
70062 - SENIOR DEPUTY DIRECTOR'S OFFICE - HEPRA	16.92	26.65	28.44	0.00	28.44
70066 - PLANNING, OPERATIONS AND TRAINING DIVISION	0.00	2.69	0.00	0.00	0.00
70067 - EMERGENCY MEDICAL MANAGEMENT DIVISION	2.04	0.11	0.11	1.00	1.11
70068 - PUBLIC HEALTH PREPAREDNESS DIVISION	5.14	2.85	3.45	0.00	3.45
TOTAL COST CENTER PARENT L1 FUNDS	**24.10**	**32.30**	**32.00**	**1.00**	**33.00**
H0901 - HEALTH REGULATION AND LICENSING ADMINISTRATION					
70070 - OFFICE OF HEALTH PROFESSIONAL LICENSING BOARDS	74.65	77.62	82.37	0.00	82.37
70071 - OFFICE OF HEALTH FACILITIES	49.82	54.90	49.81	0.00	49.81
70073 - OFFICE OF FOOD, DRUG, RADIATION AND COMMUNITY HYG	60.08	51.82	57.82	0.00	57.82
TOTAL COST CENTER PARENT L1 FUNDS	**184.55**	**184.34**	**190.00**	**0.00**	**190.00**
H1001 - HIV/AIDS, HEPATITIS, STD, AND TB ADMINISTRATION					
70076 - SENIOR DEPUTY DIRECTOR'S OFFICE - HAHSTA	8.08	18.49	27.92	0.00	27.92
70077 - DEPUTY DIRECTOR FOR OPERATIONS - HAHSTA	8.54	10.50	10.00	0.00	10.00
70078 - CARE AND TREATMENT DIVISION	61.16	35.12	33.42	0.00	33.42
70079 - PREVENTION & INTERVENTION SERVICES	34.24	31.10	30.63	0.00	30.63
70080 - STRATEGIC INFORMATION DIVISION	11.67	15.80	13.85	0.00	13.85
70081 - HOUSING CAPACITY BUILDING AND COMMUNITY OUTREACH	2.83	4.00	7.70	0.00	7.70
70082 - STD/TB CONTROL DIVISION	29.29	36.79	37.99	0.00	37.99
TOTAL COST CENTER PARENT L1 FUNDS	**155.81**	**151.80**	**161.51**	**0.00**	**161.51**
H1101 - OFFICE OF HEALTH EQUITY					
70083 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLICY I	1.38	2.00	2.00	0.00	2.00
70084 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATION	0.69	1.00	0.00	0.00	0.00
70085 - MULTI SECTOR COLLABORATION OFFICE	2.29	4.00	4.00	0.00	4.00
TOTAL COST CENTER PARENT L1 FUNDS	**4.36**	**7.00**	**6.00**	**0.00**	**6.00**
H1201 - OFFICE OF THE CHIEF OPERATING OFFICER					
70086 - INFORMATION TECHNOLOGY OFFICE - HC0	14.21	29.00	30.00	0.00	30.00
70087 - HUMAN RESOURCES OFFICE - HC0	10.20	15.00	18.00	0.00	18.00
70089 - CONTRACTS AND PROCUREMENT OFFICE - HC0	3.45	6.00	8.00	0.00	8.00
70090 - FACILITIES MANAGEMENT & SUPPORT OFFICE - HC0	6.34	5.00	4.00	0.00	4.00
70463 - LEGAL OFFICE - HC0	14.05	14.00	14.00	0.00	14.00
TOTAL COST CENTER PARENT L1 FUNDS	**48.25**	**69.00**	**74.00**	**0.00**	**74.00**
H1202 - OFFICE OF THE CHIEF OF STAFF					
70091 - COMMUNITY RELATIONS OFFICE - HC0	5.89	7.00	8.00	0.00	8.00
TOTAL COST CENTER PARENT L1 FUNDS	**5.89**	**7.00**	**8.00**	**0.00**	**8.00**
H1203 - OFFICE OF THE DIRECTOR					
70462 - EXECUTIVE OFFICE - HC0	7.70	10.00	10.00	0.00	10.00
TOTAL COST CENTER PARENT L1 FUNDS	**7.70**	**10.00**	**10.00**	**0.00**	**10.00**
H7401 - COMMUNITY HEALTH ADMINISTRATION					
70465 - PRIMARY CARE AND PREVENTION ADMINISTRATION	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**612.45**	**765.84**	**810.92**	**3.00**	**813.92**
Department of Health Care Finance					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	4.81	6.00	6.00	0.00	6.00
10002 - ACCOUNTING DIVISION	7.22	9.00	10.00	0.00	10.00
10003 - ACFO DIVISION	1.61	2.00	2.00	0.00	2.00
10071 - ACCOUNTING DIVISION - HSSC	0.00	0.00	0.00	0.00	0.00
10086 - P-CARD CLEARING	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**13.64**	**17.00**	**18.00**	**0.00**	**18.00**
H2901 - DCAS PROGRAM MANAGEMENT ADMINISTRATION					
70152 - DCAS - PROGRAM MANAGEMENT DIVISION	6.88	4.33	4.33	0.00	4.33
70153 - PROJECT MANAGEMENT DIVISION	24.05	7.79	6.92	0.00	6.92
70154 - ORGANIZATIONAL CHANGE DIVISION	8.95	6.93	6.92	0.00	6.92
70155 - DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	6.88	7.79	6.92	0.00	6.92
70535 - DCAS HHS FUNCTIONAL DIVISION	0.00	0.00	6.06	0.00	6.06
TOTAL COST CENTER PARENT L1 FUNDS	**46.76**	**26.84**	**31.15**	**0.00**	**31.15**
H2902 - HEALTH AND HUMAN SERVICES FUNCTIONAL DIVISION					
70507 - HEALTH AND HUMAN SERVICES FUNCTIONAL DIVISION	0.00	6.05	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**6.05**	**0.00**	**0.00**	**0.00**
H3001 - PROGRAM INTEGRITY ADMINISTRATION					
70156 - INVESTIGATION AND COMPLIANCE DIVISION	0.00	0.00	8.00	0.00	8.00
70157 - SURVEILLANCE AND UTILIZATION DIVISION	0.00	0.00	13.00	0.00	13.00

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
70158 - PROGRAM INTEGRITY SUPPORT DIVISION	23.05	28.00	12.00	0.00	12.00
TOTAL COST CENTER PARENT L1 FUNDS	**23.05**	**28.00**	**33.00**	**0.00**	**33.00**
H3101 - HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION					
70159 - HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION	8.02	10.00	9.00	0.00	9.00
70160 - DIVISION OF MANAGED CARE	5.61	7.00	7.00	0.00	7.00
70161 - DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SE	6.21	7.00	0.00	0.00	0.00
70162 - DIVISON OF QUALITY AND HEALTH OUTCOMES	4.01	6.00	7.00	0.00	7.00
70163 - DIVISION OF CHILDREN'S HEALTH SERVICES	5.33	7.00	7.15	0.00	7.15
TOTAL COST CENTER PARENT L1 FUNDS	**29.18**	**37.00**	**30.15**	**0.00**	**30.15**
H3201 - MEDICAID PROVIDER PAYMENTS					
70164 - INPATIENT IN STATE	0.00	0.00	0.00	0.00	0.00
70165 - INPATIENT CHIP	0.00	0.00	0.00	0.00	0.00
70166 - INPATIENT - DSH PAYMENTS	0.00	0.00	0.00	0.00	0.00
70167 - INPATIENT - GME PAYMENTS	0.00	0.00	0.00	0.00	0.00
70168 - MENTAL HEALTH FACILITY SERVICES	0.00	0.00	0.00	0.00	0.00
70170 - PSYCHIATRIC RESIDENTIAL TREATMENT FACIL.	0.00	0.00	0.00	0.00	0.00
70171 - NURSING FACILITY IN STATE	0.00	0.00	0.00	0.00	0.00
70172 - NURSING HOME QUALITY OF CARE SERVICES	0.64	0.85	0.00	0.00	0.00
70173 - ICF PRIVATE	0.75	1.00	0.00	0.00	0.00
70174 - PHYSICIAN SERVICES-MEDICAID	0.00	0.00	0.00	0.00	0.00
70175 - PHYSICIAN SERVICES CHIP	0.00	0.00	0.00	0.00	0.00
70176 - OUTPATIENT HOSPITAL IN STATE	0.00	0.00	0.00	0.00	0.00
70177 - OUTPATIENT HOSPITAL CHIP	0.00	0.00	0.00	0.00	0.00
70178 - PRESCRIBED DRUGS	0.00	0.00	0.00	0.00	0.00
70179 - PRESCRIBED DRUGS - CHIP	0.00	0.00	0.00	0.00	0.00
70180 - DENTAL SERVICES	0.00	0.00	0.00	0.00	0.00
70181 - DENTAL SERVICES - CHIP	0.00	0.00	0.00	0.00	0.00
70182 - OTHER PRACTITIONERS' SERVICES	0.00	0.00	0.00	0.00	0.00
70183 - OTHER PRACTITIONERS' SERVICES CHIP	0.00	0.00	0.00	0.00	0.00
70184 - CLINIC SERVICES - PRIVATE	0.00	0.00	0.00	0.00	0.00
70185 - CLINIC SERVICES - PRIVATE CHIP	0.00	0.00	0.00	0.00	0.00
70186 - CLINIC SERVICES - MENTAL HEALTH	0.00	0.00	0.00	0.00	0.00
70187 - CLINIC SERVICES - MENTAL HEALTH CHIP	0.00	0.00	0.00	0.00	0.00
70188 - CLINIC SERVICES - MHRS	0.00	0.00	0.00	0.00	0.00
70189 - CLINIC SERVICES - MHRS CHIP	0.00	0.00	0.00	0.00	0.00
70190 - LABORATORY & RADIOLOGICAL SERVICES	0.00	0.00	0.00	0.00	0.00
70191 - LABORATORY & RADIOLOGICAL SERVICES -CHIP	0.00	0.00	0.00	0.00	0.00
70192 - HOME HEALTH SERVICES	0.00	0.00	0.00	0.00	0.00
70193 - HOME HEALTH SERVICES - CHIP	0.00	0.00	0.00	0.00	0.00
70194 - STERILIZATIONS	0.00	0.00	0.00	0.00	0.00
70195 - EPSDT-MEDICAID	0.00	0.00	0.00	0.00	0.00
70196 - EPSDT SCREENING SERVICES - CHIP	0.00	0.00	0.00	0.00	0.00
70197 - MEDICAID PART A	0.00	0.00	0.00	0.00	0.00
70198 - MEDICAID PART B	0.00	0.00	0.00	0.00	0.00
70199 - MEDICAID PART B - NON FFP	0.00	0.00	0.00	0.00	0.00
70200 - MANAGED CARE ORGANIZATIONS (MCO)	0.00	0.00	0.00	0.00	0.00
70201 - MANAGED CARE ORGANIZATIONS (MCO) - CHIP	0.00	0.00	0.00	0.00	0.00
70202 - CASSIP	0.00	0.00	0.00	0.00	0.00
70203 - PERSONAL CARE SERVICES	0.00	0.00	0.00	0.00	0.00
70205 - HOSPICE BENEFITS	0.00	0.00	0.00	0.00	0.00
70206 - FEDERALLY-QUALIFIED HEALTH CENTER	0.00	0.00	0.00	0.00	0.00
70207 - FEDERALLY-QUALIFIED HEALTH CENTER - CHIP	0.00	0.00	0.00	0.00	0.00
70208 - NON-EMERGENCY MEDICAL TRANSPORTATION	0.00	0.00	0.00	0.00	0.00
70209 - NON-EMERGENCY MEDICAL TRANSPORT. - CHIP	0.00	0.00	0.00	0.00	0.00
70210 - PHYSICAL THERAPY	0.00	0.00	0.00	0.00	0.00
70211 - PHYSICAL THERAPY - CHIP	0.00	0.00	0.00	0.00	0.00
70212 - PROSTHETIC DEVICES, DENTURES, EYEGLASSES	0.00	0.00	0.00	0.00	0.00
70213 - PROSTHETC DVCS,DENTURES,EYEGLASSES-CHIP	0.00	0.00	0.00	0.00	0.00
70214 - NURSE MID-WIFE	0.00	0.00	0.00	0.00	0.00
70215 - EMERGENCY HOSPITAL SERVICES	0.00	0.00	0.00	0.00	0.00
70216 - EMERGENCY HOSPITAL SERVICES - CHIP	0.00	0.00	0.00	0.00	0.00
70217 - NURSE PRACTITIONER SERVICES	0.00	0.00	0.00	0.00	0.00
70218 - NURSE PRACTITIONER SERVICES - CHIP	0.00	0.00	0.00	0.00	0.00
70219 - PRIVATE DUTY NURSING	0.00	0.00	0.00	0.00	0.00
70221 - DURABLE MED EQUIP (DME)-MEDICAID	0.00	0.00	0.00	0.00	0.00
70222 - DURABLE MED EQUIP (DME)-MEDICAID - CHIP	0.00	0.00	0.00	0.00	0.00
70223 - COBRA/RECIPIENT OOP	0.00	0.00	0.00	0.00	0.00
70224 - IMMIGRANT KIDS	0.00	0.00	0.00	0.00	0.00
70225 - OPTIONAL STATE SUPPLEMENT PAYMENTS	0.00	0.00	0.00	0.00	0.00
70226 - PART-D CLAWBACK	0.00	0.00	0.00	0.00	0.00
70228 - IDD WAIVER	0.00	0.00	0.00	0.00	0.00
70229 - EPD WAIVER	0.00	0.00	0.00	0.00	0.00
70230 - ADULT DAY HEALTH	0.00	0.00	0.00	0.00	0.00
70231 - MCO-NEWLY ELIGIBLE	0.00	0.00	0.00	0.00	0.00
70232 - EMERGENCY MEDICAID (NON MEDICAID POP.)	0.00	0.00	0.00	0.00	0.00
70233 - ICF SUPPLEMENTAL PAYMENTS	0.00	0.00	0.00	0.00	0.00
70234 - APRA ASARS: ADULT SUBSTANCE ABUSE	0.00	0.00	0.00	0.00	0.00
70235 - APRA ASTEP: CHILD SUBSTANCE ABUSE	0.00	0.00	0.00	0.00	0.00
70236 - MCO- EXPANSION POPLULATION	0.00	0.00	0.00	0.00	0.00
70237 - DHCF - HEALTH HOMES I	0.00	0.00	0.00	0.00	0.00
70238 - HEALTH HOMES II	0.00	0.00	0.00	0.00	0.00
70239 - PROGRAM OF ALL-INCLUSIVE CARE (PACE)	0.00	0.00	0.00	0.00	0.00
70241 - MENTAL HEALTH FACILITY - CHIP	0.00	0.00	0.00	0.00	0.00
70242 - CASSIP - CHIP	0.00	0.00	0.00	0.00	0.00
70243 - IFS WAIVER	0.00	0.00	0.00	0.00	0.00
70451 - BEHAVIORAL HEALTH TRANSFORMATION WAIVER - MEDICAID	0.00	0.00	0.00	0.00	0.00
70456 - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY - CHIP	0.00	0.00	0.00	0.00	0.00
70479 - HOSPITAL SUPPORT	0.00	0.00	0.00	0.00	0.00
70481 - PERMANENT SUPPORTIVE HOUSING	0.00	0.00	0.00	0.00	0.00
70482 - PERMANENT SUPPORTIVE HOUSING-GROUP V111	0.00	0.00	0.00	0.00	0.00
70487 - DUAL CHOICE	0.00	0.00	0.00	0.00	0.00

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
70494 - HCBS OVERSIGHT & IMPLEMENTATION	0.00	4.95	0.00	0.00	0.00
70499 - EMERGENCY MEDICAID GROUP VIII	0.00	0.00	0.00	0.00	0.00
70500 - MCO-ABD	0.00	0.00	0.00	0.00	0.00
70501 - DOULA SERVICES	0.00	0.00	0.00	0.00	0.00
70503 - DDS HCBS ADMINISTRATIVE	0.00	0.00	0.00	0.00	0.00
70504 - HCBS ARPA HCRIA INITIATIVES	0.00	0.00	0.00	0.00	0.00
70505 - HCBS ARPA LTC IMPROVEMENTS	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**1.39**	**6.80**	**0.00**	**0.00**	**0.00**
H3202 - PUBLIC PROVIDER PAYMENTS					
70244 - DC PUBLIC SCHOOLS	0.00	0.00	0.00	0.00	0.00
70245 - DC PUBLIC SCHOOLS - CHIP	0.00	0.00	0.00	0.00	0.00
70246 - DC CHARTER SCHOOLS	0.00	0.00	0.00	0.00	0.00
70247 - DC CHARTER SCHOOLS - CHIP	0.00	0.00	0.00	0.00	0.00
70248 - OSSE-CHILDREN W/SPCL NEEDS TRNSPT	0.00	0.00	0.00	0.00	0.00
70249 - OSSE-CHILDREN W/SPCL NEEDS TRNSPT - CHIP	0.00	0.00	0.00	0.00	0.00
70250 - DBH - REHAB OPTION	0.00	0.00	0.00	0.00	0.00
70251 - DBH - REHAB OPTION - CHIP	0.00	0.00	0.00	0.00	0.00
70252 - SAINT ELIZABETHS HOSPITAL	0.00	0.00	0.00	0.00	0.00
70253 - ST ELIZBETHS HSPTL DSH (M.H. FCLTY DSH)	0.00	0.00	0.00	0.00	0.00
70254 - CHILD & FAMILY SERVICES (CFSA)	0.00	0.00	0.00	0.00	0.00
70255 - FIRE & EMS SVS. (AMBULANCE)	0.00	0.00	0.00	0.00	0.00
70256 - FIRE & EMS SVS. (AMBULANCE) - CHIP	0.00	0.00	0.00	0.00	0.00
70258 - DBH - DENTAL OPTION	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H3203 - ALLIANCE PROVIDER PAYMENT					
70259 - MCO ALLIANCE	0.00	0.00	0.00	0.00	0.00
70480 - ALLIANCE EMERGENCY MEDICAL TRANSPORT	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H3301 - HEALTH CARE OPERATIONS ADMINISTRATION					
70260 - HEALTH CARE OPERATIONS SUPPORT OFFICE	2.41	3.00	3.00	0.00	3.00
70261 - DIVISION OF CLAIMS MANAGEMENT	11.07	14.00	14.00	0.00	14.00
70262 - DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES	8.02	9.00	9.00	0.00	9.00
TOTAL COST CENTER PARENT L1 FUNDS	**21.50**	**26.00**	**26.00**	**0.00**	**26.00**
H3401 - HEALTH CARE POLICY AND RESEARCH ADMINISTRATION					
70263 - HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVI	2.41	25.00	3.00	0.00	3.00
70264 - DIVISION OF REGULATIONS & POLICY MANAGEMENT	4.81	6.00	7.00	0.00	7.00
70265 - DIVISION OF ANALYTICS AND POLICY RESEARCH	0.00	0.00	0.00	0.00	0.00
70266 - DIVISION OF ELIGIBILITY POLICY	13.63	10.00	7.00	0.00	7.00
70534 - ELIGIBILITY DETERMINATION	0.00	0.00	22.00	0.00	22.00
TOTAL COST CENTER PARENT L1 FUNDS	**20.85**	**41.00**	**39.00**	**0.00**	**39.00**
H3501 - HEALTH CARE REFORM AND INNOVATION ADMINISTRATION					
70267 - AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT D	2.26	4.00	3.00	0.00	3.00
70268 - HIT/HIE PROJECT MANAGEMENT DIVISION	5.22	6.00	7.00	0.00	7.00
70269 - HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES	1.55	2.00	3.00	0.00	3.00
TOTAL COST CENTER PARENT L1 FUNDS	**9.03**	**12.00**	**13.00**	**0.00**	**13.00**
H3601 - LONG TERM CARE ADMINISTRATION					
70270 - LONG TERM CARE SUPPORT SERVICES DIVISION	2.41	3.00	6.00	0.00	6.00
70271 - LONG TERM CARE OVERSIGHT DIVISION	10.27	13.00	18.00	0.00	18.00
70272 - LONG TERM CARE OPERATIONS DIVISION	11.22	14.00	16.00	0.00	16.00
70273 - INTAKE AND ASSESSMENT DIVISION	6.26	8.00	6.00	0.00	6.00
TOTAL COST CENTER PARENT L1 FUNDS	**30.16**	**38.00**	**46.00**	**0.00**	**46.00**
H3701 - OFFICE OF THE OSMD					
70277 - COMPLIANCE DIVISION - HT0	0.00	0.00	0.00	0.00	0.00
70488 - ANALYTICS AND RESEARCH	10.42	9.00	0.00	0.00	0.00
70528 - OFFICE OF CHIEF MEDICAL OFFICER	0.00	0.00	8.00	0.00	8.00
70530 - SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMI	0.00	0.00	6.00	0.00	6.00
TOTAL COST CENTER PARENT L1 FUNDS	**10.42**	**9.00**	**14.00**	**0.00**	**14.00**
H3702 - OFFICE OF THE CHIEF OPERATING OFFICER					
70278 - SUPPORT SERVICES DIVISION - HT0	11.98	25.25	6.00	0.00	6.00
70279 - HUMAN RESOURCES DIVISION - HT0	9.63	10.00	8.00	0.00	8.00
70280 - INFORMATION TECHNOLOGY DIVISION - HT0	12.83	8.65	18.94	0.00	18.94
70281 - CONTRACTS DIVISION	12.03	13.00	14.00	0.00	14.00
70489 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	1.61	7.00	8.00	0.00	8.00
TOTAL COST CENTER PARENT L1 FUNDS	**48.08**	**63.90**	**54.94**	**0.00**	**54.94**
H3703 - OFFICE OF THE DIRECTOR					
70274 - OFFICE OF THE OMBUDSMAN - HT0	20.42	23.00	24.00	0.00	24.00
70275 - OFFICE OF THE DIRECTOR'S ADMINISTRATIVE OFFICE	4.01	5.00	9.00	0.00	9.00
70282 - OFFICE OF THE GENERAL COUNSEL - HT0	7.94	9.06	8.85	0.00	8.85
70283 - OFFICE OF THE DEPUTY DIRECTOR, FINANCE	12.72	18.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**45.09**	**55.06**	**41.85**	**0.00**	**41.85**
H3902 - INFORMATION SYSTEMS DIVISION					
70321 - DCAS UNIT	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H3903 - PROGRAM REVIEW MONITORING AND INVESTIGATIONS DIVISION					
70323 - QUALITY CONTROL UNIT	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H8100 - DATA ANALYTICS AND RESEARCH ADMINSTRATION (DARA)					
70536 - ANALYTIC REPORTING DIVISION	0.00	0.00	4.00	0.00	4.00
70537 - RESEARCH AND DEVELOPMENT DIVISION	0.00	0.00	7.00	0.00	7.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**11.00**	**0.00**	**11.00**

Cost Center	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H8200 - OFFICE OF DDS FINANCE					
70538 - SENIOR DEPUTY DIRECTOR FINANCE ADMINSTRATIVE FUNCTI	0.00	0.00	6.00	0.00	6.00
70539 - OFFICE OF RATES REIMBURSEMENT AND FINANCIAL ANALYS	0.00	0.00	14.00	0.00	14.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**20.00**	**0.00**	**20.00**
TOTAL AGENCY FUNDS	**299.15**	**366.65**	**378.09**	**0.00**	**378.09**
Health Benefit Exchange Authority					
A0101 - AGENCY FINANCIAL OPERATIONS DEPARTMENT					
10001 - BUDGET DIVISION	0.95	1.00	1.00	0.00	1.00
10002 - ACCOUNTING DIVISION	0.95	1.00	1.00	0.00	1.00
10003 - ACFO DIVISION	0.95	1.00	1.00	0.00	1.00
10072 - ACFO DIVISION - HSSC	0.00	0.00	0.00	0.00	0.00
10086 - P-CARD CLEARING	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**2.85**	**3.00**	**3.00**	**0.00**	**3.00**
C0100 - NO COST CENTER					
00000 - NO COST CENTER	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H1901 - DIRECTOR'S OFFICE					
70117 - DIRECTOR'S ADMINISTRATIVE OFFICE - HI0	7.57	9.00	9.00	0.00	9.00
70118 - GENERAL COUNSEL'S OFFICE - HI0	4.73	6.00	6.00	0.00	6.00
TOTAL COST CENTER PARENT L1 FUNDS	**12.30**	**15.00**	**15.00**	**0.00**	**15.00**
H2001 - OPERATIONS DEPARTMENT					
70120 - HUMAN RESOURCES OFFICE - HI0	0.95	1.00	1.00	0.00	1.00
70121 - CONTRACTS AND PROCUREMENT OFFICE - HI0	3.78	4.00	4.00	0.00	4.00
70122 - FACILITIES, INVOICING AND ADMINISTRATIVE SUPPORT OFFIC	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**4.73**	**5.00**	**5.00**	**0.00**	**5.00**
H2201 - PROGRAM DEPARTMENT					
70125 - ASSISTER GRANT PROGRAM OFFICE	0.00	0.00	0.00	0.00	0.00
70468 - PROGRAM MANAGEMENT	51.09	57.00	62.00	0.00	62.00
TOTAL COST CENTER PARENT L1 FUNDS	**51.09**	**57.00**	**62.00**	**0.00**	**62.00**
H6601 - COMMUNICATIONS AND CIVIC ENGAGEMENT DEPARTMENT					
70116 - COMMUNICATIONS AND CIVIC ENGAGEMENT DEPARTMENT	6.63	7.00	7.00	0.00	7.00
TOTAL COST CENTER PARENT L1 FUNDS	**6.63**	**7.00**	**7.00**	**0.00**	**7.00**
H6701 - INFORMATION TECHNOLOGY DEPARTMENT					
70119 - INFORMATION TECHNOLOGY DEPARTMENT	33.12	36.00	36.00	0.00	36.00
TOTAL COST CENTER PARENT L1 FUNDS	**33.12**	**36.00**	**36.00**	**0.00**	**36.00**
TOTAL AGENCY FUNDS	**110.72**	**123.00**	**128.00**	**0.00**	**128.00**
Not-for-Profit Hospital Corporation					
C0100 - NO COST CENTER					
00000 - NO COST CENTER	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Not-for-Profit Hospital Corporation Subsidy					
C0100 - NO COST CENTER					
00000 - NO COST CENTER	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Office of the Deputy Mayor for Health and Human Services					
H1301 - CHIEF OF STAFF ADMINISTRATIVE OFFICE					
70094 - DEPUTY CHIEF OF STAFF OFFICE	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H1501 - OFFICE OF THE CHIEF OF STAFF					
70107 - THRIVE BY FIVE OFFICE	0.00	0.00	0.00	0.00	0.00
TOTAL COST CENTER PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H1601 - OFFICE OF THE DEPUTY MAYOR - DMHHS					
70108 - OFFICE OF THE DEPUTY MAYOR ADMINISTRATIVE OFFICE - DI	11.75	12.75	12.75	0.00	12.75
TOTAL COST CENTER PARENT L1 FUNDS	**11.75**	**12.75**	**12.75**	**0.00**	**12.75**
TOTAL AGENCY FUNDS	**11.75**	**12.75**	**12.75**	**0.00**	**12.75**
GRAND TOTAL	**6,881,381,140.42**	**6,915,098,811.06**	**7,704,622,821.61**	**2,535,206.20**	**7,707,158,027.81**

Agency Operating Budget by Program Parent L1 and Program					
Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	$896,554	$0	$690,651	$0	$690,651
TOTAL PROGRAM PARENT L1 FUNDS	**$896,554**	**$0**	**$690,651**	**$0**	**$690,651**
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$671,436	$2,182,509	$1,009,890	$0	$1,009,890
TOTAL PROGRAM PARENT L1 FUNDS	**$671,436**	**$2,182,509**	**$1,009,890**	**$0**	**$1,009,890**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$222,377	$312,564	$577,230	$0	$577,230
TOTAL PROGRAM PARENT L1 FUNDS	**$222,377**	**$312,564**	**$577,230**	**$0**	**$577,230**
AFO010 - PAYROLL DEFAULT					
150011 - PAYROLL DEFAULT	$0	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$0**	**$0**	**$0**
AFO011 - P-CARD CLEARING					
150012 - P-CARD CLEARING	$37,998	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$37,998**	**$0**	**$0**	**$0**	**$0**
AMP002 - CLAIMS SERVICES					
100002 - CLAIMS SERVICES	$2,157,390	$818,323	$844,135	$0	$844,135
TOTAL PROGRAM PARENT L1 FUNDS	**$2,157,390**	**$818,323**	**$844,135**	**$0**	**$844,135**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	$2,369,028	$3,043,988	$2,790,285	$0	$2,790,285
TOTAL PROGRAM PARENT L1 FUNDS	**$2,369,028**	**$3,043,988**	**$2,790,285**	**$0**	**$2,790,285**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	$5,671,105	$6,548,434	$5,066,119	$0	$5,066,119
TOTAL PROGRAM PARENT L1 FUNDS	**$5,671,105**	**$6,548,434**	**$5,066,119**	**$0**	**$5,066,119**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	$2,533,069	$3,665,044	$3,669,108	($242,247)	$3,426,861
TOTAL PROGRAM PARENT L1 FUNDS	**$2,533,069**	**$3,665,044**	**$3,669,108**	**($242,247)**	**$3,426,861**
AMP022 - RECORDS MANAGEMENT					
100125 - RECORDS MANAGEMENT - GENERAL	$686,471	$815,427	$807,991	$0	$807,991
TOTAL PROGRAM PARENT L1 FUNDS	**$686,471**	**$815,427**	**$807,991**	**$0**	**$807,991**
AMP023 - RESOURCE MANAGEMENT					
100127 - RESOURCE MANAGEMENT - GENERAL	$12,729,073	$14,550,358	$7,903,008	($74,167)	$7,828,841
TOTAL PROGRAM PARENT L1 FUNDS	**$12,729,073**	**$14,550,358**	**$7,903,008**	**($74,167)**	**$7,828,841**
H04201 - ACCOUNTABILITY ADMINISTRATIVE SERVICES					
700271 - ACCOUNTABILITY ADMINISTRATIVE SERVICES	$236,061	$117,215	$225,264	($46,227)	$179,037
TOTAL PROGRAM PARENT L1 FUNDS	**$236,061**	**$117,215**	**$225,264**	**($46,227)**	**$179,037**
H04202 - CERTIFICATION SERVICES					
700272 - CERTIFICATION SERVICES	$1,163,766	$943,177	$1,150,645	$0	$1,150,645
TOTAL PROGRAM PARENT L1 FUNDS	**$1,163,766**	**$943,177**	**$1,150,645**	**$0**	**$1,150,645**
H04203 - INCIDENT, MANAGEMENT AND INVESTIGATION SERVICES					
700273 - INCIDENT, MANAGEMENT AND INVESTIGATION SERVICES	$519,707	$561,097	$536,194	$0	$536,194
TOTAL PROGRAM PARENT L1 FUNDS	**$519,707**	**$561,097**	**$536,194**	**$0**	**$536,194**
H04204 - LICENSURE SERVICES					
700274 - LICENSURE SERVICES	$603,488	$606,246	$576,868	$0	$576,868
TOTAL PROGRAM PARENT L1 FUNDS	**$603,488**	**$606,246**	**$576,868**	**$0**	**$576,868**
H04205 - PROGRAM INTEGRITY SERVICES					
700275 - PROGRAM INTEGRITY SERVICES	$1,261,532	$1,183,750	$354,875	$0	$354,875
TOTAL PROGRAM PARENT L1 FUNDS	**$1,261,532**	**$1,183,750**	**$354,875**	**$0**	**$354,875**
H04301 - 35 K STREET ADULT CLINICAL SERVICES					
700276 - 35 K STREET ADULT CLINICAL SERVICES	$110,595	$2,783,877	$2,058,635	$0	$2,058,635
TOTAL PROGRAM PARENT L1 FUNDS	**$110,595**	**$2,783,877**	**$2,058,635**	**$0**	**$2,058,635**
H04302 - ACCESS HELPLINE					
700277 - ACCESS HELPLINE	$1,729,525	$2,987,375	$2,630,514	$0	$2,630,514
TOTAL PROGRAM PARENT L1 FUNDS	**$1,729,525**	**$2,987,375**	**$2,630,514**	**$0**	**$2,630,514**
H04303 - ADULT/TRANSITIONAL YOUTH SERVICES ADMINISTRATIVE SERVICES					

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
700278 - ADULT/TRANSITIONAL YOUTH SERVICES ADMINISTRATIVE SE	$88,510	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$88,510**	**$0**	**$0**	**$0**	**$0**
H04304 - ASSESSMENT AND REFERRAL CENTER SERVICES					
700279 - ASSESSMENT AND REFERRAL CENTER SERVICES	$1,765,180	$2,273,267	$2,393,309	$0	$2,393,309
TOTAL PROGRAM PARENT L1 FUNDS	**$1,765,180**	**$2,273,267**	**$2,393,309**	**$0**	**$2,393,309**
H04305 - CO-LOCATED SERVICES					
700280 - CO-LOCATED SERVICES	$759,341	$289,175	$292,557	$0	$292,557
TOTAL PROGRAM PARENT L1 FUNDS	**$759,341**	**$289,175**	**$292,557**	**$0**	**$292,557**
H04306 - COMMUNITY RESPONSE TEAM					
700281 - COMMUNITY RESPONSE TEAM	$8,146,729	$10,644,554	$9,982,467	$0	$9,982,467
TOTAL PROGRAM PARENT L1 FUNDS	**$8,146,729**	**$10,644,554**	**$9,982,467**	**$0**	**$9,982,467**
H04307 - GAMBLING ADDICTION TREATMENT SERVICES					
700282 - GAMBLING ADDICTION TREATMENT SERVICES	$27,540	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$27,540**	**$0**	**$0**	**$0**	**$0**
H04308 - HOUSING SUPPORT SERVICES					
700283 - HOUSING SUPPORT SERVICES	$27,419,358	$29,637,309	$28,987,309	($292,980)	$28,694,329
TOTAL PROGRAM PARENT L1 FUNDS	**$27,419,358**	**$29,637,309**	**$28,987,309**	**($292,980)**	**$28,694,329**
H04309 - IMPLEM OF DRUG TREATMENT CHOICE SERVICES					
700284 - IMPLEM OF DRUG TREATMENT CHOICE SERVICES	($15,988)	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**($15,988)**	**$0**	**$0**	**$0**	**$0**
H04310 - MENTAL HEALTH AND REHAB SERVICES					
700285 - MENTAL HEALTH AND REHAB SERVICES	$63,209,155	$65,255,442	$20,213,562	$0	$20,213,562
TOTAL PROGRAM PARENT L1 FUNDS	**$63,209,155**	**$65,255,442**	**$20,213,562**	**$0**	**$20,213,562**
H04311 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)					
700286 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	$15,827,069	$15,418,371	$14,338,644	$1,250,000	$15,588,644
TOTAL PROGRAM PARENT L1 FUNDS	**$15,827,069**	**$15,418,371**	**$14,338,644**	**$1,250,000**	**$15,588,644**
H04312 - PROVIDER RELATIONS SERVICES					
700287 - PROVIDER RELATIONS SERVICES	$953,455	$1,252,045	$1,152,206	$0	$1,152,206
TOTAL PROGRAM PARENT L1 FUNDS	**$953,455**	**$1,252,045**	**$1,152,206**	**$0**	**$1,152,206**
H04313 - RESIDENTIAL SUPPORT AND CONTINUITY OF CARE SERVICES					
700288 - RESIDENTIAL SUPPORT AND CONTINUITY OF CARE SERVICE	$614,491	$582,907	$599,614	$0	$599,614
TOTAL PROGRAM PARENT L1 FUNDS	**$614,491**	**$582,907**	**$599,614**	**$0**	**$599,614**
H04314 - SPECIALTY SERVICES					
700289 - SPECIALTY SERVICES	$7,060,175	$7,416,635	$5,514,618	$0	$5,514,618
TOTAL PROGRAM PARENT L1 FUNDS	**$7,060,175**	**$7,416,635**	**$5,514,618**	**$0**	**$5,514,618**
H04315 - SUBSTANCE USE DISORDER TREATMENT SERVICES					
700290 - SUBSTANCE USE DISORDER TREATMENT SERVICES	$1,192,931	$1,267,195	$1,197,609	$0	$1,197,609
TOTAL PROGRAM PARENT L1 FUNDS	**$1,192,931**	**$1,267,195**	**$1,197,609**	**$0**	**$1,197,609**
H04316 - STATE OPIOID RESPONSE PROGRAM					
700338 - STATE OPIOID RESPONSE PROGRAM	$25,404,622	$29,847,071	$36,014,647	$0	$36,014,647
TOTAL PROGRAM PARENT L1 FUNDS	**$25,404,622**	**$29,847,071**	**$36,014,647**	**$0**	**$36,014,647**
H04317 - BEHAVIORAL HEALTH REHABILITATION - LOCAL MATCH					
700365 - BEHAVIORAL HEALTH REHABILITATION - LOCAL MATCH	$0	$0	$44,638,076	$0	$44,638,076
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$44,638,076**	**$0**	**$44,638,076**
H04402 - CONSUMER AND FAMILY AFFAIRS					
700292 - CONSUMER AND FAMILY AFFAIRS	$1,996,907	$993,354	$1,018,515	$0	$1,018,515
TOTAL PROGRAM PARENT L1 FUNDS	**$1,996,907**	**$993,354**	**$1,018,515**	**$0**	**$1,018,515**
H04403 - EXECUTIVE DIRECTOR					
700293 - EXECUTIVE DIRECTOR	$2,038,329	$2,708,261	$2,609,773	$0	$2,609,773
TOTAL PROGRAM PARENT L1 FUNDS	**$2,038,329**	**$2,708,261**	**$2,609,773**	**$0**	**$2,609,773**
H04404 - LEGAL SERVICES					
700294 - LEGAL SERVICES	$1,049,390	$1,040,560	$1,046,625	$0	$1,046,625
TOTAL PROGRAM PARENT L1 FUNDS	**$1,049,390**	**$1,040,560**	**$1,046,625**	**$0**	**$1,046,625**
H04405 - LEGISLATIVE AND PUBLIC SERVICES					
700295 - LEGISLATIVE AND PUBLIC SERVICES	$932,635	$963,828	$917,518	$0	$917,518
TOTAL PROGRAM PARENT L1 FUNDS	**$932,635**	**$963,828**	**$917,518**	**$0**	**$917,518**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H04406 - OMBUDSMAN					
700296 - OMBUDSMAN	$293,560	$302,307	$401,154	$0	$401,154
TOTAL PROGRAM PARENT L1 FUNDS	**$293,560**	**$302,307**	**$401,154**	**$0**	**$401,154**
H04501 - BEHAVIORAL SERVICES - HOWARD ROAD					
700298 - BEHAVIORAL SERVICES - HOWARD ROAD	$0	$216,507	$217,385	$0	$217,385
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$216,507**	**$217,385**	**$0**	**$217,385**
H04502 - CHILD/ADOLESCENT/FAMILY SERVICES ADMINISTRATIVE SERVICES					
700299 - CHILD/ADOLESCENT/FAMILY SERVICES ADMINISTRATIVE SEI	$290,361	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$290,361**	**$0**	**$0**	**$0**	**$0**
H04503 - COURT ASSESSMENT SERVICES					
700300 - COURT ASSESSMENT SERVICES	$1,557,064	$1,630,847	$1,063,032	$0	$1,063,032
TOTAL PROGRAM PARENT L1 FUNDS	**$1,557,064**	**$1,630,847**	**$1,063,032**	**$0**	**$1,063,032**
H04504 - CRISIS SERVICES					
700301 - CRISIS SERVICES	$989,085	$1,466,544	$100,000	$0	$100,000
TOTAL PROGRAM PARENT L1 FUNDS	**$989,085**	**$1,466,544**	**$100,000**	**$0**	**$100,000**
H04505 - EARLY CHILDHOOD SERVICES					
700302 - EARLY CHILDHOOD SERVICES	$3,387,559	$3,896,600	$3,501,668	($75,968)	$3,425,700
TOTAL PROGRAM PARENT L1 FUNDS	**$3,387,559**	**$3,896,600**	**$3,501,668**	**($75,968)**	**$3,425,700**
H04506 - EVIDENCE BASED PRACTICES SERVICES					
700303 - EVIDENCE BASED PRACTICES SERVICES	$1,336,351	$1,259,287	$1,258,065	$0	$1,258,065
TOTAL PROGRAM PARENT L1 FUNDS	**$1,336,351**	**$1,259,287**	**$1,258,065**	**$0**	**$1,258,065**
H04507 - MH/SUD BEHAVIORAL HEALTH SERVICES (CHILD & FAMILY)					
700304 - MH/SUD BEHAVIORAL HEALTH SERVICES (CHILD & FAMILY)	$1,942,512	$1,378,285	$1,349,674	$0	$1,349,674
TOTAL PROGRAM PARENT L1 FUNDS	**$1,942,512**	**$1,378,285**	**$1,349,674**	**$0**	**$1,349,674**
H04508 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES					
700305 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES	$28,069,439	$38,339,743	$28,362,409	($593,780)	$27,768,629
TOTAL PROGRAM PARENT L1 FUNDS	**$28,069,439**	**$38,339,743**	**$28,362,409**	**($593,780)**	**$27,768,629**
H04509 - SPECIALTY SERVICES					
700306 - SPECIALTY SERVICES	$899,210	$1,066,899	$941,013	$0	$941,013
TOTAL PROGRAM PARENT L1 FUNDS	**$899,210**	**$1,066,899**	**$941,013**	**$0**	**$941,013**
H04601 - BEHAVIORAL HEALTH SERVICES					
700308 - BEHAVIORAL HEALTH SERVICES	$207,569	$115,681	$490,080	$0	$490,080
TOTAL PROGRAM PARENT L1 FUNDS	**$207,569**	**$115,681**	**$490,080**	**$0**	**$490,080**
H04602 - BEHAVIORAL HEALTH SERVICES-PHARMACY					
700309 - BEHAVIORAL HEALTH SERVICES-PHARMACY	$478,545	$202,510	$202,510	$0	$202,510
TOTAL PROGRAM PARENT L1 FUNDS	**$478,545**	**$202,510**	**$202,510**	**$0**	**$202,510**
H04603 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES					
700310 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	$5,098,748	$5,174,478	$7,756,394	($18,848)	$7,737,546
TOTAL PROGRAM PARENT L1 FUNDS	**$5,098,748**	**$5,174,478**	**$7,756,394**	**($18,848)**	**$7,737,546**
H04604 - DISASTER BEHAVIORAL HEALTH SERVICES AND SUPPORT SERVICES					
700311 - DISASTER BEHAVIORAL HEALTH SERVICES AND SUPPORT SE	$1,314,587	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$1,314,587**	**$0**	**$0**	**$0**	**$0**
H04605 - FORENSICS SERVICES					
700312 - FORENSICS SERVICES	$4,335,674	$4,734,130	$4,102,385	$0	$4,102,385
TOTAL PROGRAM PARENT L1 FUNDS	**$4,335,674**	**$4,734,130**	**$4,102,385**	**$0**	**$4,102,385**
H04701 - BEHAVIORAL HEALTH GRANT OVERSIGHT SERVICES					
700313 - BEHAVIORAL HEALTH GRANT OVERSIGHT SERVICES	$2,300,581	$2,623,198	$2,092,987	$0	$2,092,987
TOTAL PROGRAM PARENT L1 FUNDS	**$2,300,581**	**$2,623,198**	**$2,092,987**	**$0**	**$2,092,987**
H04702 - DATA AND PERFORMANCE MEASUREMENT SERVICES					
700314 - DATA AND PERFORMANCE MEASUREMENT SERVICES	$1,562,309	$2,062,300	$2,386,854	$0	$2,386,854
TOTAL PROGRAM PARENT L1 FUNDS	**$1,562,309**	**$2,062,300**	**$2,386,854**	**$0**	**$2,386,854**
H04703 - STRATEGIC PLANNING AND POLICY SERVICES					
700315 - STRATEGIC PLANNING AND POLICY SERVICES	$576,589	$409,361	$351,351	$0	$351,351
TOTAL PROGRAM PARENT L1 FUNDS	**$576,589**	**$409,361**	**$351,351**	**$0**	**$351,351**
H04704 - TRAINING INSTITUTE SERVICES					
700316 - TRAINING INSTITUTE SERVICES	$1,651,832	$1,197,474	$989,902	$0	$989,902
TOTAL PROGRAM PARENT L1 FUNDS	**$1,651,832**	**$1,197,474**	**$989,902**	**$0**	**$989,902**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H04801 - CLINICAL ADMINISTRATIVE SERVICES					
700317 - CLINICAL ADMINISTRATIVE SERVICES	$11,897,527	$12,605,564	$12,833,528	($9,044)	$12,824,484
TOTAL PROGRAM PARENT L1 FUNDS	**$11,897,527**	**$12,605,564**	**$12,833,528**	**($9,044)**	**$12,824,484**
H04802 - CLINICAL AND MEDICAL SERVICES					
700318 - CLINICAL AND MEDICAL SERVICES	$21,786,123	$21,153,193	$22,867,584	($27,168)	$22,840,416
TOTAL PROGRAM PARENT L1 FUNDS	**$21,786,123**	**$21,153,193**	**$22,867,584**	**($27,168)**	**$22,840,416**
H04803 - ENIGINEERING AND MAINTENANCE SERVICES					
700319 - ENIGINEERING AND MAINTENANCE SERVICES	$5,615,293	$4,853,078	$4,843,077	($29,093)	$4,813,984
TOTAL PROGRAM PARENT L1 FUNDS	**$5,615,293**	**$4,853,078**	**$4,843,077**	**($29,093)**	**$4,813,984**
H04804 - FISCAL AND SUPPORT SERVICES					
700320 - FISCAL AND SUPPORT SERVICES	$461,748	$951,917	$874,419	$0	$874,419
TOTAL PROGRAM PARENT L1 FUNDS	**$461,748**	**$951,917**	**$874,419**	**$0**	**$874,419**
H04805 - HOSPITAL ADMINISTRATIVE SERVICES					
700321 - HOSPITAL ADMINISTRATIVE SERVICES	$1,147,716	$1,180,735	$5,737,277	($46,175)	$5,691,101
TOTAL PROGRAM PARENT L1 FUNDS	**$1,147,716**	**$1,180,735**	**$5,737,277**	**($46,175)**	**$5,691,101**
H04806 - HOUSEKEEPING SERVICES					
700322 - HOUSEKEEPING SERVICES	$3,023,269	$2,788,853	$2,659,363	$0	$2,659,363
TOTAL PROGRAM PARENT L1 FUNDS	**$3,023,269**	**$2,788,853**	**$2,659,363**	**$0**	**$2,659,363**
H04807 - MATERIAL MANAGEMENT SERVICES					
700323 - MATERIAL MANAGEMENT SERVICES	$1,307,104	$1,586,638	$1,511,558	($4,562)	$1,506,996
TOTAL PROGRAM PARENT L1 FUNDS	**$1,307,104**	**$1,586,638**	**$1,511,558**	**($4,562)**	**$1,506,996**
H04808 - NURSING SERVICES					
700324 - NURSING SERVICES	$53,997,718	$46,290,762	$50,248,168	$0	$50,248,168
TOTAL PROGRAM PARENT L1 FUNDS	**$53,997,718**	**$46,290,762**	**$50,248,168**	**$0**	**$50,248,168**
H04809 - NUTRITIONAL SERVICES					
700325 - NUTRITIONAL SERVICES	$3,391,505	$4,375,449	$3,414,479	$0	$3,414,479
TOTAL PROGRAM PARENT L1 FUNDS	**$3,391,505**	**$4,375,449**	**$3,414,479**	**$0**	**$3,414,479**
H04810 - QUALITY AND DATA MANAGEMENT SERVICES					
700326 - QUALITY AND DATA MANAGEMENT SERVICES	$1,454,629	$1,571,602	$1,575,347	($11,275)	$1,564,072
TOTAL PROGRAM PARENT L1 FUNDS	**$1,454,629**	**$1,571,602**	**$1,575,347**	**($11,275)**	**$1,564,072**
H04811 - SECURITY AND SAFETY SERVICES					
700327 - SECURITY AND SAFETY SERVICES	$5,257,172	$4,741,694	$4,941,617	($744)	$4,940,873
TOTAL PROGRAM PARENT L1 FUNDS	**$5,257,172**	**$4,741,694**	**$4,941,617**	**($744)**	**$4,940,873**
H04812 - TRANSPORATION AND GROUNDS SERVICES					
700328 - TRANSPORATION AND GROUNDS SERVICES	$675,905	$667,042	$632,457	($11,226)	$621,231
TOTAL PROGRAM PARENT L1 FUNDS	**$675,905**	**$667,042**	**$632,457**	**($11,226)**	**$621,231**
H05201 - DIRECTOR AND COMMISSION SUPPORT					
700356 - DIRECTOR AND COMMISSION SUPPORT	$0	$548,000	$14,655,500	$0	$14,655,500
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$548,000**	**$14,655,500**	**$0**	**$14,655,500**
H05301 - CHILD/YOUTH CRISIS & COMMUNITY TRAUMA RESPONS					
700357 - CHILD/YOUTH CRISIS & COMMUNITY TRAUMA RESPONSE	$0	$0	$1,366,544	$0	$1,366,544
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$1,366,544**	**$0**	**$1,366,544**
PRG001 - NO PROGRAM					
000000 - NO PROGRAM	($199,479)	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**($199,479)**	**$0**	**$0**	**$0**	**$0**
TOTAL AGENCY FUNDS	**$358,176,811**	**$380,100,036**	**$385,536,240**	**($233,506)**	**$385,302,734**
Department of Health					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	$1,054,412	$1,329,845	$1,277,475	$0	$1,277,475
TOTAL PROGRAM PARENT L1 FUNDS	**$1,054,412**	**$1,329,845**	**$1,277,475**	**$0**	**$1,277,475**
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$1,124,210	$1,272,746	$1,315,053	($2,000)	$1,313,053
TOTAL PROGRAM PARENT L1 FUNDS	**$1,124,210**	**$1,272,746**	**$1,315,053**	**($2,000)**	**$1,313,053**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$751,491	$869,005	$857,559	$0	$857,559
TOTAL PROGRAM PARENT L1 FUNDS	**$751,491**	**$869,005**	**$857,559**	**$0**	**$857,559**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
AMP003 - COMMUNICATIONS					
100003 - COMMUNICATIONS - GENERAL	$728,677	$956,599	$1,335,580	$0	$1,335,580
100007 - LANGUAGE ACCESS	$93,379	$100,000	$106,000	$0	$106,000
TOTAL PROGRAM PARENT L1 FUNDS	**$822,057**	**$1,056,599**	**$1,441,580**	**$0**	**$1,441,580**
AMP005 - CONTRACTING AND PROCUREMENT					
100022 - CONTRACTING AND PROCUREMENT - GENERAL	$870,607	$785,676	$1,261,399	$0	$1,261,399
TOTAL PROGRAM PARENT L1 FUNDS	**$870,607**	**$785,676**	**$1,261,399**	**$0**	**$1,261,399**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	$1,386,869	$1,742,355	$2,060,721	$0	$2,060,721
TOTAL PROGRAM PARENT L1 FUNDS	**$1,386,869**	**$1,742,355**	**$2,060,721**	**$0**	**$2,060,721**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	$6,405,450	$4,165,806	$8,070,145	$0	$8,070,145
TOTAL PROGRAM PARENT L1 FUNDS	**$6,405,450**	**$4,165,806**	**$8,070,145**	**$0**	**$8,070,145**
AMP013 - LABOR RELATIONS					
100087 - LABOR RELATIONS - GENERAL	$115,021	$180,829	$170,800	$0	$170,800
TOTAL PROGRAM PARENT L1 FUNDS	**$115,021**	**$180,829**	**$170,800**	**$0**	**$170,800**
AMP014 - LEGAL SERVICES					
100092 - LEGAL SERVICES - GENERAL	$2,293,932	$2,716,132	$2,702,454	$0	$2,702,454
TOTAL PROGRAM PARENT L1 FUNDS	**$2,293,932**	**$2,716,132**	**$2,702,454**	**$0**	**$2,702,454**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	$16,404,285	$19,639,133	$16,991,359	$0	$16,991,359
TOTAL PROGRAM PARENT L1 FUNDS	**$16,404,285**	**$19,639,133**	**$16,991,359**	**$0**	**$16,991,359**
AMP024 - RISK MANAGEMENT					
100135 - RISK MANAGEMENT - GENERAL	$125,012	$132,064	$132,119	$0	$132,119
TOTAL PROGRAM PARENT L1 FUNDS	**$125,012**	**$132,064**	**$132,119**	**$0**	**$132,119**
AMP030 - EXECUTIVE ADMINISTRATION					
100151 - EXECUTIVE ADMINISTRATION	$4,242,384	$1,700,763	$1,708,472	($3,556)	$1,704,916
TOTAL PROGRAM PARENT L1 FUNDS	**$4,242,384**	**$1,700,763**	**$1,708,472**	**($3,556)**	**$1,704,916**
H00401 - CANCER AND CHRONIC DISEASE PREVENTION					
700023 - CANCER AND CHRONIC DISEASE PREVENTION	$11,384,446	$9,710,496	$10,702,362	$771,160	$11,473,522
TOTAL PROGRAM PARENT L1 FUNDS	**$11,384,446**	**$9,710,496**	**$10,702,362**	**$771,160**	**$11,473,522**
H00403 - COMMUNITY OF HEALTH SUPPORT SERVICES					
700329 - COMMUNITY OF HEALTH SUPPORT SERVICES	$7,367,002	$9,481,382	$9,136,206	($17,720)	$9,118,486
TOTAL PROGRAM PARENT L1 FUNDS	**$7,367,002**	**$9,481,382**	**$9,136,206**	**($17,720)**	**$9,118,486**
H00405 - FAMILY HEALTH					
700026 - FAMILY HEALTH	$41,757,053	$39,868,174	$39,722,688	$2,155,206	$41,877,894
TOTAL PROGRAM PARENT L1 FUNDS	**$41,757,053**	**$39,868,174**	**$39,722,688**	**$2,155,206**	**$41,877,894**
H00406 - HEALTH CARE ACCESS					
700027 - HEALTH CARE ACCESS	$20,090,982	$9,589,010	$10,278,374	$0	$10,278,374
TOTAL PROGRAM PARENT L1 FUNDS	**$20,090,982**	**$9,589,010**	**$10,278,374**	**$0**	**$10,278,374**
H00407 - NUTRITION AND PHYSICAL FITNESS					
700028 - NUTRITION AND PHYSICAL FITNESS	$22,255,563	$22,474,173	$22,523,173	$720,000	$23,243,173
TOTAL PROGRAM PARENT L1 FUNDS	**$22,255,563**	**$22,474,173**	**$22,523,173**	**$720,000**	**$23,243,173**
H00408 - PERINATAL AND INFANT HEALTH					
700029 - PERINATAL AND INFANT HEALTH	$166,744	$326,381	$334,864	$0	$334,864
TOTAL PROGRAM PARENT L1 FUNDS	**$166,744**	**$326,381**	**$334,864**	**$0**	**$334,864**
H00409 - PCPA SUPPORT SERVICES					
700336 - PCPA SUPPORT SERVICES	$98,187	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$98,187**	**$0**	**$0**	**$0**	**$0**
H00601 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE					
700031 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE	$14,548,361	$14,128,003	$14,032,978	($25,550)	$14,007,428
TOTAL PROGRAM PARENT L1 FUNDS	**$14,548,361**	**$14,128,003**	**$14,032,978**	**($25,550)**	**$14,007,428**
H00701 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLICY EVALUATION					
700032 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLICY	$43,031	$231,663	$254,888	$0	$254,888
TOTAL PROGRAM PARENT L1 FUNDS	**$43,031**	**$231,663**	**$254,888**	**$0**	**$254,888**
H00702 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATION					

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
700033 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATIOI	$125,182	$102,390	$12,333	$0	$12,333
TOTAL PROGRAM PARENT L1 FUNDS	**$125,182**	**$102,390**	**$12,333**	**$0**	**$12,333**
H00703 - MULTI SECTOR COLLABORATION					
700034 - MULTI SECTOR COLLABORATION	$478,091	$567,539	$695,024	$0	$695,024
TOTAL PROGRAM PARENT L1 FUNDS	**$478,091**	**$567,539**	**$695,024**	**$0**	**$695,024**
H00801 - DIRECT CARE SERVICES FOR TUBERCULOSIS					
700331 - DIRECT CARE SERVICES FOR TUBERCULOSIS	$2,058,048	$1,751,308	$1,987,553	$0	$1,987,553
TOTAL PROGRAM PARENT L1 FUNDS	**$2,058,048**	**$1,751,308**	**$1,987,553**	**$0**	**$1,987,553**
H00802 - DRUG ASSISTANCE					
700035 - DRUG ASSISTANCE	$12,123,755	$9,081,291	$10,782,274	$0	$10,782,274
TOTAL PROGRAM PARENT L1 FUNDS	**$12,123,755**	**$9,081,291**	**$10,782,274**	**$0**	**$10,782,274**
H00803 - GRANTS AND CONTRACTS MANAGEMENT					
700036 - GRANTS AND CONTRACTS MANAGEMENT	$1,591,651	$1,918,229	$1,639,108	$0	$1,639,108
TOTAL PROGRAM PARENT L1 FUNDS	**$1,591,651**	**$1,918,229**	**$1,639,108**	**$0**	**$1,639,108**
H00804 - HIV HEALTH AND SUPPORT SERVICES					
700037 - HIV HEALTH AND SUPPORT SERVICES	$36,937,310	$39,975,052	$38,221,847	$0	$38,221,847
TOTAL PROGRAM PARENT L1 FUNDS	**$36,937,310**	**$39,975,052**	**$38,221,847**	**$0**	**$38,221,847**
H00805 - HIV/AIDS DATA AND RESEARCH					
700038 - HIV/AIDS DATA AND RESEARCH	$2,037,954	$4,165,821	$3,991,618	$0	$3,991,618
TOTAL PROGRAM PARENT L1 FUNDS	**$2,037,954**	**$4,165,821**	**$3,991,618**	**$0**	**$3,991,618**
H00806 - HIV/AIDS HOUSING AND SUPPORTIVE SERVICES					
700039 - HIV/AIDS HOUSING AND SUPPORTIVE SERVICES	$11,863,045	$13,664,395	$13,980,418	$0	$13,980,418
TOTAL PROGRAM PARENT L1 FUNDS	**$11,863,045**	**$13,664,395**	**$13,980,418**	**$0**	**$13,980,418**
H00807 - HIV/AIDS POLICY AND PLANNING					
700040 - HIV/AIDS POLICY AND PLANNING	$4,008,263	$5,477,633	$6,126,224	$0	$6,126,224
TOTAL PROGRAM PARENT L1 FUNDS	**$4,008,263**	**$5,477,633**	**$6,126,224**	**$0**	**$6,126,224**
H00808 - PREVENTION AND INTERVENTION SERVICES					
700041 - PREVENTION AND INTERVENTION SERVICES	$11,238,316	$11,099,079	$11,834,332	$500,000	$12,334,332
TOTAL PROGRAM PARENT L1 FUNDS	**$11,238,316**	**$11,099,079**	**$11,834,332**	**$500,000**	**$12,334,332**
H00809 - STD CONTROL					
700042 - STD CONTROL	$3,485,957	$3,191,638	$3,168,803	$0	$3,168,803
TOTAL PROGRAM PARENT L1 FUNDS	**$3,485,957**	**$3,191,638**	**$3,168,803**	**$0**	**$3,168,803**
H00902 - PUBLIC HEALTH EMERGENCY OPERATIONS AND PROGRAM SUPPORT					
700045 - PUBLIC HEALTH EMERGENCY OPERATIONS AND PROGRAM	$7,572,780	$4,381,480	$4,799,908	$0	$4,799,908
TOTAL PROGRAM PARENT L1 FUNDS	**$7,572,780**	**$4,381,480**	**$4,799,908**	**$0**	**$4,799,908**
H00903 - PUBLIC HEALTH EMERGENCY PREPAREDNESS					
700046 - PUBLIC HEALTH EMERGENCY PREPAREDNESS	$2,023,169	$1,502,138	$1,481,355	$0	$1,481,355
TOTAL PROGRAM PARENT L1 FUNDS	**$2,023,169**	**$1,502,138**	**$1,481,355**	**$0**	**$1,481,355**
H01101 - HEALTH CARE FACILITIES REGULATION					
700048 - HEALTH CARE FACILITIES REGULATION	$6,217,104	$8,215,422	$7,372,921	$0	$7,372,921
TOTAL PROGRAM PARENT L1 FUNDS	**$6,217,104**	**$8,215,422**	**$7,372,921**	**$0**	**$7,372,921**
H01201 - HEALTH LICENSING					
700049 - HEALTH LICENSING	$13,808,084	$11,853,378	$12,599,294	$0	$12,599,294
TOTAL PROGRAM PARENT L1 FUNDS	**$13,808,084**	**$11,853,378**	**$12,599,294**	**$0**	**$12,599,294**
H01301 - EMERGENCY MEDICAL SERVICES REGULATION					
700050 - EMERGENCY MEDICAL SERVICES REGULATION	$106,421	$201,301	$135,479	$167,541	$303,020
TOTAL PROGRAM PARENT L1 FUNDS	**$106,421**	**$201,301**	**$135,479**	**$167,541**	**$303,020**
H01401 - EPIDEMIOLOGIC STUDIES AND OUTBREAK INVESTIGATION					
700051 - EPIDEMIOLOGIC STUDIES AND OUTBREAK INVESTIGATION	$6,971,445	$7,737,812	$3,314,419	$0	$3,314,419
TOTAL PROGRAM PARENT L1 FUNDS	**$6,971,445**	**$7,737,812**	**$3,314,419**	**$0**	**$3,314,419**
H01501 - DEVELOPMENT OF THE STATE HEALTH PLAN AND ANNUAL IMPLEMENTATION					
700052 - DEVELOPMENT OF THE STATE HEALTH PLAN AND ANNUAL IM	$1,457,705	$1,582,930	$1,795,798	$0	$1,795,798
TOTAL PROGRAM PARENT L1 FUNDS	**$1,457,705**	**$1,582,930**	**$1,795,798**	**$0**	**$1,795,798**
H01601 - BIRTH AND DEATH RECORD COLLECTION, PROCESSING, ANALYZING AND DISSEMINATION					
700054 - BIRTH AND DEATH RECORD COLLECTION, PROCESSING, AI	$11,278,368	$24,259,532	$35,915,620	$0	$35,915,620
TOTAL PROGRAM PARENT L1 FUNDS	**$11,278,368**	**$24,259,532**	**$35,915,620**	**$0**	**$35,915,620**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
PRG001 - NO PROGRAM					
000000 - NO PROGRAM	$6,800	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$6,800**	**$0**	**$0**	**$0**	**$0**
TOTAL AGENCY FUNDS	**$288,696,544**	**$292,128,607**	**$304,828,997**	**$4,265,081**	**$309,094,078**
Department of Health Care Finance					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	$3,353,048	$7,133,253	$7,249,272	$0	$7,249,272
TOTAL PROGRAM PARENT L1 FUNDS	**$3,353,048**	**$7,133,253**	**$7,249,272**	**$0**	**$7,249,272**
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$589,362	$740,233	$835,970	$0	$835,970
TOTAL PROGRAM PARENT L1 FUNDS	**$589,362**	**$740,233**	**$835,970**	**$0**	**$835,970**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$326,499	$356,386	$368,559	$0	$368,559
TOTAL PROGRAM PARENT L1 FUNDS	**$326,499**	**$356,386**	**$368,559**	**$0**	**$368,559**
AFO010 - PAYROLL DEFAULT					
150011 - PAYROLL DEFAULT	$0	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$0**	**$0**	**$0**
AFO011 - P-CARD CLEARING					
150012 - P-CARD CLEARING	$637	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$637**	**$0**	**$0**	**$0**	**$0**
AMP003 - COMMUNICATIONS					
100003 - COMMUNICATIONS - GENERAL	$649,379	$1,819,551	$0	$0	$0
100007 - LANGUAGE ACCESS	$0	$36,000	$36,000	$0	$36,000
TOTAL PROGRAM PARENT L1 FUNDS	**$649,379**	**$1,855,551**	**$36,000**	**$0**	**$36,000**
AMP005 - CONTRACTING AND PROCUREMENT					
100022 - CONTRACTING AND PROCUREMENT - GENERAL	$1,960,062	$1,875,735	$1,882,726	$0	$1,882,726
100026 - CONTRACTS REPORTING	$0	$0	$193,274	$0	$193,274
TOTAL PROGRAM PARENT L1 FUNDS	**$1,960,062**	**$1,875,735**	**$2,076,000**	**$0**	**$2,076,000**
AMP006 - CUSTOMER SERVICE					
100028 - CUSTOMER SERVICE - GENERAL	$3,143,763	$4,700,046	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$3,143,763**	**$4,700,046**	**$0**	**$0**	**$0**
AMP010 - GRANTS ADMINISTRATION					
100045 - GRANTS MANAGEMENT OVERSIGHT	$2,824,067	$1,857,541	$0	$0	$0
100047 - SUB-GRANT ADMINISTRATION	$8,000,000	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$10,824,067**	**$1,857,541**	**$0**	**$0**	**$0**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	$1,044,114	$2,047,874	$1,514,471	$0	$1,514,471
TOTAL PROGRAM PARENT L1 FUNDS	**$1,044,114**	**$2,047,874**	**$1,514,471**	**$0**	**$1,514,471**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	$0	$0	$10,989,856	($757,043)	$10,232,813
100072 - INTERNAL SUPPORT	$5,537,551	$11,944,268	$1,476,148	$0	$1,476,148
100076 - IT SECURITY	$0	$0	$531,398	$0	$531,398
TOTAL PROGRAM PARENT L1 FUNDS	**$5,537,551**	**$11,944,268**	**$12,997,403**	**($757,043)**	**$12,240,360**
AMP014 - LEGAL SERVICES					
100092 - LEGAL SERVICES - GENERAL	$1,220,335	$1,633,025	$1,470,759	$0	$1,470,759
TOTAL PROGRAM PARENT L1 FUNDS	**$1,220,335**	**$1,633,025**	**$1,470,759**	**$0**	**$1,470,759**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	$2,750,902	$11,770,256	$4,024,851	$0	$4,024,851
TOTAL PROGRAM PARENT L1 FUNDS	**$2,750,902**	**$11,770,256**	**$4,024,851**	**$0**	**$4,024,851**
AMP021 - RATES, REIMBURSEMENT, FINANCIAL ANALYSIS					
100122 - FINANCE SERVICES	$3,277,035	$4,848,496	$0	$0	$0
100123 - REIMBURSEMENT SERVICES	$129,814	$236,163	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$3,406,849**	**$5,084,658**	**$0**	**$0**	**$0**
AMP026 - TRAINING AND DEVELOPMENT					
100147 - SPECIAL PROGRAMS	$1,035,000	$0	$0	$0	$0
100148 - TRAINING AND DEVELOPMENT - GENERAL	$5,455	$16,809	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$1,040,455**	**$16,809**	**$0**	**$0**	**$0**
AMP030 - EXECUTIVE ADMINISTRATION					

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
100151 - EXECUTIVE ADMINISTRATION	$1,225,519	$1,409,438	$1,445,209	$0	$1,445,209
TOTAL PROGRAM PARENT L1 FUNDS	**$1,225,519**	**$1,409,438**	**$1,445,209**	**$0**	**$1,445,209**
AMP037 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR					
100180 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	$0	$0	$4,418,885	($310,694)	$4,108,191
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$4,418,885**	**($310,694)**	**$4,108,191**
AMP038 - SENIOR DEPUTY DIRECTOR/FINANCE					
100181 - SENIOR DEPUTY DIRECTOR/FINANCE	$0	$0	$6,405,395	($10,553)	$6,394,842
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$6,405,395**	**($10,553)**	**$6,394,842**
AMP039 - CHIEF OPERATING OFFICE					
100182 - CHIEF OPERATING OFFICE	$0	$0	$2,615,172	($256,423)	$2,358,750
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$2,615,172**	**($256,423)**	**$2,358,750**
AMP040 - DATA ANALYTICS AND RESEARCH ADMINISTRATION					
100183 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	$0	$0	$2,089,445	($10,150)	$2,079,295
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$2,089,445**	**($10,150)**	**$2,079,295**
AMP041 - PROGRAM INTEGRITY					
100184 - PROGRAM INTEGRITY	$0	$0	$4,770,656	($16,367)	$4,754,289
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$4,770,656**	**($16,367)**	**$4,754,289**
AMP042 - HEALTH CARE OMBUDSMAN					
100185 - HEALTH CARE OMBUDSMAN	$0	$0	$4,957,285	$0	$4,957,285
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$4,957,285**	**$0**	**$4,957,285**
AMP043 - HEALTH CARE DELIVERY MGT SUPPORT SVCS					
100186 - HEALTH CARE DELIVERY MGT SUPPORT SVCS	$0	$0	$1,445,848	($2,351)	$1,443,498
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$1,445,848**	**($2,351)**	**$1,443,498**
AMP044 - MANAGED CARE MGT					
100187 - MANAGED CARE MGT	$0	$0	$9,885,450	($300,000)	$9,585,450
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$9,885,450**	**($300,000)**	**$9,585,450**
AMP045 - CHILDREN'S HEALTH SERVICES					
100188 - CHILDREN'S HEALTH SERVICES	$0	$0	$1,291,675	$0	$1,291,675
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$1,291,675**	**$0**	**$1,291,675**
AMP046 - HEALTH CARE QUALITY AND HEALTH OUTCOMES					
100189 - HEALTH CARE QUALITY AND HEALTH OUTCOMES	$0	$0	$2,948,407	$0	$2,948,407
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$2,948,407**	**$0**	**$2,948,407**
AMP047 - CLINICIANS, RX AND ACUTE CARE					
100190 - CLINICIANS, RX AND ACUTE CARE	$0	$0	$8,363,600	$1,201,921	$9,565,521
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$8,363,600**	**$1,201,921**	**$9,565,521**
AMP048 - LONG TERM CARE SUPPORT SERVICES					
100191 - LONG TERM CARE SUPPORT SERVICES	$0	$0	$866,068	($6,660)	$859,408
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$866,068**	**($6,660)**	**$859,408**
AMP049 - OVERSIGHT					
100192 - OVERSIGHT	$0	$0	$2,100,082	$0	$2,100,082
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$2,100,082**	**$0**	**$2,100,082**
AMP050 - OPERATIONS					
100193 - OPERATIONS	$0	$0	$12,557,880	($135,000)	$12,422,880
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$12,557,880**	**($135,000)**	**$12,422,880**
AMP051 - INTAKE AND ASSESSMENT					
100194 - INTAKE AND ASSESSMENT	$0	$0	$9,775,936	$0	$9,775,936
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$9,775,936**	**$0**	**$9,775,936**
AMP052 - HEALTH CARE POLICY					
100195 - HEALTH CARE POLICY	$0	$0	$1,004,024	$0	$1,004,024
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$1,004,024**	**$0**	**$1,004,024**
AMP053 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES					
100196 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES	$0	$0	$1,957,327	($352,415)	$1,604,912
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$1,957,327**	**($352,415)**	**$1,604,912**
AMP054 - ELIGIBILITY POLICY & OVERSIGHT					
100197 - ELIGIBILITY POLICY & OVERSIGHT	$0	$0	$3,978,628	$0	$3,978,628
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$3,978,628**	**$0**	**$3,978,628**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
AMP055 - DCAS PROGRAM MANAGEMENT					
100198 - DCAS PROGRAM MANAGEMENT	$0	$0	$1,807,361	($209,776)	$1,597,585
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$1,807,361**	**($209,776)**	**$1,597,585**
AMP056 - DCAS PROJECT MANAGEMENT					
100199 - DCAS PROJECT MANAGEMENT	$0	$0	$4,350,037	($22,281)	$4,327,756
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$4,350,037**	**($22,281)**	**$4,327,756**
AMP057 - DCAS HHS FUNCTIONAL					
100200 - DCAS HHS FUNCTIONAL	$0	$0	$814,115	$0	$814,115
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$814,115**	**$0**	**$814,115**
AMP058 - DCAS ORGANIZATIONAL CHANGE MANAGEMENT					
100201 - DCAS ORGANIZATIONAL CHANGE MANAGEMENT	$0	$0	$13,202,557	$0	$13,202,557
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$13,202,557**	**$0**	**$13,202,557**
AMP059 - DCAS INFORMATION TECHNOLOGY					
100202 - DCAS INFORMATION TECHNOLOGY	$0	$0	$57,293,250	$1,219,517	$58,512,767
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$57,293,250**	**$1,219,517**	**$58,512,767**
AMP060 - CLAIMS MANAGEMENT					
100203 - CLAIMS MANAGEMENT	$0	$0	$59,722,222	$0	$59,722,222
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$59,722,222**	**$0**	**$59,722,222**
AMP061 - HCOA SUPPORT SERVICES					
100204 - HCOA SUPPORT SERVICES	$0	$0	$454,445	$0	$454,445
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$454,445**	**$0**	**$454,445**
AMP062 - PUBLIC AND PRIVATE PROVIDER SERVICES					
100205 - PUBLIC AND PRIVATE PROVIDER SERVICES	$0	$0	$3,664,604	$0	$3,664,604
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$3,664,604**	**$0**	**$3,664,604**
AMP063 - HC REFORM AND INNOVATIVE SUPPORT SVS					
100206 - HC REFORM AND INNOVATIVE SUPPORT SVS	$0	$0	$454,012	$0	$454,012
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$454,012**	**$0**	**$454,012**
AMP064 - GRANTS ADMINISTRATION FUNCTION					
100207 - GRANTS ADMINISTRATION FUNCTION	$0	$0	$5,921,060	$100,000	$6,021,060
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$5,921,060**	**$100,000**	**$6,021,060**
AMP065 - HIE: HEALTH INFORMATION EXCHANGE					
100208 - HIE: HEALTH INFORMATION EXCHANGE	$0	$0	$11,321,423	$0	$11,321,423
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$0**	**$11,321,423**	**$0**	**$11,321,423**
H02301 - E & E SYSTEMS					
700079 - E & E SYSTEMS	$40,471,460	$53,190,564	$98,671	$0	$98,671
TOTAL PROGRAM PARENT L1 FUNDS	**$40,471,460**	**$53,190,564**	**$98,671**	**$0**	**$98,671**
H02302 - E&E OVERSIGHT & MANAGEMENT					
700080 - E&E OVERSIGHT & MANAGEMENT	$786,962	$1,301,808	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$786,962**	**$1,301,808**	**$0**	**$0**	**$0**
H02305 - E&E SUPPORT - PMO/SME - DCAS					
700083 - E&E SUPPORT - PMO/SME - DCAS	$14,766,622	$23,992,806	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$14,766,622**	**$23,992,806**	**$0**	**$0**	**$0**
H02401 - HEALTH CARE AGENCY MONITORING AND KPIS					
700084 - HEALTH CARE AGENCY MONITORING AND KPIS	$1,200,031	$2,173,055	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$1,200,031**	**$2,173,055**	**$0**	**$0**	**$0**
H02402 - HEALTH CARE DATA ANALYTICS					
700085 - HEALTH CARE DATA ANALYTICS	$1,164,399	$2,350,527	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$1,164,399**	**$2,350,527**	**$0**	**$0**	**$0**
H02403 - HEALTH CARE INNOVATION					
700086 - HEALTH CARE INNOVATION	$9,550,927	$9,859,596	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$9,550,927**	**$9,859,596**	**$0**	**$0**	**$0**
H02501 - CLAIMS PROCESSING & QUALITY ASSURANCE/CONTROL					
700087 - CLAIMS PROCESSING & QUALITY ASSURANCE/CONTROL	$43,855,271	$51,481,198	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$43,855,271**	**$51,481,198**	**$0**	**$0**	**$0**
H02601 - ASSESSMENTS AND CARE COORDINATION					
700090 - ASSESSMENTS AND CARE COORDINATION	$972,146	$1,133,956	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$972,146**	**$1,133,956**	**$0**	**$0**	**$0**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H02602 - FRAUD, WASTE, AND ABUSE					
700091 - FRAUD, WASTE, AND ABUSE	$3,494,872	$3,986,654	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$3,494,872**	**$3,986,654**	**$0**	**$0**	**$0**
H02603 - POLICY					
700092 - POLICY	$2,784,417	$5,455,721	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$2,784,417**	**$5,455,721**	**$0**	**$0**	**$0**
H02604 - PROVIDER OVERSIGHT					
700093 - PROVIDER OVERSIGHT	$38,840,732	$51,946,617	$2,125,000	$0	$2,125,000
TOTAL PROGRAM PARENT L1 FUNDS	**$38,840,732**	**$51,946,617**	**$2,125,000**	**$0**	**$2,125,000**
H02605 - QUALITY & HEALTH OUTCOMES					
700094 - QUALITY & HEALTH OUTCOMES	$3,163,423	$4,731,601	$500,827	$0	$500,827
TOTAL PROGRAM PARENT L1 FUNDS	**$3,163,423**	**$4,731,601**	**$500,827**	**$0**	**$500,827**
H02703 - 1115/1915 - MEDICAID					
700097 - 1115/1915 - MEDICAID	$456,081,846	$422,481,022	$439,257,068	$0	$439,257,068
TOTAL PROGRAM PARENT L1 FUNDS	**$456,081,846**	**$422,481,022**	**$439,257,068**	**$0**	**$439,257,068**
H02704 - FFS - CHILDLESS ADULTS (GROUP 8)					
700098 - FFS - CHILDLESS ADULTS (GROUP 8)	$8,829,284	$43,574,114	$49,225,265	$0	$49,225,265
TOTAL PROGRAM PARENT L1 FUNDS	**$8,829,284**	**$43,574,114**	**$49,225,265**	**$0**	**$49,225,265**
H02705 - FFS - CHIP					
700099 - FFS - CHIP	$7,000,970	$10,171,550	$8,565,942	$0	$8,565,942
TOTAL PROGRAM PARENT L1 FUNDS	**$7,000,970**	**$10,171,550**	**$8,565,942**	**$0**	**$8,565,942**
H02706 - FFS - MEDICAID					
700100 - FFS - MEDICAID	$1,345,709,365	$1,326,335,113	$1,221,596,634	$0	$1,221,596,634
TOTAL PROGRAM PARENT L1 FUNDS	**$1,345,709,365**	**$1,326,335,113**	**$1,221,596,634**	**$0**	**$1,221,596,634**
H02707 - MCO - ALLIANCE					
700101 - MCO - ALLIANCE	$111,194,270	$118,327,853	$132,493,843	$150,259	$132,644,102
TOTAL PROGRAM PARENT L1 FUNDS	**$111,194,270**	**$118,327,853**	**$132,493,843**	**$150,259**	**$132,644,102**
H02708 - MCO - CHILDLESS ADULTS (GROUP 8)					
700102 - MCO - CHILDLESS ADULTS (GROUP 8)	$770,921,572	$668,545,729	$932,119,710	($1,141,071)	$930,978,639
TOTAL PROGRAM PARENT L1 FUNDS	**$770,921,572**	**$668,545,729**	**$932,119,710**	**($1,141,071)**	**$930,978,639**
H02709 - MCO - CHIP					
700103 - MCO - CHIP	$52,093,788	$94,379,291	$72,535,053	($3,785)	$72,531,268
TOTAL PROGRAM PARENT L1 FUNDS	**$52,093,788**	**$94,379,291**	**$72,535,053**	**($3,785)**	**$72,531,268**
H02710 - MCO - IMMIGRANT CHILDREN					
700104 - MCO - IMMIGRANT CHILDREN	$15,118,596	$10,491,795	$18,270,916	($29,121)	$18,241,795
TOTAL PROGRAM PARENT L1 FUNDS	**$15,118,596**	**$10,491,795**	**$18,270,916**	**($29,121)**	**$18,241,795**
H02711 - MCO - MEDICAID					
700105 - MCO - MEDICAID	$1,248,648,704	$1,201,967,187	$1,526,896,949	($1,208,812)	$1,525,688,138
TOTAL PROGRAM PARENT L1 FUNDS	**$1,248,648,704**	**$1,201,967,187**	**$1,526,896,949**	**($1,208,812)**	**$1,525,688,138**
H02712 - MCO- WAIVER					
700340 - MCO- WAIVER	$146,010,822	$143,269,843	$187,300,552	$0	$187,300,552
TOTAL PROGRAM PARENT L1 FUNDS	**$146,010,822**	**$143,269,843**	**$187,300,552**	**$0**	**$187,300,552**
H02713 - HCBS ARPA INITIATIVE					
700344 - HCBS ARPA INITIATIVE	$475,094	$491,050	$0	$0	$0
700347 - HCBS ARPA PROVIDER PAYMENTS	$12,058,076	$0	$0	$0	$0
700348 - HCBS ARPA ENHANCED WAGE SUPPLEMENTAL	$47,780,913	$0	$0	$0	$0
700349 - HCBS ARPA WORKFORCE INCENTIVES AND PROVIDER REIM	$19,765,734	$0	$0	$0	$0
700350 - HCBS ARPA INITIATIVES (DDS)	$1,390,822	$0	$0	$0	$0
700352 - HCBS ARPA EXPANSION OF SERVICE AND ACCESS	$204,807	$0	$0	$0	$0
700353 - HCBS ARPA QUALITY OVERSIGHT & PROVIDER CAPACITY	$1,149,500	$0	$0	$0	$0
700355 - HCBS ARPA INITIATIVES (DHCF)	$0	$0	$224,775	$0	$224,775
TOTAL PROGRAM PARENT L1 FUNDS	**$82,824,946**	**$491,050**	**$224,775**	**$0**	**$224,775**
TOTAL AGENCY FUNDS	**$4,442,557,965**	**$4,304,063,725**	**$4,863,666,552**	**($2,100,804)**	**$4,861,565,747**
Health Benefit Exchange Authority					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	$136,302	$207,584	$161,150	$0	$161,150
TOTAL PROGRAM PARENT L1 FUNDS	**$136,302**	**$207,584**	**$161,150**	**$0**	**$161,150**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	$208,124	$207,584	$206,407	$0	$206,407
TOTAL PROGRAM PARENT L1 FUNDS	**$208,124**	**$207,584**	**$206,407**	**$0**	**$206,407**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	$350,239	$413,879	$412,483	$0	$412,483
TOTAL PROGRAM PARENT L1 FUNDS	**$350,239**	**$413,879**	**$412,483**	**$0**	**$412,483**
AFO011 - P-CARD CLEARING					
150012 - P-CARD CLEARING	$3,806	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$3,806**	**$0**	**$0**	**$0**	**$0**
AMP005 - CONTRACTING AND PROCUREMENT					
100022 - CONTRACTING AND PROCUREMENT - GENERAL	$691,214	$651,920	$678,608	$0	$678,608
TOTAL PROGRAM PARENT L1 FUNDS	**$691,214**	**$651,920**	**$678,608**	**$0**	**$678,608**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	$353,898	$377,369	$386,089	$0	$386,089
TOTAL PROGRAM PARENT L1 FUNDS	**$353,898**	**$377,369**	**$386,089**	**$0**	**$386,089**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100076 - IT SECURITY	$173,188	$158,883	$130,310	$0	$130,310
100080 - OPERATIONS, MAINTENANCE, AND DEVELOPMENT	$17,463,169	$13,225,400	$14,011,289	$0	$14,011,289
TOTAL PROGRAM PARENT L1 FUNDS	**$17,636,357**	**$13,384,283**	**$14,141,599**	**$0**	**$14,141,599**
AMP014 - LEGAL SERVICES					
100092 - LEGAL SERVICES - GENERAL	$1,071,716	$1,278,375	$1,303,422	$0	$1,303,422
TOTAL PROGRAM PARENT L1 FUNDS	**$1,071,716**	**$1,278,375**	**$1,303,422**	**$0**	**$1,303,422**
AMP016 - PERFORMANCE AND STRATEGIC MANAGEMENT					
100154 - PERFORMANCE AND STRATEGIC MANAGEMENT	$5,648,657	$2,392,033	$2,573,589	$0	$2,573,589
TOTAL PROGRAM PARENT L1 FUNDS	**$5,648,657**	**$2,392,033**	**$2,573,589**	**$0**	**$2,573,589**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	$1,315,943	$1,506,499	$1,492,410	$0	$1,492,410
TOTAL PROGRAM PARENT L1 FUNDS	**$1,315,943**	**$1,506,499**	**$1,492,410**	**$0**	**$1,492,410**
H01901 - CONSUMER EDUCATION AND OUTREACH SUPPORT SERVICES					
700059 - CONSUMER EDUCATION AND OUTREACH SUPPORT SERVIC	$1,143,862	$1,340,759	$1,353,335	$0	$1,353,335
TOTAL PROGRAM PARENT L1 FUNDS	**$1,143,862**	**$1,340,759**	**$1,353,335**	**$0**	**$1,353,335**
H01902 - MARKETING AND COMMUNICATION					
700060 - MARKETING AND COMMUNICATION	$927,936	$972,946	$963,451	$0	$963,451
TOTAL PROGRAM PARENT L1 FUNDS	**$927,936**	**$972,946**	**$963,451**	**$0**	**$963,451**
H01903 - NAVIGATORS, CERTIFIED APPLICATION COUNSELORS AND IN-PERSON ENROLLMENT HELP					
700061 - NAVIGATORS, CERTIFIED APPLICATION COUNSELORS AND I	$962,820	$1,050,000	$1,050,000	$0	$1,050,000
TOTAL PROGRAM PARENT L1 FUNDS	**$962,820**	**$1,050,000**	**$1,050,000**	**$0**	**$1,050,000**
H02001 - CONTACT CENTER SERVICES					
700062 - CONTACT CENTER SERVICES	$4,087,031	$3,906,947	$6,156,717	$0	$6,156,717
TOTAL PROGRAM PARENT L1 FUNDS	**$4,087,031**	**$3,906,947**	**$6,156,717**	**$0**	**$6,156,717**
H02002 - DATA ANALYTICS AND REPORTING					
700063 - DATA ANALYTICS AND REPORTING	$106,891	$182,253	$181,932	$0	$181,932
TOTAL PROGRAM PARENT L1 FUNDS	**$106,891**	**$182,253**	**$181,932**	**$0**	**$181,932**
H02003 - ELIGIBILITY AND ENROLLMENT					
700064 - ELIGIBILITY AND ENROLLMENT	$1,274,035	$1,785,931	$1,950,590	$0	$1,950,590
TOTAL PROGRAM PARENT L1 FUNDS	**$1,274,035**	**$1,785,931**	**$1,950,590**	**$0**	**$1,950,590**
H02004 - MEMBER SERVICES					
700065 - MEMBER SERVICES	$6,532,352	$1,977,168	$2,119,831	$0	$2,119,831
TOTAL PROGRAM PARENT L1 FUNDS	**$6,532,352**	**$1,977,168**	**$2,119,831**	**$0**	**$2,119,831**
H02005 - PLAN MANAGEMENT					
700066 - PLAN MANAGEMENT	$1,890,079	$2,235,723	$2,215,018	$0	$2,215,018
TOTAL PROGRAM PARENT L1 FUNDS	**$1,890,079**	**$2,235,723**	**$2,215,018**	**$0**	**$2,215,018**
H02006 - S.H.O.P.					
700067 - S.H.O.P.	$3,220,453	$3,680,894	$4,406,154	$0	$4,406,154
TOTAL PROGRAM PARENT L1 FUNDS	**$3,220,453**	**$3,680,894**	**$4,406,154**	**$0**	**$4,406,154**
PRG001 - NO PROGRAM					
000000 - NO PROGRAM	($3,806)	$0	$0	$0	$0

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
TOTAL PROGRAM PARENT L1 FUNDS	**($3,806)**	**$0**	**$0**	**$0**	**$0**
TOTAL AGENCY FUNDS	**$47,557,909**	**$37,552,148**	**$41,752,784**	**$0**	**$41,752,784**
Not-for-Profit Hospital Corporation					
C02001 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY					
200147 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY	$0	$155,000,000	$155,000,000	$0	$155,000,000
TOTAL PROGRAM PARENT L1 FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
TOTAL AGENCY FUNDS	**$0**	**$155,000,000**	**$155,000,000**	**$0**	**$155,000,000**
Not-for-Profit Hospital Corporation Subsidy					
C02101 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY FUNDING					
200148 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY FUNDING	$22,000,000	$15,000,000	$25,200,000	$0	$25,200,000
TOTAL PROGRAM PARENT L1 FUNDS	**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**
TOTAL AGENCY FUNDS	**$22,000,000**	**$15,000,000**	**$25,200,000**	**$0**	**$25,200,000**
Office of the Deputy Mayor for Health and Human Services					
AMP030 - EXECUTIVE ADMINISTRATION					
100151 - EXECUTIVE ADMINISTRATION	$1,856,314	$2,071,890	$2,175,904	($29,368)	$2,146,536
TOTAL PROGRAM PARENT L1 FUNDS	**$1,856,314**	**$2,071,890**	**$2,175,904**	**($29,368)**	**$2,146,536**
H01701 - AGENCY OVERSIGHT AND SUPPORT SERVICES					
700055 - AGENCY OVERSIGHT AND SUPPORT SERVICES	$117,020	$405,671	$304,583	$0	$304,583
TOTAL PROGRAM PARENT L1 FUNDS	**$117,020**	**$405,671**	**$304,583**	**$0**	**$304,583**
H01702 - COMMUNITY ENGAGEMENT SERVICES					
700056 - COMMUNITY ENGAGEMENT SERVICES	$71,577	$0	$0	$0	$0
TOTAL PROGRAM PARENT L1 FUNDS	**$71,577**	**$0**	**$0**	**$0**	**$0**
TOTAL AGENCY FUNDS	**$2,044,911**	**$2,477,561**	**$2,480,487**	**($29,368)**	**$2,451,119**
GRAND TOTAL	**$5,161,034,141**	**$5,186,322,077**	**$5,778,465,060**	**$1,901,402**	**$5,780,366,462**

Agency FT Equivalent by Program Parent L1 and Program

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
Department of Behavioral Health					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	7.89	0.00	7.00	0.00	7.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.89**	**0.00**	**7.00**	**0.00**	**7.00**
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	4.39	14.00	7.00	0.00	7.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.39**	**14.00**	**7.00**	**0.00**	**7.00**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	1.75	2.00	2.00	0.00	2.00
TOTAL PROGRAM PARENT L1 FUNDS	**1.75**	**2.00**	**2.00**	**0.00**	**2.00**
AFO010 - PAYROLL DEFAULT					
150011 - PAYROLL DEFAULT	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
AFO011 - P-CARD CLEARING					
150012 - P-CARD CLEARING	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
AMP002 - CLAIMS SERVICES					
100002 - CLAIMS SERVICES	5.23	6.00	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**5.23**	**6.00**	**6.00**	**0.00**	**6.00**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	19.29	22.00	21.00	0.00	21.00
TOTAL PROGRAM PARENT L1 FUNDS	**19.29**	**22.00**	**21.00**	**0.00**	**21.00**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	20.47	22.00	21.00	0.00	21.00
TOTAL PROGRAM PARENT L1 FUNDS	**20.47**	**22.00**	**21.00**	**0.00**	**21.00**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	18.40	22.83	22.83	0.00	22.83

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
TOTAL PROGRAM PARENT L1 FUNDS	**18.40**	**22.83**	**22.83**	**0.00**	**22.83**
AMP022 - RECORDS MANAGEMENT					
100125 - RECORDS MANAGEMENT - GENERAL	7.86	9.00	9.00	0.00	9.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.86**	**9.00**	**9.00**	**0.00**	**9.00**
AMP023 - RESOURCE MANAGEMENT					
100127 - RESOURCE MANAGEMENT - GENERAL	6.14	9.00	10.00	0.00	10.00
TOTAL PROGRAM PARENT L1 FUNDS	**6.14**	**9.00**	**10.00**	**0.00**	**10.00**
H04201 - ACCOUNTABILITY ADMINISTRATIVE SERVICES					
700271 - ACCOUNTABILITY ADMINISTRATIVE SERVICES	0.88	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.88**	**1.00**	**1.00**	**0.00**	**1.00**
H04202 - CERTIFICATION SERVICES					
700272 - CERTIFICATION SERVICES	7.02	8.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.02**	**8.00**	**8.00**	**0.00**	**8.00**
H04203 - INCIDENT, MANAGEMENT AND INVESTIGATION SERVICES					
700273 - INCIDENT, MANAGEMENT AND INVESTIGATION SERVICES	3.51	4.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**3.51**	**4.00**	**4.00**	**0.00**	**4.00**
H04204 - LICENSURE SERVICES					
700274 - LICENSURE SERVICES	3.51	4.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**3.51**	**4.00**	**4.00**	**0.00**	**4.00**
H04205 - PROGRAM INTEGRITY SERVICES					
700275 - PROGRAM INTEGRITY SERVICES	8.16	8.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**8.16**	**8.00**	**3.00**	**0.00**	**3.00**
H04301 - 35 K STREET ADULT CLINICAL SERVICES					
700276 - 35 K STREET ADULT CLINICAL SERVICES	16.42	15.50	9.50	0.00	9.50
TOTAL PROGRAM PARENT L1 FUNDS	**16.42**	**15.50**	**9.50**	**0.00**	**9.50**
H04302 - ACCESS HELPLINE					
700277 - ACCESS HELPLINE	19.37	31.00	27.00	0.00	27.00
TOTAL PROGRAM PARENT L1 FUNDS	**19.37**	**31.00**	**27.00**	**0.00**	**27.00**
H04303 - ADULT/TRANSITIONAL YOUTH SERVICES ADMINISTRATIVE SERVICES					
700278 - ADULT/TRANSITIONAL YOUTH SERVICES ADMINISTRATIVE SE	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04304 - ASSESSMENT AND REFERRAL CENTER SERVICES					
700279 - ASSESSMENT AND REFERRAL CENTER SERVICES	17.74	21.00	21.00	0.00	21.00
TOTAL PROGRAM PARENT L1 FUNDS	**17.74**	**21.00**	**21.00**	**0.00**	**21.00**
H04305 - CO-LOCATED SERVICES					
700280 - CO-LOCATED SERVICES	1.75	2.00	2.00	0.00	2.00
TOTAL PROGRAM PARENT L1 FUNDS	**1.75**	**2.00**	**2.00**	**0.00**	**2.00**
H04306 - COMMUNITY RESPONSE TEAM					
700281 - COMMUNITY RESPONSE TEAM	60.79	72.00	73.00	0.00	73.00
TOTAL PROGRAM PARENT L1 FUNDS	**60.79**	**72.00**	**73.00**	**0.00**	**73.00**
H04307 - GAMBLING ADDICTION TREATMENT SERVICES					
700282 - GAMBLING ADDICTION TREATMENT SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04308 - HOUSING SUPPORT SERVICES					
700283 - HOUSING SUPPORT SERVICES	3.47	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**3.47**	**0.00**	**0.00**	**0.00**	**0.00**
H04309 - IMPLEM OF DRUG TREATMENT CHOICE SERVICES					
700284 - IMPLEM OF DRUG TREATMENT CHOICE SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04310 - MENTAL HEALTH AND REHAB SERVICES					
700285 - MENTAL HEALTH AND REHAB SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04311 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)					
700286 - MH/SUD BEHAVIORAL HEALTH SERVICES (ADULT)	20.45	21.50	16.50	0.00	16.50
TOTAL PROGRAM PARENT L1 FUNDS	**20.45**	**21.50**	**16.50**	**0.00**	**16.50**
H04312 - PROVIDER RELATIONS SERVICES					

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
700287 - PROVIDER RELATIONS SERVICES	8.67	9.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**8.67**	**9.00**	**8.00**	**0.00**	**8.00**
H04313 - RESIDENTIAL SUPPORT AND CONTINUITY OF CARE SERVICES					
700288 - RESIDENTIAL SUPPORT AND CONTINUITY OF CARE SERVICE	3.47	4.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**3.47**	**4.00**	**4.00**	**0.00**	**4.00**
H04314 - SPECIALTY SERVICES					
700289 - SPECIALTY SERVICES	13.56	20.50	16.50	0.00	16.50
TOTAL PROGRAM PARENT L1 FUNDS	**13.56**	**20.50**	**16.50**	**0.00**	**16.50**
H04315 - SUBSTANCE USE DISORDER TREATMENT SERVICES					
700290 - SUBSTANCE USE DISORDER TREATMENT SERVICES	10.19	9.00	9.00	0.00	9.00
TOTAL PROGRAM PARENT L1 FUNDS	**10.19**	**9.00**	**9.00**	**0.00**	**9.00**
H04316 - STATE OPIOID RESPONSE PROGRAM					
700338 - STATE OPIOID RESPONSE PROGRAM	10.98	20.50	20.50	0.00	20.50
TOTAL PROGRAM PARENT L1 FUNDS	**10.98**	**20.50**	**20.50**	**0.00**	**20.50**
H04317 - BEHAVIORAL HEALTH REHABILITATION - LOCAL MATCH					
700365 - BEHAVIORAL HEALTH REHABILITATION - LOCAL MATCH	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04402 - CONSUMER AND FAMILY AFFAIRS					
700292 - CONSUMER AND FAMILY AFFAIRS	7.84	9.00	9.00	0.00	9.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.84**	**9.00**	**9.00**	**0.00**	**9.00**
H04403 - EXECUTIVE DIRECTOR					
700293 - EXECUTIVE DIRECTOR	9.65	11.65	11.65	0.00	11.65
TOTAL PROGRAM PARENT L1 FUNDS	**9.65**	**11.65**	**11.65**	**0.00**	**11.65**
H04404 - LEGAL SERVICES					
700294 - LEGAL SERVICES	4.82	5.50	5.50	0.00	5.50
TOTAL PROGRAM PARENT L1 FUNDS	**4.82**	**5.50**	**5.50**	**0.00**	**5.50**
H04405 - LEGISLATIVE AND PUBLIC SERVICES					
700295 - LEGISLATIVE AND PUBLIC SERVICES	8.72	8.35	7.52	0.00	7.52
TOTAL PROGRAM PARENT L1 FUNDS	**8.72**	**8.35**	**7.52**	**0.00**	**7.52**
H04406 - OMBUDSMAN					
700296 - OMBUDSMAN	2.02	2.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**2.02**	**2.00**	**3.00**	**0.00**	**3.00**
H04501 - BEHAVIORAL SERVICES - HOWARD ROAD					
700298 - BEHAVIORAL SERVICES - HOWARD ROAD	1.75	2.00	2.00	0.00	2.00
TOTAL PROGRAM PARENT L1 FUNDS	**1.75**	**2.00**	**2.00**	**0.00**	**2.00**
H04502 - CHILD/ADOLESCENT/FAMILY SERVICES ADMINISTRATIVE SERVICES					
700299 - CHILD/ADOLESCENT/FAMILY SERVICES ADMINISTRATIVE SEI	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04503 - COURT ASSESSMENT SERVICES					
700300 - COURT ASSESSMENT SERVICES	6.14	7.00	5.00	0.00	5.00
TOTAL PROGRAM PARENT L1 FUNDS	**6.14**	**7.00**	**5.00**	**0.00**	**5.00**
H04504 - CRISIS SERVICES					
700301 - CRISIS SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04505 - EARLY CHILDHOOD SERVICES					
700302 - EARLY CHILDHOOD SERVICES	22.69	22.50	21.50	0.00	21.50
TOTAL PROGRAM PARENT L1 FUNDS	**22.69**	**22.50**	**21.50**	**0.00**	**21.50**
H04506 - EVIDENCE BASED PRACTICES SERVICES					
700303 - EVIDENCE BASED PRACTICES SERVICES	4.37	5.00	5.00	0.00	5.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.37**	**5.00**	**5.00**	**0.00**	**5.00**
H04507 - MH/SUD BEHAVIORAL HEALTH SERVICES (CHILD & FAMILY)					
700304 - MH/SUD BEHAVIORAL HEALTH SERVICES (CHILD & FAMILY)	8.70	10.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**8.70**	**10.00**	**8.00**	**0.00**	**8.00**
H04508 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES					
700305 - SCHOOL BASED BEHAVIORAL HEALTH SERVICES	67.44	77.17	66.87	0.00	66.87
TOTAL PROGRAM PARENT L1 FUNDS	**67.44**	**77.17**	**66.87**	**0.00**	**66.87**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H04509 - SPECIALTY SERVICES					
700306 - SPECIALTY SERVICES	7.02	8.00	7.00	0.00	7.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.02**	**8.00**	**7.00**	**0.00**	**7.00**
H04601 - BEHAVIORAL HEALTH SERVICES					
700308 - BEHAVIORAL HEALTH SERVICES	0.00	2.00	2.00	0.00	2.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**2.00**	**2.00**	**0.00**	**2.00**
H04602 - BEHAVIORAL HEALTH SERVICES-PHARMACY					
700309 - BEHAVIORAL HEALTH SERVICES-PHARMACY	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04603 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES					
700310 - COMPREHENSIVE PSYCHIATRIC EMERGENCY SERVICES	35.63	41.25	52.00	0.00	52.00
TOTAL PROGRAM PARENT L1 FUNDS	**35.63**	**41.25**	**52.00**	**0.00**	**52.00**
H04604 - DISASTER BEHAVIORAL HEALTH SERVICES AND SUPPORT SERVICES					
700311 - DISASTER BEHAVIORAL HEALTH SERVICES AND SUPPORT SE	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H04605 - FORENSICS SERVICES					
700312 - FORENSICS SERVICES	20.97	24.00	26.00	0.00	26.00
TOTAL PROGRAM PARENT L1 FUNDS	**20.97**	**24.00**	**26.00**	**0.00**	**26.00**
H04701 - BEHAVIORAL HEALTH GRANT OVERSIGHT SERVICES					
700313 - BEHAVIORAL HEALTH GRANT OVERSIGHT SERVICES	0.88	1.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.88**	**1.00**	**4.00**	**0.00**	**4.00**
H04702 - DATA AND PERFORMANCE MEASUREMENT SERVICES					
700314 - DATA AND PERFORMANCE MEASUREMENT SERVICES	13.13	15.00	15.00	0.00	15.00
TOTAL PROGRAM PARENT L1 FUNDS	**13.13**	**15.00**	**15.00**	**0.00**	**15.00**
H04703 - STRATEGIC PLANNING AND POLICY SERVICES					
700315 - STRATEGIC PLANNING AND POLICY SERVICES	2.63	3.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**2.63**	**3.00**	**3.00**	**0.00**	**3.00**
H04704 - TRAINING INSTITUTE SERVICES					
700316 - TRAINING INSTITUTE SERVICES	6.13	7.17	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**6.13**	**7.17**	**6.00**	**0.00**	**6.00**
H04801 - CLINICAL ADMINISTRATIVE SERVICES					
700317 - CLINICAL ADMINISTRATIVE SERVICES	97.35	112.00	114.00	0.00	114.00
TOTAL PROGRAM PARENT L1 FUNDS	**97.35**	**112.00**	**114.00**	**0.00**	**114.00**
H04802 - CLINICAL AND MEDICAL SERVICES					
700318 - CLINICAL AND MEDICAL SERVICES	97.31	111.05	116.05	0.00	116.05
TOTAL PROGRAM PARENT L1 FUNDS	**97.31**	**111.05**	**116.05**	**0.00**	**116.05**
H04803 - ENIGINEERING AND MAINTENANCE SERVICES					
700319 - ENIGINEERING AND MAINTENANCE SERVICES	15.79	18.00	18.00	0.00	18.00
TOTAL PROGRAM PARENT L1 FUNDS	**15.79**	**18.00**	**18.00**	**0.00**	**18.00**
H04804 - FISCAL AND SUPPORT SERVICES					
700320 - FISCAL AND SUPPORT SERVICES	4.34	5.93	4.92	0.00	4.92
TOTAL PROGRAM PARENT L1 FUNDS	**4.34**	**5.93**	**4.92**	**0.00**	**4.92**
H04805 - HOSPITAL ADMINISTRATIVE SERVICES					
700321 - HOSPITAL ADMINISTRATIVE SERVICES	9.65	9.00	10.00	0.00	10.00
TOTAL PROGRAM PARENT L1 FUNDS	**9.65**	**9.00**	**10.00**	**0.00**	**10.00**
H04806 - HOUSEKEEPING SERVICES					
700322 - HOUSEKEEPING SERVICES	41.12	46.00	44.00	0.00	44.00
TOTAL PROGRAM PARENT L1 FUNDS	**41.12**	**46.00**	**44.00**	**0.00**	**44.00**
H04807 - MATERIAL MANAGEMENT SERVICES					
700323 - MATERIAL MANAGEMENT SERVICES	7.89	9.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.89**	**9.00**	**8.00**	**0.00**	**8.00**
H04808 - NURSING SERVICES					
700324 - NURSING SERVICES	380.49	431.00	428.00	0.00	428.00
TOTAL PROGRAM PARENT L1 FUNDS	**380.49**	**431.00**	**428.00**	**0.00**	**428.00**
H04809 - NUTRITIONAL SERVICES					
700325 - NUTRITIONAL SERVICES	24.64	28.10	27.10	0.00	27.10
TOTAL PROGRAM PARENT L1 FUNDS	**24.64**	**28.10**	**27.10**	**0.00**	**27.10**

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H04810 - QUALITY AND DATA MANAGEMENT SERVICES					
700326 - QUALITY AND DATA MANAGEMENT SERVICES	9.65	11.00	11.00	0.00	11.00
TOTAL PROGRAM PARENT L1 FUNDS	**9.65**	**11.00**	**11.00**	**0.00**	**11.00**
H04811 - SECURITY AND SAFETY SERVICES					
700327 - SECURITY AND SAFETY SERVICES	26.89	31.00	30.00	0.00	30.00
TOTAL PROGRAM PARENT L1 FUNDS	**26.89**	**31.00**	**30.00**	**0.00**	**30.00**
H04812 - TRANSPORATION AND GROUNDS SERVICES					
700328 - TRANSPORATION AND GROUNDS SERVICES	4.38	4.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.38**	**4.00**	**4.00**	**0.00**	**4.00**
H05201 - DIRECTOR AND COMMISSION SUPPORT					
700356 - DIRECTOR AND COMMISSION SUPPORT	0.00	4.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**4.00**	**4.00**	**0.00**	**4.00**
H05301 - CHILD/YOUTH CRISIS & COMMUNITY TRAUMA RESPONS					
700357 - CHILD/YOUTH CRISIS & COMMUNITY TRAUMA RESPONSE	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
PRG001 - NO PROGRAM					
000000 - NO PROGRAM	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**1,251.39**	**1,439.50**	**1,411.94**	**0.00**	**1,411.94**
Department of Health					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	8.12	11.00	11.00	0.00	11.00
TOTAL PROGRAM PARENT L1 FUNDS	**8.12**	**11.00**	**11.00**	**0.00**	**11.00**
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	5.86	8.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**5.86**	**8.00**	**8.00**	**0.00**	**8.00**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	3.98	5.00	5.00	0.00	5.00
TOTAL PROGRAM PARENT L1 FUNDS	**3.98**	**5.00**	**5.00**	**0.00**	**5.00**
AMP003 - COMMUNICATIONS					
100003 - COMMUNICATIONS - GENERAL	5.89	7.00	8.00	0.00	8.00
100007 - LANGUAGE ACCESS	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**5.89**	**7.00**	**8.00**	**0.00**	**8.00**
AMP005 - CONTRACTING AND PROCUREMENT					
100022 - CONTRACTING AND PROCUREMENT - GENERAL	3.45	6.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**3.45**	**6.00**	**8.00**	**0.00**	**8.00**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	8.55	13.00	16.00	0.00	16.00
TOTAL PROGRAM PARENT L1 FUNDS	**8.55**	**13.00**	**16.00**	**0.00**	**16.00**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	14.21	29.00	30.00	0.00	30.00
TOTAL PROGRAM PARENT L1 FUNDS	**14.21**	**29.00**	**30.00**	**0.00**	**30.00**
AMP013 - LABOR RELATIONS					
100087 - LABOR RELATIONS - GENERAL	0.96	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.96**	**1.00**	**1.00**	**0.00**	**1.00**
AMP014 - LEGAL SERVICES					
100092 - LEGAL SERVICES - GENERAL	14.05	14.00	14.00	0.00	14.00
TOTAL PROGRAM PARENT L1 FUNDS	**14.05**	**14.00**	**14.00**	**0.00**	**14.00**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	6.34	5.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**6.34**	**5.00**	**4.00**	**0.00**	**4.00**
AMP024 - RISK MANAGEMENT					
100135 - RISK MANAGEMENT - GENERAL	0.69	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.69**	**1.00**	**1.00**	**0.00**	**1.00**
AMP030 - EXECUTIVE ADMINISTRATION					
100151 - EXECUTIVE ADMINISTRATION	7.70	10.00	10.00	0.00	10.00

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
TOTAL PROGRAM PARENT L1 FUNDS	**7.70**	**10.00**	**10.00**	**0.00**	**10.00**
H00401 - CANCER AND CHRONIC DISEASE PREVENTION					
700023 - CANCER AND CHRONIC DISEASE PREVENTION	25.45	28.50	34.50	0.00	34.50
TOTAL PROGRAM PARENT L1 FUNDS	**25.45**	**28.50**	**34.50**	**0.00**	**34.50**
H00403 - COMMUNITY OF HEALTH SUPPORT SERVICES					
700329 - COMMUNITY OF HEALTH SUPPORT SERVICES	18.07	23.50	28.05	0.00	28.05
TOTAL PROGRAM PARENT L1 FUNDS	**18.07**	**23.50**	**28.05**	**0.00**	**28.05**
H00405 - FAMILY HEALTH					
700026 - FAMILY HEALTH	30.04	28.25	30.18	2.00	32.18
TOTAL PROGRAM PARENT L1 FUNDS	**30.04**	**28.25**	**30.18**	**2.00**	**32.18**
H00406 - HEALTH CARE ACCESS					
700027 - HEALTH CARE ACCESS	27.95	54.00	52.37	0.00	52.37
TOTAL PROGRAM PARENT L1 FUNDS	**27.95**	**54.00**	**52.37**	**0.00**	**52.37**
H00407 - NUTRITION AND PHYSICAL FITNESS					
700028 - NUTRITION AND PHYSICAL FITNESS	13.11	19.00	20.00	0.00	20.00
TOTAL PROGRAM PARENT L1 FUNDS	**13.11**	**19.00**	**20.00**	**0.00**	**20.00**
H00408 - PERINATAL AND INFANT HEALTH					
700029 - PERINATAL AND INFANT HEALTH	0.96	2.75	2.75	0.00	2.75
TOTAL PROGRAM PARENT L1 FUNDS	**0.96**	**2.75**	**2.75**	**0.00**	**2.75**
H00409 - PCPA SUPPORT SERVICES					
700336 - PCPA SUPPORT SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H00601 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE					
700031 - FOOD, DRUG, RADIATION, AND COMMUNITY HYGIENE	60.08	51.82	57.95	0.00	57.95
TOTAL PROGRAM PARENT L1 FUNDS	**60.08**	**51.82**	**57.95**	**0.00**	**57.95**
H00701 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLICY EVALUATION					
700032 - COMMUNITY BASED PARTNERSHIP, RESEARCH AND POLICY	1.38	2.00	2.00	0.00	2.00
TOTAL PROGRAM PARENT L1 FUNDS	**1.38**	**2.00**	**2.00**	**0.00**	**2.00**
H00702 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATION					
700033 - HEALTH EQUITY PRACTICE AND PROGRAM IMPLEMENTATIO	0.69	1.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.69**	**1.00**	**0.00**	**0.00**	**0.00**
H00703 - MULTI SECTOR COLLABORATION					
700034 - MULTI SECTOR COLLABORATION	2.29	4.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**2.29**	**4.00**	**4.00**	**0.00**	**4.00**
H00801 - DIRECT CARE SERVICES FOR TUBERCULOSIS					
700331 - DIRECT CARE SERVICES FOR TUBERCULOSIS	6.16	9.20	11.27	0.00	11.27
TOTAL PROGRAM PARENT L1 FUNDS	**6.16**	**9.20**	**11.27**	**0.00**	**11.27**
H00802 - DRUG ASSISTANCE					
700035 - DRUG ASSISTANCE	14.17	12.90	10.50	0.00	10.50
TOTAL PROGRAM PARENT L1 FUNDS	**14.17**	**12.90**	**10.50**	**0.00**	**10.50**
H00803 - GRANTS AND CONTRACTS MANAGEMENT					
700036 - GRANTS AND CONTRACTS MANAGEMENT	6.05	13.88	11.66	0.00	11.66
TOTAL PROGRAM PARENT L1 FUNDS	**6.05**	**13.88**	**11.66**	**0.00**	**11.66**
H00804 - HIV HEALTH AND SUPPORT SERVICES					
700037 - HIV HEALTH AND SUPPORT SERVICES	61.16	35.12	33.71	0.00	33.71
TOTAL PROGRAM PARENT L1 FUNDS	**61.16**	**35.12**	**33.71**	**0.00**	**33.71**
H00805 - HIV/AIDS DATA AND RESEARCH					
700038 - HIV/AIDS DATA AND RESEARCH	11.67	15.80	13.85	0.00	13.85
TOTAL PROGRAM PARENT L1 FUNDS	**11.67**	**15.80**	**13.85**	**0.00**	**13.85**
H00806 - HIV/AIDS HOUSING AND SUPPORTIVE SERVICES					
700039 - HIV/AIDS HOUSING AND SUPPORTIVE SERVICES	2.83	4.00	7.70	0.00	7.70
TOTAL PROGRAM PARENT L1 FUNDS	**2.83**	**4.00**	**7.70**	**0.00**	**7.70**
H00807 - HIV/AIDS POLICY AND PLANNING					
700040 - HIV/AIDS POLICY AND PLANNING	16.62	23.00	28.38	0.00	28.38
TOTAL PROGRAM PARENT L1 FUNDS	**16.62**	**23.00**	**28.38**	**0.00**	**28.38**
H00808 - PREVENTION AND INTERVENTION SERVICES					

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
700041 - PREVENTION AND INTERVENTION SERVICES	20.07	18.20	20.21	0.00	20.21
TOTAL PROGRAM PARENT L1 FUNDS	**20.07**	**18.20**	**20.21**	**0.00**	**20.21**
H00809 - STD CONTROL					
700042 - STD CONTROL	17.08	19.70	24.10	0.00	24.10
TOTAL PROGRAM PARENT L1 FUNDS	**17.08**	**19.70**	**24.10**	**0.00**	**24.10**
H00902 - PUBLIC HEALTH EMERGENCY OPERATIONS AND PROGRAM SUPPORT					
700045 - PUBLIC HEALTH EMERGENCY OPERATIONS AND PROGRAM	16.92	29.34	28.44	0.00	28.44
TOTAL PROGRAM PARENT L1 FUNDS	**16.92**	**29.34**	**28.44**	**0.00**	**28.44**
H00903 - PUBLIC HEALTH EMERGENCY PREPAREDNESS					
700046 - PUBLIC HEALTH EMERGENCY PREPAREDNESS	5.14	2.85	3.45	0.00	3.45
TOTAL PROGRAM PARENT L1 FUNDS	**5.14**	**2.85**	**3.45**	**0.00**	**3.45**
H01101 - HEALTH CARE FACILITIES REGULATION					
700048 - HEALTH CARE FACILITIES REGULATION	49.82	54.90	49.81	0.00	49.81
TOTAL PROGRAM PARENT L1 FUNDS	**49.82**	**54.90**	**49.81**	**0.00**	**49.81**
H01201 - HEALTH LICENSING					
700049 - HEALTH LICENSING	74.65	77.62	82.37	0.00	82.37
TOTAL PROGRAM PARENT L1 FUNDS	**74.65**	**77.62**	**82.37**	**0.00**	**82.37**
H01301 - EMERGENCY MEDICAL SERVICES REGULATION					
700050 - EMERGENCY MEDICAL SERVICES REGULATION	2.04	0.11	0.11	1.00	1.11
TOTAL PROGRAM PARENT L1 FUNDS	**2.04**	**0.11**	**0.11**	**1.00**	**1.11**
H01401 - EPIDEMIOLOGIC STUDIES AND OUTBREAK INVESTIGATION					
700051 - EPIDEMIOLOGIC STUDIES AND OUTBREAK INVESTIGATION	1.71	9.78	12.38	0.00	12.38
TOTAL PROGRAM PARENT L1 FUNDS	**1.71**	**9.78**	**12.38**	**0.00**	**12.38**
H01501 - DEVELOPMENT OF THE STATE HEALTH PLAN AND ANNUAL IMPLEMENTATION					
700052 - DEVELOPMENT OF THE STATE HEALTH PLAN AND ANNUAL IM	9.54	9.50	9.50	0.00	9.50
TOTAL PROGRAM PARENT L1 FUNDS	**9.54**	**9.50**	**9.50**	**0.00**	**9.50**
H01601 - BIRTH AND DEATH RECORD COLLECTION, PROCESSING, ANALYZING AND DISSEMINATION					
700054 - BIRTH AND DEATH RECORD COLLECTION, PROCESSING, AN	37.00	105.12	115.68	0.00	115.68
TOTAL PROGRAM PARENT L1 FUNDS	**37.00**	**105.12**	**115.68**	**0.00**	**115.68**
PRG001 - NO PROGRAM					
000000 - NO PROGRAM	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**612.45**	**765.84**	**810.92**	**3.00**	**813.92**
Department of Health Care Finance					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	7.22	9.00	10.00	0.00	10.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.22**	**9.00**	**10.00**	**0.00**	**10.00**
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	4.81	6.00	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.81**	**6.00**	**6.00**	**0.00**	**6.00**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	1.61	2.00	2.00	0.00	2.00
TOTAL PROGRAM PARENT L1 FUNDS	**1.61**	**2.00**	**2.00**	**0.00**	**2.00**
AFO010 - PAYROLL DEFAULT					
150011 - PAYROLL DEFAULT	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
AFO011 - P-CARD CLEARING					
150012 - P-CARD CLEARING	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
AMP003 - COMMUNICATIONS					
100003 - COMMUNICATIONS - GENERAL	4.01	5.00	0.00	0.00	0.00
100007 - LANGUAGE ACCESS	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.01**	**5.00**	**0.00**	**0.00**	**0.00**
AMP005 - CONTRACTING AND PROCUREMENT					
100022 - CONTRACTING AND PROCUREMENT - GENERAL	12.03	13.00	13.00	0.00	13.00
100026 - CONTRACTS REPORTING	0.00	0.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**12.03**	**13.00**	**14.00**	**0.00**	**14.00**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
AMP006 - CUSTOMER SERVICE					
100028 - CUSTOMER SERVICE - GENERAL	20.42	23.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**20.42**	**23.00**	**0.00**	**0.00**	**0.00**
AMP010 - GRANTS ADMINISTRATION					
100045 - GRANTS MANAGEMENT OVERSIGHT	2.26	4.00	0.00	0.00	0.00
100047 - SUB-GRANT ADMINISTRATION	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**2.26**	**4.00**	**0.00**	**0.00**	**0.00**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	9.63	10.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**9.63**	**10.00**	**8.00**	**0.00**	**8.00**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100071 - INFORMATION TECHNOLOGY SERVICES - GENERAL	0.00	0.00	1.00	0.00	1.00
100072 - INTERNAL SUPPORT	5.10	7.60	13.87	0.00	13.87
100076 - IT SECURITY	0.00	0.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**5.10**	**7.60**	**17.87**	**0.00**	**17.87**
AMP014 - LEGAL SERVICES					
100092 - LEGAL SERVICES - GENERAL	7.94	9.06	8.85	0.00	8.85
TOTAL PROGRAM PARENT L1 FUNDS	**7.94**	**9.06**	**8.85**	**0.00**	**8.85**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	4.81	16.25	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.81**	**16.25**	**6.00**	**0.00**	**6.00**
AMP021 - RATES, REIMBURSEMENT, FINANCIAL ANALYSIS					
100122 - FINANCE SERVICES	11.86	16.35	0.00	0.00	0.00
100123 - REIMBURSEMENT SERVICES	0.86	1.65	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**12.72**	**18.00**	**0.00**	**0.00**	**0.00**
AMP026 - TRAINING AND DEVELOPMENT					
100147 - SPECIAL PROGRAMS	0.00	0.00	0.00	0.00	0.00
100148 - TRAINING AND DEVELOPMENT - GENERAL	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
AMP030 - EXECUTIVE ADMINISTRATION					
100151 - EXECUTIVE ADMINISTRATION	1.61	7.00	9.00	0.00	9.00
TOTAL PROGRAM PARENT L1 FUNDS	**1.61**	**7.00**	**9.00**	**0.00**	**9.00**
AMP037 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR					
100180 - SENIOR DEPUTY DIRECTOR/MEDICAID DIRECTOR	0.00	0.00	14.00	0.00	14.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**14.00**	**0.00**	**14.00**
AMP038 - SENIOR DEPUTY DIRECTOR/FINANCE					
100181 - SENIOR DEPUTY DIRECTOR/FINANCE	0.00	0.00	20.00	0.00	20.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**20.00**	**0.00**	**20.00**
AMP039 - CHIEF OPERATING OFFICE					
100182 - CHIEF OPERATING OFFICE	0.00	0.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**8.00**	**0.00**	**8.00**
AMP040 - DATA ANALYTICS AND RESEARCH ADMINISTRATION					
100183 - DATA ANALYTICS AND RESEARCH ADMINISTRATION	0.00	0.00	11.00	0.00	11.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**11.00**	**0.00**	**11.00**
AMP041 - PROGRAM INTEGRITY					
100184 - PROGRAM INTEGRITY	0.00	0.00	33.00	0.00	33.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**33.00**	**0.00**	**33.00**
AMP042 - HEALTH CARE OMBUDSMAN					
100185 - HEALTH CARE OMBUDSMAN	0.00	0.00	24.00	0.00	24.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**24.00**	**0.00**	**24.00**
AMP043 - HEALTH CARE DELIVERY MGT SUPPORT SVCS					
100186 - HEALTH CARE DELIVERY MGT SUPPORT SVCS	0.00	0.00	9.00	0.00	9.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**9.00**	**0.00**	**9.00**
AMP044 - MANAGED CARE MGT					
100187 - MANAGED CARE MGT	0.00	0.00	7.00	0.00	7.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**7.00**	**0.00**	**7.00**
AMP045 - CHILDREN'S HEALTH SERVICES					

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100188 - CHILDREN'S HEALTH SERVICES	0.00	0.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**4.00**	**0.00**	**4.00**
AMP046 - HEALTH CARE QUALITY AND HEALTH OUTCOMES					
100189 - HEALTH CARE QUALITY AND HEALTH OUTCOMES	0.00	0.00	7.00	0.00	7.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**7.00**	**0.00**	**7.00**
AMP047 - CLINICIANS, RX AND ACUTE CARE					
100190 - CLINICIANS, RX AND ACUTE CARE	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
AMP048 - LONG TERM CARE SUPPORT SERVICES					
100191 - LONG TERM CARE SUPPORT SERVICES	0.00	0.00	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**6.00**	**0.00**	**6.00**
AMP049 - OVERSIGHT					
100192 - OVERSIGHT	0.00	0.00	17.00	0.00	17.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**17.00**	**0.00**	**17.00**
AMP050 - OPERATIONS					
100193 - OPERATIONS	0.00	0.00	17.00	0.00	17.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**17.00**	**0.00**	**17.00**
AMP051 - INTAKE AND ASSESSMENT					
100194 - INTAKE AND ASSESSMENT	0.00	0.00	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**6.00**	**0.00**	**6.00**
AMP052 - HEALTH CARE POLICY					
100195 - HEALTH CARE POLICY	0.00	0.00	7.00	0.00	7.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**7.00**	**0.00**	**7.00**
AMP053 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES					
100196 - HEALTH CARE POLICY AND RESEARCH SUPPORT SERVICES	0.00	0.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**3.00**	**0.00**	**3.00**
AMP054 - ELIGIBILITY POLICY & OVERSIGHT					
100197 - ELIGIBILITY POLICY & OVERSIGHT	0.00	0.00	29.00	0.00	29.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**29.00**	**0.00**	**29.00**
AMP055 - DCAS PROGRAM MANAGEMENT					
100198 - DCAS PROGRAM MANAGEMENT	0.00	0.00	4.33	0.00	4.33
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**4.33**	**0.00**	**4.33**
AMP056 - DCAS PROJECT MANAGEMENT					
100199 - DCAS PROJECT MANAGEMENT	0.00	0.00	6.92	0.00	6.92
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**6.92**	**0.00**	**6.92**
AMP057 - DCAS HHS FUNCTIONAL					
100200 - DCAS HHS FUNCTIONAL	0.00	0.00	6.06	0.00	6.06
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**6.06**	**0.00**	**6.06**
AMP058 - DCAS ORGANIZATIONAL CHANGE MANAGEMENT					
100201 - DCAS ORGANIZATIONAL CHANGE MANAGEMENT	0.00	0.00	6.92	0.00	6.92
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**6.92**	**0.00**	**6.92**
AMP059 - DCAS INFORMATION TECHNOLOGY					
100202 - DCAS INFORMATION TECHNOLOGY	0.00	0.00	6.92	0.00	6.92
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**6.92**	**0.00**	**6.92**
AMP060 - CLAIMS MANAGEMENT					
100203 - CLAIMS MANAGEMENT	0.00	0.00	14.00	0.00	14.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**14.00**	**0.00**	**14.00**
AMP061 - HCOA SUPPORT SERVICES					
100204 - HCOA SUPPORT SERVICES	0.00	0.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**3.00**	**0.00**	**3.00**
AMP062 - PUBLIC AND PRIVATE PROVIDER SERVICES					
100205 - PUBLIC AND PRIVATE PROVIDER SERVICES	0.00	0.00	9.00	0.00	9.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**9.00**	**0.00**	**9.00**
AMP063 - HC REFORM AND INNOVATIVE SUPPORT SVS					
100206 - HC REFORM AND INNOVATIVE SUPPORT SVS	0.00	0.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**3.00**	**0.00**	**3.00**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
AMP064 - GRANTS ADMINISTRATION FUNCTION					
100207 - GRANTS ADMINISTRATION FUNCTION	0.00	0.00	3.00	0.00	3.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**3.00**	**0.00**	**3.00**
AMP065 - HIE: HEALTH INFORMATION EXCHANGE					
100208 - HIE: HEALTH INFORMATION EXCHANGE	0.00	0.00	7.00	0.00	7.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**7.00**	**0.00**	**7.00**
H02301 - E & E SYSTEMS					
700079 - E & E SYSTEMS	21.84	17.25	1.07	0.00	1.07
TOTAL PROGRAM PARENT L1 FUNDS	**21.84**	**17.25**	**1.07**	**0.00**	**1.07**
H02302 - E&E OVERSIGHT & MANAGEMENT					
700080 - E&E OVERSIGHT & MANAGEMENT	13.63	10.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**13.63**	**10.00**	**0.00**	**0.00**	**0.00**
H02305 - E&E SUPPORT - PMO/SME - DCAS					
700083 - E&E SUPPORT - PMO/SME - DCAS	32.65	16.69	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**32.65**	**16.69**	**0.00**	**0.00**	**0.00**
H02401 - HEALTH CARE AGENCY MONITORING AND KPIS					
700084 - HEALTH CARE AGENCY MONITORING AND KPIS	7.17	9.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.17**	**9.00**	**0.00**	**0.00**	**0.00**
H02402 - HEALTH CARE DATA ANALYTICS					
700085 - HEALTH CARE DATA ANALYTICS	10.42	9.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**10.42**	**9.00**	**0.00**	**0.00**	**0.00**
H02403 - HEALTH CARE INNOVATION					
700086 - HEALTH CARE INNOVATION	6.77	8.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**6.77**	**8.00**	**0.00**	**0.00**	**0.00**
H02501 - CLAIMS PROCESSING & QUALITY ASSURANCE/CONTROL					
700087 - CLAIMS PROCESSING & QUALITY ASSURANCE/CONTROL	13.48	17.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**13.48**	**17.00**	**0.00**	**0.00**	**0.00**
H02601 - ASSESSMENTS AND CARE COORDINATION					
700090 - ASSESSMENTS AND CARE COORDINATION	6.26	8.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**6.26**	**8.00**	**0.00**	**0.00**	**0.00**
H02602 - FRAUD, WASTE, AND ABUSE					
700091 - FRAUD, WASTE, AND ABUSE	23.05	28.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**23.05**	**28.00**	**0.00**	**0.00**	**0.00**
H02603 - POLICY					
700092 - POLICY	7.22	31.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.22**	**31.00**	**0.00**	**0.00**	**0.00**
H02604 - PROVIDER OVERSIGHT					
700093 - PROVIDER OVERSIGHT	51.76	63.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**51.76**	**63.00**	**0.00**	**0.00**	**0.00**
H02605 - QUALITY & HEALTH OUTCOMES					
700094 - QUALITY & HEALTH OUTCOMES	9.34	13.00	3.15	0.00	3.15
TOTAL PROGRAM PARENT L1 FUNDS	**9.34**	**13.00**	**3.15**	**0.00**	**3.15**
H02703 - 1115/1915 - MEDICAID					
700097 - 1115/1915 - MEDICAID	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02704 - FFS - CHILDLESS ADULTS (GROUP 8)					
700098 - FFS - CHILDLESS ADULTS (GROUP 8)	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02705 - FFS - CHIP					
700099 - FFS - CHIP	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02706 - FFS - MEDICAID					
700100 - FFS - MEDICAID	1.39	1.85	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**1.39**	**1.85**	**0.00**	**0.00**	**0.00**
H02707 - MCO - ALLIANCE					
700101 - MCO - ALLIANCE	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H02708 - MCO - CHILDLESS ADULTS (GROUP 8)					
700102 - MCO - CHILDLESS ADULTS (GROUP 8)	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02709 - MCO - CHIP					
700103 - MCO - CHIP	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02710 - MCO - IMMIGRANT CHILDREN					
700104 - MCO - IMMIGRANT CHILDREN	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02711 - MCO - MEDICAID					
700105 - MCO - MEDICAID	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02712 - MCO- WAIVER					
700340 - MCO- WAIVER	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02713 - HCBS ARPA INITIATIVE					
700344 - HCBS ARPA INITIATIVE	0.00	4.95	0.00	0.00	0.00
700347 - HCBS ARPA PROVIDER PAYMENTS	0.00	0.00	0.00	0.00	0.00
700348 - HCBS ARPA ENHANCED WAGE SUPPLEMENTAL	0.00	0.00	0.00	0.00	0.00
700349 - HCBS ARPA WORKFORCE INCENTIVES AND PROVIDER REIM	0.00	0.00	0.00	0.00	0.00
700350 - HCBS ARPA INITIATIVES (DDS)	0.00	0.00	0.00	0.00	0.00
700352 - HCBS ARPA EXPANSION OF SERVICE AND ACCESS	0.00	0.00	0.00	0.00	0.00
700353 - HCBS ARPA QUALITY OVERSIGHT & PROVIDER CAPACITY	0.00	0.00	0.00	0.00	0.00
700355 - HCBS ARPA INITIATIVES (DHCF)	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**4.95**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**299.15**	**366.65**	**378.09**	**0.00**	**378.09**
Health Benefit Exchange Authority					
AFO002 - AGENCY ACCOUNTING SERVICES					
150002 - AGENCY ACCOUNTING SERVICES	0.95	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.95**	**1.00**	**1.00**	**0.00**	**1.00**
AFO003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVICES					
150003 - AGENCY BUDGETING AND FINANCIAL MANAGEMENT SERVIC	0.95	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.95**	**1.00**	**1.00**	**0.00**	**1.00**
AFO005 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION SERVICES					
150001 - AGENCY /CLUSTER FINANCIAL EXECUTIVE ADMINISTRATION	0.95	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.95**	**1.00**	**1.00**	**0.00**	**1.00**
AFO011 - P-CARD CLEARING					
150012 - P-CARD CLEARING	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
AMP005 - CONTRACTING AND PROCUREMENT					
100022 - CONTRACTING AND PROCUREMENT - GENERAL	3.78	4.00	4.00	0.00	4.00
TOTAL PROGRAM PARENT L1 FUNDS	**3.78**	**4.00**	**4.00**	**0.00**	**4.00**
AMP011 - HUMAN RESOURCE SERVICES					
100058 - HUMAN RESOURCE SERVICES - GENERAL	0.95	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.95**	**1.00**	**1.00**	**0.00**	**1.00**
AMP012 - INFORMATION TECHNOLOGY SERVICES					
100076 - IT SECURITY	0.95	1.00	1.00	0.00	1.00
100080 - OPERATIONS, MAINTENANCE, AND DEVELOPMENT	32.17	35.00	35.00	0.00	35.00
TOTAL PROGRAM PARENT L1 FUNDS	**33.12**	**36.00**	**36.00**	**0.00**	**36.00**
AMP014 - LEGAL SERVICES					
100092 - LEGAL SERVICES - GENERAL	4.73	6.00	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.73**	**6.00**	**6.00**	**0.00**	**6.00**
AMP016 - PERFORMANCE AND STRATEGIC MANAGEMENT					
100154 - PERFORMANCE AND STRATEGIC MANAGEMENT	7.57	9.00	9.00	0.00	9.00
TOTAL PROGRAM PARENT L1 FUNDS	**7.57**	**9.00**	**9.00**	**0.00**	**9.00**
AMP019 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT					
100113 - PROPERTY, ASSET, AND LOGISTICS MANAGEMENT - GENERA	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Program	FY 2023 Actuals	FY 2024 Approved	Mayor's FY 2025 Proposed	Committee Variance	Committee's FY 2025 Recommendation
H01901 - CONSUMER EDUCATION AND OUTREACH SUPPORT SERVICES					
700059 - CONSUMER EDUCATION AND OUTREACH SUPPORT SERVIC	5.68	6.00	6.00	0.00	6.00
TOTAL PROGRAM PARENT L1 FUNDS	**5.68**	**6.00**	**6.00**	**0.00**	**6.00**
H01902 - MARKETING AND COMMUNICATION					
700060 - MARKETING AND COMMUNICATION	0.95	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.95**	**1.00**	**1.00**	**0.00**	**1.00**
H01903 - NAVIGATORS, CERTIFIED APPLICATION COUNSELORS AND IN-PERSON ENROLLMENT HELP					
700061 - NAVIGATORS, CERTIFIED APPLICATION COUNSELORS AND I	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02001 - CONTACT CENTER SERVICES					
700062 - CONTACT CENTER SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H02002 - DATA ANALYTICS AND REPORTING					
700063 - DATA ANALYTICS AND REPORTING	0.95	1.00	1.00	0.00	1.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.95**	**1.00**	**1.00**	**0.00**	**1.00**
H02003 - ELIGIBILITY AND ENROLLMENT					
700064 - ELIGIBILITY AND ENROLLMENT	4.73	8.00	8.00	0.00	8.00
TOTAL PROGRAM PARENT L1 FUNDS	**4.73**	**8.00**	**8.00**	**0.00**	**8.00**
H02004 - MEMBER SERVICES					
700065 - MEMBER SERVICES	11.82	12.50	12.50	0.00	12.50
TOTAL PROGRAM PARENT L1 FUNDS	**11.82**	**12.50**	**12.50**	**0.00**	**12.50**
H02005 - PLAN MANAGEMENT					
700066 - PLAN MANAGEMENT	10.88	10.50	10.50	0.00	10.50
TOTAL PROGRAM PARENT L1 FUNDS	**10.88**	**10.50**	**10.50**	**0.00**	**10.50**
H02006 - S.H.O.P.					
700067 - S.H.O.P.	22.71	25.00	30.00	0.00	30.00
TOTAL PROGRAM PARENT L1 FUNDS	**22.71**	**25.00**	**30.00**	**0.00**	**30.00**
PRG001 - NO PROGRAM					
000000 - NO PROGRAM	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**110.72**	**123.00**	**128.00**	**0.00**	**128.00**
Not-for-Profit Hospital Corporation					
C02001 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY					
200147 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Not-for-Profit Hospital Corporation Subsidy					
C02101 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY FUNDING					
200148 - NOT FOR PROFIT HOSPITAL CORP SUBSIDY FUNDING	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Office of the Deputy Mayor for Health and Human Services					
AMP030 - EXECUTIVE ADMINISTRATION					
100151 - EXECUTIVE ADMINISTRATION	11.75	12.75	12.75	0.00	12.75
TOTAL PROGRAM PARENT L1 FUNDS	**11.75**	**12.75**	**12.75**	**0.00**	**12.75**
H01701 - AGENCY OVERSIGHT AND SUPPORT SERVICES					
700055 - AGENCY OVERSIGHT AND SUPPORT SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
H01702 - COMMUNITY ENGAGEMENT SERVICES					
700056 - COMMUNITY ENGAGEMENT SERVICES	0.00	0.00	0.00	0.00	0.00
TOTAL PROGRAM PARENT L1 FUNDS	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
TOTAL AGENCY FUNDS	**11.75**	**12.75**	**12.75**	**0.00**	**12.75**
GRAND TOTAL	**6,881,381,140.42**	**6,915,098,811.06**	**7,704,622,821.61**	**2,535,206.20**	**7,707,158,027.81**

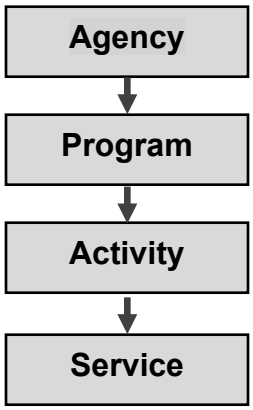
Our Budget has a New Look

The District recently updated its financial system to DIFS (District Integrated Financial System). With this new system come some changes in the way our budget is organized and reported relative to the legacy SOAR system. Agency budgets continue to be presented by program attributes, but now they are also grouped by cost center. Fund designations are similar, but instead of Comp Source Group, personnel and non-personnel budgets are subdivided by account attributes. The titles of most budget lines will be familiar to those who have reviewed prior budgets, but attribute codes will be different. Some agency budget structures have been modified to standardize agency budgets or more accurately reflect agency operations.

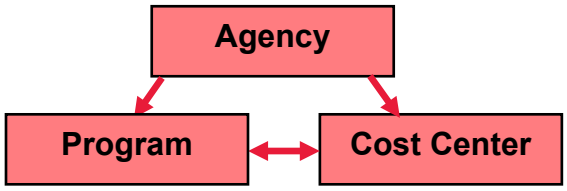
Below is a comparison of old and new attribute groups, and on the back are some agency programs presented with the old SOAR and new DIFS attributes. Please note that the titles of and codes for agencies themselves have not changed between SOAR and DIFS.

DIFS Program and Cost Center

In previous budget cycles, there was a one-to-one, linear relationship between each budget attribute:



In the new DIFS structure the budget can be viewed linearly by Program or Cost Center. The budget can also be viewed by both attributes, which have a many-to-many relationship:



The Program is the agency function the funds are spent on, and the Cost Center is the unit that controls the funds. This new system allows for more clarity on how much initiatives cost if multiple offices or agencies are involved in the work.

DIFS Funds replace SOAR Appropriation Fund/Fund Detail

DIFS Fund values denote the revenue source of the funds being budgeted. DIFS Fund values are always 7 digits long, with the first 4 digits denoting the classification of the funds (the "appropriation" type) and the remaining 3 digits indicating the exact fund.

Sample Funds (SOAR Approp Fund vs. DIFS Fund)
0100 is now 1010### Local Fund
0110 is now 1011### Dedicated Taxes
0600 is now 1060### Special Purpose Revenue Funds
0150 is now 4015### Federal Payments

DIFS Accounts replace SOAR Comptroller Source Groups (CSGs)

The DIFS Account designates what the funds are being used to purchase. This provides the same information as Comp Source Groups (CSGs) in previous budget cycles. Accounts starting with "70" designate Personal Services spending. Accounts starting with "71" designate Non-Personal Services spending. Accounts are always 7 digits long.

Sample Accounts (SOAR CSG vs. DIFS Account)
CSG 11 is now 7011###: Continuing Full Time
CSG 12 is now 7012###: Continuing Full Time – Other
CSG 14 is now 7014###: Fringe Benefits
CSG 20 is now 7111###: Supplies & Materials
CSG 40 is now 7131###: Other Services
CSG 41 is now 7132###: Contractual Services – Other
CSG 50 is now 7141###: Gov't Subsidies & Grant

SOAR and DIFS Attribute Crosswalk

Financial Attribute Field Name	Crosswalk Example 1	Crosswalk Example 2
Agency Name	Department of Human Services	District Department of Transportation
Agency Code	JA0	KA0
SOAR Appropriation Fund	0100 – Local Fund	0200 – Federal Grant Fund
SOAR Fund Detail	0100 – Local Funds	8200 – Federal Grants
DIFS Fund	1010001 – Local Funds	4020002 – Federal Grants
SOAR Program	2000 – Economic Security Administration	PD00 – Project Delivery Administration
SOAR Activity	2030 – Case Management	TDDV – Transit Delivery Division
DIFS Program (Parent Lvl 2)	HS0029 – Economic Security Services	GS0004 – Transit Operations
DIFS Program (Parent Lvl 1)	H02902 – Case Management	G00403 – Pedestrian and Bicycle Programs
DIFS Cost Center (Parent Lvl 2)	HS038 – Economic Security Administration	GS006 – Project Delivery Administration
DIFS Cost Center (Parent Lvl 1)	H3801 – Division of Program Operations (DPO)	G0602 – Transit Delivery Division
SOAR Comp Source Group	0011 – Regular Pay-Cont Full Time	0040 – Other Services and Charges
SOAR Comp Object	0111 – Regular Pay-Cont Full Time	0408 – Prof Service Fees and Contr
DIFS Account (Parent Lvl 1)	701100C – Continuing Full Time	713100C – Other Services & Charges
DIFS Account	7011001 – Continuing Full Time	7131009 – Prof Service Fees & Contr

Sample Agency Programs Presented with SOAR and DIFS Attributes

SOAR PROGRAM		DIFS PROGRAM (PARENT LVL 2)		SOAR ACTIVITY		DIFS PROGRAM (PARENT LVL 1)		BUDGET AMOUNT
JA0-Department of Human Services								
2000	ECONOMIC SECURITY ADMINISTRATION	HS0029	ECONOMIC SECURITY SERVICES	2030	CASE MANAGEMENT	H02902	CASE MANAGEMENT	43,717,563
				2020	TEMPORARY ASST TO NEEDY FAMILIES (TANF)	H02905	ELIGIBILITY DETERMINATION SERVICES	464,700
						H02909	TEMPORARY ASST TO NEEDY FAMILIES (TANF)	1,485,000
				2040	ELIGIBILITY DETERMINATION SERVICES	H02905	ELIGIBILITY DETERMINATION SERVICES	90,790,937
				2011	BURIAL ASSISTANCE	H02901	BURIAL ASSISTANCE	438,231
				2013	INTERIM DISABILITY ASSISTANCE	H02906	INTERIM DISABILITY ASSISTANCE	3,241,432
				2021	CASH ASSISTANCE (TANF)	H02903	CASH ASSISTANCE (TANF)	92,020,724
				2055	MONITORING AND QUALITY ASSURANCE	H02905	ELIGIBILITY DETERMINATION SERVICES	182,202
						H02908	MONITORING AND QUALITY ASSURANCE	7,585,813
				2024	SUPPLEMENTAL FOOD ASSISTANCE	H02911	SUPPLEMENTAL FOOD ASSISTANCE	1,155,000
				2012	GENERAL ASSISTANCE FOR CHILDREN	H02910	GENERAL ASSISTANCE FOR CHILDREN	725,094
				2022	JOB OPPORTUNITY AND TRAINING (TANF)	H02907	JOB OPPORTUNITY AND TRAINING (TANF)	34,707,721
				2065	EARLY EDUCATION SUBSIDY TRANSFER	H02904	EARLY EDUCATION SUBSIDY TRANSFER	24,049,214
KA0-District Department of Transportation								
PD00	PROJECT DELIVERY ADMINISTRATION	GS0004	TRANSIT OPERATIONS	PSDV	PLANNING AND SUSTAINABILITY	G00403	PEDESTRIAN AND BICYCLE PROGRAMS	7,200,000
				TDDV	TRANSIT DELIVERY DIVISION	G00401	CIRCULATOR	1,700,000
						G00402	MASS TRANSIT	1,153,023
						G00403	PEDESTRIAN AND BICYCLE PROGRAMS	40,890,124
						G00404	STREETCAR	9,960,017

ATTACHMENT
F

TITLE IV, SUBTITLE B. HEALTHY SCHOOLS FUND

Sec. 4011. Short title.

This subtitle may be cited as the "Healthy Schools Fund Amendment Act of 2024".

Sec. 4012. ~~Section 102 of the~~ The Healthy Schools Act of 2010, effective July 27, 2010 (D.C. Law 18-209; D.C. Official Code 38-821.~~02 01~~ *et seq.*), is amended as follows:

(a) Section 101(1G) is repealed.

(b) Section 102 is amended to read as follows:

(1) The section heading is amended to read as follows:

"Sec. 102. Healthy school meal subsidies and healthy school grants."

~~(b)~~ (2) Subsections (a) and (b) are repealed.

~~(c)~~ (3) Subsection (c) is amended as follows:

~~(1)~~ (A) The lead-in ~~text~~ language is amended to read as follows: ~~by striking the phrase "The funds in the Fund shall be used as follows:"~~

"(c) In Fiscal Year 2025, $5,690,000 in local funds shall be used as follows:".

~~(2)~~ (B) Paragraph (7) is amended by striking the phrase "~~shall make grants available,~~ subject to the availability of funds in the Fund," and inserting the phrase "~~may issue grants~~ subject to the availability of funds," in its place.

~~(3) Paragraph (8) is repealed.~~

~~(4)~~ (C) Paragraph (9) is amended by striking the phrase "~~shall make grants available,~~ subject to the availability of funds in the Fund," and inserting the phrase "~~may issue grants~~ subject to the availability of funds," in its place.

(d) Subsections (f) and (g) are repealed.

TITLE V, SUBTITLE A. DIRECT CARE PROFESSIONAL PAYMENT RATES

Sec. 5001. Short title.

This subtitle may be cited as the "Direct Care Professional Payment Rate Amendment Act of 2024".

Sec. 5002. The Direct Support Professional Payment Rate Act of 2020, effective April 16, 2020 (D.C. Law 23-77; D.C. Official Code § 4-2001 *et seq.*), is amended as follows:

(a) Section 3 (D.C. Official Code § 4-2002) is amended as follows:

(1) Subsection (a) is amended by striking the phrase "By Fiscal Year 2025" and inserting the phrase "By Fiscal Year 2026" in its place.

(2) A new subsection (a-1) is added to read as follows:

"(a-1) In Fiscal Year 2025, the Mayor shall provide a supplemental payment from the Home and Community-Based Services Enhancement Fund established pursuant to section 8d of the Department of Health Care Finance Establishment Act of 2007, effective September 21, 2022 (D.C. Law 24-167; D.C. Official Code § 7-771.07d), to direct care service providers for the purpose of supporting payments to direct care professionals of a wage that, on average, is equal to at least the greater of either 117.6% of the District minimum wage pursuant to section 4 of the Minimum Wage Act Revision Act of 1992, effective March 25, 1993 (D.C. Law 9-248; D.C. Official Code § 32-1003), or 117.6% of the District living wage pursuant to the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code § 2-220.01 *et seq.*).".

(b) Section 5 (D.C Official Code § 4-2004) is amended as follows:

(1) Subsection (b) is amended by striking the phrase "During Fiscal Year 2025" and inserting the phrase "During Fiscal Year 2026" in its place.

(2) A new subsection (c) is added to read as follows:

"(c) A direct care service provider who received a supplemental payment from the District in Fiscal Year 2025 pursuant to section 3(a-1) shall demonstrate to the Mayor that it paid its direct care professionals a wage that, on average, is equal to at least the greater of either 117.6% of the District minimum wage pursuant to section 4 of the Minimum Wage Act Revision Act of 1992, effective March 25, 1993 (D.C. Law 9-248; D.C. Official Code § 32-1003), or 117.6% of the District living wage pursuant to the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code § 2-220.01 *et seq.*), in the service provider's operating budget cycle, inclusive of overtime wages and bonuses.".

TITLE V, SUBTITLE C. MEDICAID INPATIENT FUND AND DIRECTED PAYMENTS

Sec. xxx1. Short title.

This subtitle may be cited as the "Medicaid Inpatient Hospital Directed Payment Act of 2024".

Sec. xxx2. Definitions.

For the purposes of this subtitle, the term:

(1) "Department" means the Department of Health Care Finance.

(2) "District retention" means an amount equal to 13.125% of the fees collected under section 5024(a)(1), plus the salary and fringe benefits for one full-time equivalent staff position at the Department.

(3) "Fund" means the Inpatient Hospital Directed Payment Provider Fee Fund established by this subtitle.

(4) "Hospital" shall have the same meaning as provided in section 2(a)(9) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501(a)(9)), but excludes any specialty hospital, as defined by the District of Columbia's Medicaid State Plan, a hospital that is reimbursed under a specialty hospital reimbursement methodology under the State Plan, or a hospital operated by the federal government.

(5) "Hospital system" means a group of hospitals licensed separately but operated, owned, or maintained by a common entity.

(6) "Medicaid" means the medical assistance programs authorized by Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 *et seq.*), and by section 1 of An Act To enable the District of Columbia to receive Federal financial assistance

under title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), and administered by the Department.

(7)(A) "Inpatient net patient revenue" means the result of the following calculation:

(i) The quotient of the number appearing in Column 1 of Line 28 on Worksheet G-2 of the hospital's most recently available filed Hospital and Hospital Health Care Complex Cost Report ("Form CMS-2552-10");

(ii) Divided by the number appearing in Column 3 of Line 28 on Worksheet G-2 of that report; and

(iii) Multiplied by the number appearing in Column 1 of Line 3 of Worksheet G-3 of that report.

(B) Notwithstanding subparagraph (A) of this paragraph, for a hospital that has not yet filed its first Form CMS-2552-10, the term "inpatient net patient revenue" shall mean a dollar value determined by the Department, based on projected utilization volume and projected utilization migration from other area hospitals, that approximates the hospital's expected inpatient net patient revenue.

(8) "State directed payment" means a Medicaid managed care delivery system and provider payment initiative authorized under 42 C.F.R. § 438.6(c).

Sec. xxx3. Inpatient Hospital Directed Payment Provider Fee Fund.

(a) There is established as a special fund the Inpatient Hospital Directed Payment Provider Fee Fund, which shall be administered by the Department in accordance with subsections (c) and (d) of this section.

(b) Revenue from the following sources shall be deposited in the Fund:

(1) Fees collected under this subtitle; and

(2) Interest and penalties collected under this subtitle.

(c) Money in the Fund shall be used only for the following purposes:

(1) Making separate payments to Medicaid managed care organizations to fund Medicaid inpatient hospital directed payments to hospitals as required under section 5026;

(2) Providing refunds to hospitals pursuant to section 5025; and

(3) Through the District retention:

(A) Paying the salary and fringe benefits of one full-time equivalent staff position at the Department;

(B) Funding the local match for Medicaid fee-for-service hospital reimbursements;

(C) Funding Title I of the Prior Authorization Reform Amendment Act of 2023, effective January 17, 2024 (D.C. Law 25-100; D.C. Official Code § 31-3875.01 *et seq.*), using an amount from the District retention equal to 1.125% of the fees collected by this subtitle; and

(D) Making a transfer to the General Fund in an amount not to exceed 13.125% of the fees collected by this subtitle.

(d)(1) Except as otherwise provided in subsection (c)(3)(D) of this section, the money deposited into Fund shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

(2) Subject to authorization in an approved budget and financial plan, any funds appropriated in the Fund shall be continually available without regard to fiscal year limitation.

Sec. xxx4. Inpatient hospital directed payment provider fee.

(a) The District may charge each hospital a fee based on its inpatient net patient revenue. The fee shall be charged at a uniform rate among all hospitals. The rate of the fee shall be established by the Department and generate an amount equal to:

(1) The non-federal share of the quarterly inpatient hospital directed payment, consistent with the applicable State directed payment preprint approved by the Centers for Medicare and Medicaid Services; and

(2) The District retention.

(b) If the Department calculates the fee under subsection (a) based in part on the inpatient net patient revenue of a new hospital that has not yet filed its first Hospital and Hospital Health Care Complex Cost Report ("Form CMS-2552-10"), the Department shall, after the hospital files its first Form CMS-2552-10:

(1) Adjust the fee retroactively based on the inpatient net patient revenue of the new hospital using the calculation provided by section 5022(7)(A);

(2) Bill the new hospital for any difference in amount owed, if any; and

(3) Retroactively adjust the fees charged to all other hospitals to account for the change in the new hospital's fee obligations.

(c)(1) Except as provided in paragraph (2) of this subsection, the following hospitals shall be exempt from the fee imposed under subsection (a) of this subsection:

(A) A psychiatric hospital that is an agency or a unit of the District government;

(B) Howard University Hospital.

(2) If an exemption provided to a hospital by paragraph (1) of this subsection is not approved for a provider tax waiver from the Centers for Medicare and Medicaid Services (if such waiver is determined to be necessary), the hospital shall be subject to the fee imposed under subsection (a) of this section.

Sec. xxx5. Federal Determination; Suspension and Termination of Assessment; and Applicability of fees.

(a) The fee imposed by section 5024 shall apply as of October 1, 2024.

(b) The fee imposed by section 5024 shall cease to be imposed, and any moneys remaining in the Fund shall be refunded to hospitals in proportion to the amounts paid by them if the payments under section 5026 are not eligible for federal matching funds or if the fee is determined to be an impermissible tax under section 1903(w) of the Social Security Act, approved July 30, 1965 (70 Stat. 349; 42 U.S.C. § 1396b(w)).

(c) The Department shall include policy initiatives in the Medicaid State directed payment preprint application to the Centers for Medicare and Medicaid Services that would require hospitals to implement and supplement existing programs dedicated to improving maternal and child health outcomes, discharge for long term care and transitions of care plans, substance use, and workforce pipelines.

Sec. xxx6. Medicaid inpatient hospital directed payments.

For services beginning on October 1, 2024, the Department shall require Medicaid managed care organizations to make inpatient directed payments to hospitals consistent with the applicable State directed payment preprint approved by the Centers for Medicare and Medicaid Services.

Sec. xxx7. Quarterly notice and collection.

(a) The fee imposed under section 5024 shall be calculated on a quarterly basis and shall be due and payable by the 15th day after the last month of each quarter; provided, that the fee shall not be due and payable until:

(1) The District issues written notice that the payment methodologies for payments to hospitals required under section 5026 have been approved by the Centers for Medicare and Medicaid Services; and

(2) The District issues written notice to the hospital informing the hospital of its fee rate, inpatient net patient revenue subject to the fee, and the fee amount owed on a quarterly basis, including, in the initial written notice from the District to the hospital, all fee amounts owed beginning with the period commencing on October 1, 2024.

(b)(1) If a hospital fails to pay the full amount of the fee in accordance with this subtitle, the unpaid balance shall accrue interest at the rate of 1.5% per month or any fraction thereof, which shall be added to the unpaid balance.

(2) The Chief Financial Officer may arrange a payment plan for the amount of the fee and interest in arrears.

Sec. xxx8. Multi-hospital systems, closure, merger, and new hospitals.

(a) If a hospital system owns, operates, or maintains more than one hospital licensed by the Department of Health, the hospital system shall pay the fee for each hospital separately.

(b)(1) Notwithstanding any other provision in this subtitle, if a hospital system or person ceases to own, operate, or maintain a hospital that is subject to a fee under section 5024, as evidenced by the transfer or surrender of the hospital license, the fee for the fiscal year in which the cessation occurs shall be adjusted by multiplying the fee computed under section 5024 by a fraction, the numerator of which is the number of days in the year during which the hospital

system or person conducted, operated, or maintained the hospital, and the denominator of which is 365.

(2) Within 15 days after ceasing to own, operate, or maintain a hospital, the hospital system or person shall pay the fee for the year as so adjusted, to the extent not previously paid.

Sec. xxx9. Rules.

The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), may issue rules to implement the provisions of this subtitle.

Sec. xx10. Sunset.

This subtitle shall expire on September 30, 2029.

TITLE V, SUBTITLE D. MEDICAID OUTPATIENT FUND AND DIRECTED PAYMENTS

Sec. xxx1. Short title.

This subtitle may be cited as the "Medicaid Outpatient Hospital Directed Payment Act of 2024".

Sec. xxx2. Definitions.

For the purposes of this subtitle, the term:

(1) "Department" means the Department of Health Care Finance.

(2) "District retention" means an amount equal to 13.125% of the fees collected pursuant to section 5034(a)(1), plus the salary and fringe benefits for one full-time equivalent staff position at the Department.

(3) "Fund" means the Outpatient Hospital Directed Payment Provider Fee Fund established by this subtitle.

(4) "Hospital" shall have the same meaning as provided in section 2(a)(1) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501(a)(9)); except that the term "hospital" shall not include a hospital operated by the federal government.

(5) "Hospital system" means a group of hospitals licensed separately, but operated, owned, or maintained by a common entity.

(6) "Medicaid" means the medical assistance programs authorized by Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 *et seq.*), and by section 1 of An Act To enable the District of Columbia to receive Federal financial assistance under title XIX of the Social Security Act for a medical assistance program, and for other

purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), and administered by the Department.

(7)(A) "Outpatient gross patient revenue" means the amount that is reported in column 2 of line 28 of Worksheet G-2 of the hospital's most recently available Hospital and Hospital Health Care Complex Cost Report ("Form CMS 2552-10").

(B) Notwithstanding subparagraph (A) of this paragraph, for a hospital that has not yet filed its first Form CMS-2552-10, the term "outpatient gross patient revenue" shall mean a dollar value determined by the Department, based on projected utilization volume and projected utilization migration from other area hospitals, that approximates the hospital's expected outpatient gross patient revenue.

(8) "State directed payment" means a Medicaid managed care delivery system and provider payment initiative authorized under 42 C.F.R § 438.6(c).

Sec. xxx3. Outpatient Hospital Directed Payment Provider Fee Fund.

(a) There is established as a special fund the Outpatient Hospital Directed Payment Provider Fee Fund, which shall be administered by the Department in accordance with subsections (c) and (d) of this section.

(b) Revenue from the following sources shall be deposited in the Fund:

(1) Fees collected under this subtitle; and

(2) Interest and penalties collected under this subtitle.

(c) Money in the Fund shall be used only for the following purposes:

(1) Making separate payments to Medicaid managed care organizations to fund Medicaid outpatient hospital directed payments to hospitals as required under section 5036;

(2) Providing refunds to hospitals pursuant to section 5035; and

(3) Through the District retention:

(A) Paying the salary and fringe benefits of one full-time equivalent staff position at the Department;

(B) Funding the local match for Medicaid fee-for-service hospital reimbursements;

(C) Funding Title I of the Prior Authorization Reform Amendment Act of 2023, effective January 17, 2024 (D.C. Law 25-100; D.C. Official Code § 31-3875.01 *et seq.*), using an amount from the District retention equal to 1.125% of the fees collected by this subtitle; and

(D) Making a transfer to the General Fund in an amount not to exceed 13.125% of the fees collected by this subtitle.

(d)(1) Except as otherwise provided in subsection (c)(3)(D) of this section, the money deposited into the Fund shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

(2) Subject to authorization in an approved budget and financial plan, any funds appropriated in the Fund shall be continually available without regard to fiscal year limitation.

Sec. xxx4. Outpatient hospital directed payment provider fee.

(a) The District may charge each hospital a fee based on its outpatient gross patient revenue. The fee shall be charged at a uniform rate among all hospitals. The rate of the fee shall be established by the Department and generate an amount equal to:

(1) The non-federal share of the quarterly outpatient hospital directed payment, consistent with the applicable State directed payment preprint approved by the Centers for Medicare and Medicaid Services; and

(2) The District retention.

(b) If the Department calculates the fee under subsection (a) based in part on the outpatient gross patient revenue of a new hospital that has not yet filed its first Hospital and Hospital Health Care Complex Cost Report ("Form CMS-2552-10"), the Department shall, after the hospital files its first Form CMS-2552-10:

(1) Adjust the fee retroactively based on the outpatient gross patient revenue of the new hospital using the calculation provided by section 5032(7)(A);

(2) Bill the new hospital for any difference in amount owed, if any; and

(3) Retroactively adjust the fees charged to all other hospitals to account for the change in the new hospital's fee obligations.

(c)(1) Except as provided in paragraph (2) of this subsection, the following hospitals shall be exempt from the fee imposed under subsection (a) of this subsection:

(A) A psychiatric hospital that is an agency or a unit of the District government;

(B) Howard University Hospital.

(2) If an exemption provided to a hospital by paragraph (1) of this subsection is not approved for a provider tax waiver from the Centers for Medicare and Medicaid Services (if such waiver is determined to be necessary), the hospital shall be subject to the fee imposed under subsection (a) of this section.

Sec. xxx5. Federal Determination; Suspension and Termination of Assessment; and Applicability of fees.

(a) The fee imposed by section 5034 shall be applicable as of October 1, 2024.

(b) The fee imposed by section 5034 shall cease to be imposed, and any moneys remaining in the Fund shall be refunded to hospitals in proportion to the amounts paid by them if the payments under section 5036 are not eligible for federal matching funds or if the fee is deemed to be an impermissible tax under section 1903(w) of the Social Security Act, approved July 30, 1965 (70 Stat. 349; 42 U.S.C. §1396b(w)).

(c) The Department shall include policy initiatives in the Medicaid State directed payment preprint application to Centers for Medicare and Medicaid Services that would require hospitals to implement and supplement existing programs dedicated to improving maternal and child health outcomes, discharge for long term care and transitions of care plans, substance use, and workforce pipelines.

Sec. xxx6. Medicaid outpatient hospital directed payments.

For visits and services beginning on October 1, 2024, the Department shall require Medicaid managed care organizations to make outpatient directed payments to hospitals consistent with the applicable State directed payment preprint approved by the Centers for Medicare and Medicaid Services.

Sec. xxx7. Quarterly notice and collection.

(a) The fee imposed under section 5034 shall be calculated on a quarterly basis, and shall be due and payable by the 15th day after the last month of each quarter; provided, that the fee shall not be due and payable until:

(1) The District issues written notice that the payment methodologies for payments to hospitals required under section 5036 have been approved by the Centers for Medicare and Medicaid Services; and

(2) The District issues written notice to the hospital informing the hospital of its fee rate, outpatient gross patient revenue subject to the fee, and the fee amount owed on a quarterly basis, including, in the initial written notice from the District to the hospital, all fee amounts owed beginning with the period commencing on October 1, 2024.

(b)(1) If a hospital fails to pay the full amount of the fee in accordance with this subtitle, the unpaid balance shall accrue interest at the rate of 1.5% per month or any fraction thereof, which shall be added to the unpaid balance.

(2) The Chief Financial Officer may arrange a payment plan for the amount of the fee and interest in arrears.

Sec. xxx8. Multi-hospital systems, closure, merger, and new hospitals.

(a) If a hospital system owns, operates, or maintains more than one hospital licensed by the Department of Health, the hospital system shall pay the fee for each hospital separately.

(b)(1) Notwithstanding any other provision in this subtitle, if a hospital system or person ceases to own, operate, or maintain a hospital that is subject to a fee under section 5034, as evidenced by the transfer or surrender of the hospital license, the fee for the fiscal year in which the cessation occurs shall be adjusted by multiplying the fee computed under section 5034 by a fraction, the numerator of which is the number of days in the year during which the hospital system or person conducted, operated, or maintained the hospital, and the denominator of which is 365.

(2) Within 15 days after ceasing to own, operate, or maintain a hospital, the hospital system or person shall pay the fee for the year as so adjusted, to the extent not previously paid.

Sec. xxx9. Rules.

The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat.1204; D.C. Official Code § 2-501 *et seq.*), may issue rules to implement the provisions of this subtitle.

Sec. xx10. Sunset.

This subtitle shall expire on September 30, 2029.

TITLE V, SUBTITLE E. MEDICAID HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT AND HOSPITAL INPATIENT RATE SUPPLEMENT ADJUSTMENTS

Sec. xxx1. Short title.

This subtitle may be cited as the "Medicaid Hospital Outpatient Supplemental Payment and Hospital Inpatient Rate Supplement Adjustments Amendment Act of 2024".

Sec. xxx2. The Medicaid Hospital Outpatient Supplemental Payment Act of 2017, effective December 13, 2017 (D.C. Law 22-33; D.C. Official Code § 44-664.01 *et seq.*), is amended as follows:

(a) Section 5062(5) (D.C. Official Code § 44-664.01(5)) is amended to read as follows:

~~"(5)(A) Except as provided in subparagraph (B) of this paragraph, "outpatient~~

"(5)(A) "Outpatient gross patient revenue" means the amount that is reported in column 2 of line 28 of Worksheet G-2 of the hospital's most recently available Hospital and Hospital Health Care Complex Cost Report ~~(~~("Form CMS 2552-10~~).~~").

"(B) ~~For~~Notwithstanding subparagraph (A) of this paragraph, for a hospital that has not yet filed its first ~~Hospital and Hospital Health Care Complex Cost Report (~~Form CMS-2552-10~~),~~, the term "outpatient ~~net~~gross patient revenue" shall mean a dollar value determined by the Department~~,~~ based on projected utilization volume and projected utilization migration from other area hospitals~~,~~ that approximates the hospital's expected ~~inpatient net~~outpatient gross patient revenue ~~as defined by subparagraph (A) of this paragraph~~.".

~~(b) Section 5064~~(b) (D.C. Official Code § 44-664.03) is amended ~~as follows:~~

~~(1) Subsection (b) is amended~~ to read as follows:

~~"~~(b)(1) Except as provided in paragraph (2) of this subsection, the following hospitals shall be exempt from the fee imposed under subsection (a) of this subsection:

"(A) A psychiatric hospital that is an agency or a unit of the District government; and

"(B) Howard University Hospital.

"(2) If an exemption provided to a hospital by paragraph (1) of this subsection is ~~adjudged to be unlawful or otherwise invalid, or is~~ not approved for a provider tax waiver from the Centers for Medicare and Medicaid Services (if such waiver is determined to be necessary), the hospital shall be subject to the fee imposed under subsection (a) of this section.".

Sec. xxx3. The Medicaid Hospital Inpatient Rate Supplement Act of 2017, effective December 13, 2017 (D.C. Law 22-33; D.C. Official Code § 44-664.11 *et seq.*), is amended as follows:

~~(a)~~ Section 5082(4) (D.C. Official Code § 44-664.11(4)) is amended to read as follows:

~~"(4)(A) Except as provided in subparagraph (B) of this paragraph, "inpatient~~

"(4)(A) "Inpatient net patient revenue" means, with respect to a hospital, the result of the following calculation:

"(i) The quotient of the number appearing in Column 1 of Line 28 on Worksheet G-2 of the hospital's most recently available filed Hospital and Hospital Health Care Complex Cost Report ~~(~~("Form CMS-2552-10~~)~~"), divided by the number appearing in Column 3 of Line 28 on Worksheet G-2 of that report; ~~multiplied by~~and

"(ii) ~~The~~Multiplied by the number appearing in Column 1 of Line 3 of Worksheet G-3 of that report.

"(B) ~~For~~Notwithstanding subparagraph (A) of this paragraph, for a hospital that has not yet filed its first ~~Hospital and Hospital Health Care Complex Cost Report~~

~~(~~Form CMS-2552-10~~),~~ the term "inpatient net patient revenue" shall mean a dollar value determined by the Department, based on projected utilization volume and projected utilization migration from other area hospitals, that approximates the hospital's expected ~~outpatient~~inpatient net patient revenue ~~as defined by subparagraph (A) of this paragraph~~.".

~~———~~(b) Section 5084 (D.C. Official Code § 44-664.13) is amended as follows:

~~———~~ (1) Subsection (b) is amended to read as follows:

~~———~~"(b)(1) Except as provided in paragraph (2) of this subsection, the following hospitals shall be exempt from the fee imposed under subsection (a) of this subsection:

~~———~~ "(A) A psychiatric hospital that is an agency or a unit of the District government; and

~~———~~ "(B) Howard University Hospital.

"(2) If an exemption provided to a hospital by paragraph (1) of this subsection is ~~adjudged to be unlawful or otherwise invalid, or is~~ not approved for a provider tax waiver from the Centers for Medicare and Medicaid Services (if such waiver is determined to be necessary), the hospital shall be subject to the fee imposed under subsection (a) of this section.".

(2) Subsection (c) is repealed.

TITL V, SUBTITLE H. HEALTHY DC FUND

Sec. xxx1. Short title.

This subtitle may be cited as the “Healthy DC Fund Amendment Act of 2024”.

Sec. xxx2. Section 15b of the Hospital and Medical Services Corporation Regulatory Act of 1996, effective March 2, 2007 (D.C. Law 16-192; D.C. Official Code § 31-3514.02), is amended by adding a new subsection (d) to read as follows:

“(d) Notwithstanding subsection (a) of this section, in each of fiscal years 2025, 2026, 2027, and 2028, $5,567,566 shall be transferred from the Fund to the General Fund of the District.”.

TITLE V, SUBTITLE I. NOT-FOR-PROFIT HOSPITAL CORPORATION SUBSIDY

Sec. xxx1. Short title.

This subtitle may be cited as the "Not-For-Profit Hospital Corporation Subsidy Amendment Act of 2024".

Sec. xxx2. The Not-for-Profit Hospital Corporation Establishment Amendment Act of 2011, effective September 14, 2011 (D.C. Law 19-21; D.C. Official Code § 44-951.01 *et seq.*), is amended as follows:

(a) Section 5115(l)(1) (D.C. Official Code § 44-951.04(l)(1)) is amended as follows:

(1) Subparagraph (B) is amended by striking the phrase "; or" and inserting a semicolon in its place.

(2) Subparagraph (C) is amended to read as follows:

"(C) At any time during Fiscal Year 2021 through Fiscal Year 2024, a District annual operating subsidy of more than $15 million per fiscal year is required; or".

(3) A new subparagraph (D) is added to read as follows:

"(D) At any time after September 30, 2024, a District annual operating subsidy of more than $26 million per fiscal year is required.".

(b) Section 5120(b)(1) (D.C. Official Code § 44-951.09(b)(1)) is amended by striking the phrase "and no greater than $22 million per year thereafter," and inserting the phrase "no greater than $22 million per year in Fiscal Years 2022 through 2024, and no greater than $26 million per year thereafter," in its place.

TITLE V, SUBTITLE M. CHILDCARE FOR PREGNANT AND BIRTHING PARENTS GRANTS

Sec. xxx1. Short title.

This subtitle may be cited as the "Childcare for Pregnant and Birthing Parents Grants Amendment Act of 2024".

Sec. xxx2. Section 4907a of the Department of Health Functions Clarification Act of 2001, effective March 3, 2010 (D.C. Law 18-111; D.C. Official Code § 7-736.01), is amended by adding a new subsection (m) to read as follows:

"(m)(1) For Fiscal Year 2025, the Director of the Department of Health shall issue one or more grants totaling $300,000 to non-governmental entities to provide childcare to pregnant and birthing parents or legal guardians who are receiving urgent treatment related to pregnancy at a hospital or birthing facility in the District.

"(2)(A) For childcare lasting 5 hours or less, the grantee shall provide on-site childcare.

"(B) For childcare lasting for more than 5 hours, the grantee may transfer the child to a childcare facility; provided, that the Department of Health and the parents or legal guardians of the child are notified of the transfer and the identity and location of the childcare facility.

"(3) For the purposes of this subsection:

"(A) "On-site childcare" means childcare provided at the same hospital or birthing facility where the parent or legal guardian is receiving urgent treatment related to pregnancy.

“(B) “Urgent treatment related to pregnancy” means healthcare treatment outside of standard prenatal care and labor and delivery services that is recommended by a licensed health professional to occur immediately to protect the health of the pregnant or birthing individual or the fetus.”.

ATTACHMENT
G

SUBTITLE X. GROCERY ACCESS PILOT PROGRAM

Sec. XXX1. Short title.

This subtitle may be cited as the "Grocery Access Pilot Program Establishment Amendment Act of 2024".

Sec. XXX2. The Department of Health Functions Clarification Act of 2001, effective October 3, 2001 (D.C. Law 14-28; D.C. Official Code § 7-731 *et seq.*), is amended by adding a new section 4907d to read as follows:

"Sec. 4907d. Establishment of the grocery access pilot grant program.

"(a) In Fiscal Year 2025, the Department of Health shall establish a grocery access pilot grant program for the purpose of providing up to 1,000 eligible District residents with membership to a grocery delivery service at no cost for one year.

"(b)(1) To be eligible to participate in the pilot program, an applicant shall:

"(A) Be a resident of the District; and

"(B) Be enrolled in the Supplemental Nutrition Assistance Program Education ("SNAP-Ed").

"(2) The Department of Health shall give preference to an applicant who lives in an "eligible area" as that term is defined in D.C. Official Code § 47-3801(1D)(A).

"(c) At the conclusion of the one-year pilot program, the Department of Health shall incorporate the data collected in the program in their SNAP-Ed program.

"(d) The data collected pursuant to subsection (d) of this section shall be made available to the Council upon request.".

SUBTITLE X. MENTAL HEALTH COURT URGENT CARE CLINIC

Sec. xxx1. Short title.

This subtitle may be cited as the "Mental Health Court Urgent Care Clinic Amendment Act of 2024".

Sec. xxx2. The Department of Behavioral Health Establishment Act of 2013, effective December 24, 2013 (D.C. Law 20-61, D.C. Official Code § 7-1141.01 *et seq.*), is amended by adding a new section 5117a.

"5117a. Superior Court mental health urgent care clinic.

"(a) By October 1, 2024, the Department shall contract with a non-governmental organization for the purpose of establishing and operating a mental health urgent care clinic located within the Moultrie Courthouse, located at 500 Indiana Avenue, NW, of the Superior Court of the District of Columbia.

"(b) To qualify, the non-governmental organization shall:

"(1) Have experience operating a mental health urgent care clinic within the Superior Court that provides behavioral health and substance use disorder services to individuals;

"(2) Possess no less than 2 years of experience in establishing and managing free-standing mental health clinics;

"(3) Be certified by the Department to provide mental health rehabilitation services;

"(4) Have previously been awarded a contract by a local, state, or federal agency to conduct mental health and substance abuse assessments and treatment, conduct housing need assessments and referrals, and deliver brief therapeutic interventions for individuals within the justice system;

"(5) Possess no less than 3 years of experience working with individuals with behavioral health needs involved in the legal system, including the ability to collaborate with Superior Court personnel, criminal justice agencies, and community-based providers;

"(6) Possess expertise in providing comprehensive mental health and substance use disorder services to diverse populations;

"(7) Possess knowledge of local laws and regulations related to mental health crisis support and hospitalization; and

"(8) Possess a commitment to person-center care and evidence-based practices in mental health and substance abuse disorder treatment.

"(c) The mental health urgent care clinic established by this section shall:

"(1) Employ an evidence-based or evidence-informed care management model that provides individualized support and referrals to resources;

"(2)(A) Ensure that one or more staff members are qualified to conduct petitions for emergency evaluation and observation when there is concern that an individual poses a significant risk to themselves or others due to a severe mental health condition.

"(B) A staff member is qualified to conduct an emergency evaluation if they are permitted by law to conduct an emergency evaluation or certified by the Department as an Officer Agent;

"(3) Maintain staffing sufficient to provide services to no fewer than 600 individuals each year;

"(4) Conduct assessments, diagnose mental health and co-occurring disorders, and conduct substance abuse screenings;

"(5) Maintain an electronic health record system that collects uniform

information that meets at least the following criteria:

"(A) Maintains and keeps track of an individual's health history;

"(B) Provides a method for clinic communication and treatment planning amoung providers and practitioners serving individuals visiting the clinic;

"(C) Serves as a legal document describing healthcare services provided; and

"(D) Serves as a source of data for the behavioral health services and outcomes that are rendered.

"(6) Provide care coordination and intervention management services for high utilizers of the District's behavioral health and justice system;

"(7) Provide evaluations for juveniles who are court-ordered for emergency evaluation;

"(8) Conduct housing assessments;

"(9) Provide immediate mental health clinical interventions, as required;

"(10) Coordinate with organizations certified by the Department to provide behavioral health services, if necessary; and

"(11) Refer individuals to community-based treatment and resources.".

SUBTITLE X. OPIOID ABATEMENT DIRECTED FUNDING

Sec. XXX1. Short title.

This subtitle may be cited as the "Opioid Abatement Directed Funding Amendment Act of 2024".

Sec. XXX2. Section 5012 of the Opioid Abatement Fund Establishment Act of 2022, effective September 21, 2022 (D.C. Law 24-167; D.C. Official Code § 7-3221), is amended by adding a new subsection (b-5) to read as follows:

"(b-5) Notwithstanding any other provision of this act, in Fiscal Year 2025, a total amount of $1,125,000 from the Fund shall be used for the following purposes:

"(1) $400,000 for behavioral health and substance abuse targeted outreach services at locations in Wards 5 and 6 identified in the Substance Abuse and Behavioral Health Services Targeted Outreach Grant Act of 2024, as approved by the Committee on Health on May 9, 2024 (Committee Print of Bill 25-784);

"(2) $325,000 to implement the School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2024, as approved by the Committee on Health on May 9, 2024 (Committee Print Bill 25-784); and

"(3) $400,000 to the Office of the Chief Medical Officer for the purpose of enabling the testing of illicit drug misuse and the development of novel testing methods for opioids within the agency's Forensic Toxicology Lab and Data Fusion Center.".

SUBTITLE X. PRIOR AUTHORIZATION REFORM AMENDMENT

Sec. xxx1. Short title.

This subtitle may be cited as the "Prior Authorization Reform Amendment Act of 2024".

Sec. xxx2. Section 109(c) of the Prior Authorization Reform Amendment Act of 2023, effective January 17, 2024 (D.C. Law 25-100; D.C. Official Code § 31-3875.09(c)), is amended to read as follows:

"(c) For the purposes of this section, the term "utilization review entity" shall not include an individual or entity that performs prior authorization review for a health benefits plan provided through Medicaid or the DC HealthCare Alliance.".

SUBTITLE X. SCHOOL-BASED BEHAVIORAL HEALTH STUDENT PEER EDUCATOR PILOT

Sec. XXX1. Short title.

This subtitle may be cited as the "School-Based Behavioral Health Student Peer Educator Pilot Amendment Act of 2024".

Sec. XXX2. Section 204 of the Early Childhood and School-based Behavioral Health Infrastructure Act of 2012, effective September 6, 2023 (D.C. Law 25-50; D.C. Official Code § 2-1517.33), is amended by adding a new subsection (a-1) to read as follows:

"(a-1) In Fiscal Year 2025, DBH shall award by October 15, 2024, grants totaling $325,000 to the same non-governmental entities who received the grant under subsection (a) of this section to continue to perform the functions identified in subsections (d) and (e) of this section.".

SUBTITLE X. SUBSTANCE ABUSE AND BEHAVIORAL HEALTH SERVICES TARGETED OUTREACH GRANTS

Sec. xxx1. Short title.

This subtitle may be cited as the "Substance Abuse and Behavioral Health Services Targeted Outreach Grants Act of 2024".

Sec. xxx2. Substance abuse and behavioral health services targeted outreach pilot.

(a) By October 31, 2024, the Department Behavioral Health ("DBH") shall award one or more grants in the amount of $1,200,000 to 501(c)(3) not-for-profit organizations with experience in substance abuse harm reduction services to provide direct support, relationship development, and resource brokering to individuals in need of substance abuse and behavioral health services at the following locations:

(1) The vicinity of the 600 block of T Street, NW;

(2) The vicinity of the 1100-1300 blocks of Mount Olivet Road, NE;

(3) The vicinity of the 3800-4000 blocks of Minnesota Avenue, NE;

(4) The vicinity of the 1300-1800 blocks of Marion Barry Avenue, SE;

(5) The vicinity of King Greenleaf Recreation Center located at 201 N Street, SW; and

(6) The vicinity of the of the 1300-1700 blocks of North Capitol Street, NW and 1600-1700 blocks of Lincoln, Road, NE.

(b) By October 31, 2024, DBH shall award a grant in the amount of $750,000 to an organization responsible for maintaining a Main Street corridor in Ward 1 to hire 8 full-time positions to provide direct support, relationship development and resource brokering to individuals at the following locations:

(1) Columbia Heights Civic Plaza;

(2) The intersection of Mount Pleasant Street, NW and Kenyon Street, NW;

(3) Georgia Avenue, NW, between New Hampshire Avenue, NW, and Harvard Street, NW; and

(4) U Street, NW, between 14th Street, NW, and Georgia Avenue, NW.

(c) By November 30, 2025, the not-for-profit organizations awarded a grant pursuant to this act shall submit a report to DBH, which shall include the following information, broken down by location:

(1) The number of individuals or groups the grantee engaged through outreach efforts;

(2) The number of individuals the grantee connected to substance use disorder treatment programs, primary healthcare, mental health services, housing assistance, employment support, or other services;

(3) The number of overdose reversals or interventions performed by the grantee using naloxone or other overdose reversal medications;

(4) The amount of harm reduction supplies distributed by the grantee, including clean needles, syringes, naloxone kits, condoms, or other materials that reduce the risks associated with drug use; and

(5) The number of educational sessions, workshops or prevention activities delivered by the grantee to target populations.

(d) Within 30 days of receiving the report described in subsection (c) of this section, DBH shall submit the report to the Council and publicly post the report on its website.

(e) For the locations specified in subsections (a)(1), (2), (3), and (b) of this section, DBH shall award a grant to the same organization who received the grant under the Department of Behaviorial Health Target Outreach Grants Act of 2023, effective September 6, 2023 (D.C. Law 25-50; D.C. Official Code § 7-1141.01, note).

SUBTITLE X. SEXUAL HEALTH PEER EDUCATORS GRANT

Sec. XXX1. Short title.

This subtitle may be cited as the "Sexual Health Peer Educators Grant Amendment Act of 2024".

Sec. XXX2. Section 4907a of the Department of Health Functions Clarification Act of 2001, effective March 3, 2010 (D.C. Law 18-111; D.C. Official Code § 7-736.01), is amended by adding a new subsection (n) to read as follows:

"(n)(1) By October 21, 2024, the Department of Health ("Department") shall award one or more competitive grants totaling at least $150,000 to non-governmental entities to train, compensate, and supervise at least 50 high school students to work in public and public charter high schools as sexual health educators ("student health educators").

"(2) To qualify for the grant established by this subsection, an applicant shall include in its application:

"(A) A list of at least 8 public or public charter school high schools, with a preference for schools located in Wards 5, 7, or 8, with whom the applicant intends to partner;

"(B) The number of student health educators the applicant plans to hire, train, compensate, and supervise;

"(C) The types of interventions the applicant will train student health educators to perform, including classroom presentations on pregnancy prevention, condom distribution, and referrals to sexually transmitted infection testing centers, and target numbers for each intervention type;

"(D) Confirmation that the applicant is based in the District;

"(E) Demonstrated experience providing programming to youth ages 14 to 21 related to sexual and reproductive health; and

"(F) A commitment to provide quarterly reports to the Department that shall include:

"(i) A list of public and public charter high school students working as student health educators;

"(ii) A list of interventions performed by student health educators and how many students were reached by each intervention;

"(iii) The total number of training hours conducted with student health educators and the topics covered, including the number of student health educators who participated in each training session;

"(iv) A list of the training topics that were covered during the reporting period; and

"(v) Progress made on objectives and benchmarks identified in the grant agreement.".

SUBTITLE X. TOBACCO USE CESSATION INITIATIVES

Sec. xxx1. Short title.

This subtitle may be cited as the "Tobacco Use Cessation Initiatives Amendment Act of 2024".

Sec. xxx2. The Department of Health Functions Clarification Act of 2001, effective October 3, 2001 (D.C. Law 14-28, D.C. Official Code § 7-731 *et seq*), is amended by adding a new section 4907d to read as follows:

"Sec. 4907d. Tobacco Use Cessation Fund.

"(a) There is established as a special fund the Smoking Cessation Fund ("Fund"), which shall be administered by the Department of Health in accordance with subsections (c) of this section.

"(b) There shall be deposited into the Fund:

"(1) Such funds as may be appropriated; and

"(2) Beginning in Fiscal Year 2025, 50% of the amounts received by the District in the settlement of *District of Columbia v. JUUL Labs Inc.*, Superior Court of the District of Columbia Case No. 2019 CA 007795 B ("Settlement Funds").

"(c) Money in the Fund shall be used for the following purposes:

"(1)Investigators, including youth associates, to attempt vaping purchases;

"(2) Social media countermarking campaign featuring District youth;

"(3) Developing and conducting a bi-annual survey on District youth use of vaping products; and

"(4)(A) Developing a bi-annual report detailing how the Settlement Funds allocated to the Department have been spent and providing updated data from the survey required in paragraph (1)(C) and other relevant sources on District youth use of vaping products.

"(B) The report required by this paragraph shall be published each year that the Department is not conducting the survey required in paragraph (1)(C).

"(d)(1) The money deposited into the Fund but not expended in a fiscal year shall not revert to the unassigned fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

"(2) Subject to authorization in an approved budget and financial plan, any funds appropriated in the Fund shall be continually available without regard to fiscal year limitation.".

Sec. xxx3. Section 47-2402(l) is repealed.

SUBTITLE X. SUBJECT TO APPROPRIATIONS REPEALERS

Sec. xxx1. Short title.

This subtitle may be cited as the "Subject to Appropriations Repealers Amendment Act of 2024".

Sec. xxx2. Section 301 of the Prior Authorization Reform Amendment Act of 2023, effective January 17, 2024 (D.C. Law 25-100; D.C. Official Code § 31-3875.01 *et seq.*), is repealed.

Sec. xxx3. Section 3 of the Access to Emergency Medications Amendment Act of 2023, effective February 23, 2024 (D.C. Law 25-0124; 70 DCR 16578), is repealed.

Sec. xxx4. Section 3 of the Expanding Access to Fertility Treatment Amendment Act of 2023, effective September 22, 2023 (D.C. Law 25-0049; 70 DCR 10351), is repealed.

ATTACHMENT
H

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH

ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Not-For-Profit Hospital Corporation
(United Medical Center)
And
Health Benefit Exchange Authority

ON

Monday April 8, 2024, 9:00 A.M.
Hybrid in Room 412 and Virtual via Zoom
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Health Benefit Exchange Authority

Virtual

1. Ana Jones Owner/Director, Kids Village Learning Center LLC
2. Julie Lujan, Public Witness

In Person

3. Anne Gunderson, Senior Policy Analyst, DC Fiscal Policy Institute
4. Kimberly Perry, Executive Director, DC Action
5. Sia Barbara Kamara

Virtual

6. Ruqiyyah Anbar-Shaheen, Publci Witness
7. Floyd May, Program Manager, Leadership Council for Healthy Communities
8. Shawn Townsend, President & CEO, Restaurant Association of Metropolitan Washington
9. Jaye Yarbrough, Public Benefits and Insurance Navigation Manager for Data and Training, Whitman-Walker Health
10. Nicole Quiroga, President and CEO, GWHCC
11. Carlos Duque, Director, Amazing Life Games Preschool
12. Rachelle Ellison, Assistant Director, People for Fairness Coalition
13. Dennis Angel, Public Witness
14. Angela Franco, President/CEO, DC Chamber of Commerce
15. Cecilia Ayala-De-Muslera, Nido Nurturing Center
16. Bridgette Hall, Public Witness
17. Claire Heyison, Senior Policy Analyst, Center on Budget and Policy Priorities
18. Yasmina Castellanos, Public Witness
19. Verónica Hernandez, Entitlement Manager, Mary's Center
20. Jessica Scott. Public Witness
21. Emma Mehrabi, Public Witness
22. Van Freeman, Young Invincibles organization

United Medical Center

Virtual

23. Kenneth Page, Public Witness

Government Witnesses

Panel I

1. Mila Kofman, Executive Director of the DC Health Benefit Exchange Authority

Panel II

2. Angell Jacobs, Chair of the United Medical Center Fiscal Management Board

3. Dr. Payne-Borden, United Medical Center Chief Executive Officer and Chief Nursing Officer

4. Lilian Chukwuma, United Medical Center Chief Financial Officer

Fiscal Year 2025 Budget Oversight Hearing on the Not-for-Profit Hospital Corporation (UMC)

Before the
Committee on Health
Council of the District of Columbia

The Honorable Christina Henderson, Chairman

April 8, 2024, 9:00 am.

Testimony of
Angell Jacobs
Chair, Fiscal Management Board
Not-for-Profit Hospital Corporation and
Deputy Chief Financial Officer and Chief of Staff
Office of the Chief Financial Officer

Glen Lee
Chief Financial Officer
Government of the District of Columbia

Good morning, Chairperson Henderson and members of the Committee on Health. I am Angell Jacobs, Chair of the Fiscal Management Board (Board) for the Not-for-Profit Hospital Corporation, commonly known as United Medical Center or UMC. I am pleased to appear before you today with CEO Dr. Jacqueline Payne-Borden and CFO Lilian Chukwuma to discuss the Fiscal Year (FY) 2025 budget of UMC.

During FY 2025, we will continue our mission of providing quality medical care to residents, while prudently and appropriately managing our resources. As indicated in my testimony during the performance oversight hearing, UMC experienced a significant reduction in DSH of $8 million in FY 2023. We will continue to closely monitor the impact of DSH on the FY 2024 and FY 2025 budgets, and if necessary, take appropriate action to remain in balance.

In December of 2021, the construction process for the new Cedar Hill Regional Medical Center began. Since that time, the hospital construction team has successfully reached all key project milestones to date. By December of this year, the work on the construction of the hospital will be largely complete. Subsequently, hospital staff at the new facility will spend the first quarter of 2025 executing the required activities to prepare for the hospital's first patients by March 2025.

As a result, FY 2025 will be the last year of operations for UMC. Our focus will be on ensuring the safe transition of patients to the new hospital as well as the complete and effective closure of UMC operations and facilities. To support the closure effort, UMC will onboard a project manager, experienced in hospital decommissioning, in the coming weeks. With these factors in mind, our FY 2025 budget request represents the resources required to accomplish the tasks outlined here.

I would now like to turn to our CEO, Dr. Jacqueline Payne-Borden, who will provide testimony on the FY 2025 budget, after which, the panel would be pleased to answer questions that you or the Committee may have.

Testimony of Angela Franco
President & CEO
DC Chamber of Commerce

Health Benefit Exchange Budget Oversight Hearing
Before the Committee on Health

Monday, April 8, 2024
Virtual

Good morning Chairwoman Henderson and members of the Committee. I am Angela Franco, President & CEO at the DC Chamber of Commerce. I am pleased to be here today to represent the member companies of the Chamber, and the vast array of individuals they employ. Thank you for the opportunity to testify on the proposed FY 2025 budget submission for the District of Columbia's Health Benefit Exchange Authority (DCHBX).

We are pleased to support the DC Health Benefit Exchange's FY 2025 budget as proposed, and we ask that you and the members of the Committee continue to support the work of the Exchange and the funding required to support its outreach, education, and enrollment initiatives for individual residents and the District's job creators.

Throughout the year, the DC Chamber has continuously partnered with DC Health Link through virtual and in-person interactions and web-based information sessions designed to educate the small business community about their critical health coverage options. These initiatives serve to promoting our joint small business health insurance enrollment campaign during open season, including

direct outreach to DC Chamber members informing them of the benefits offered by DC Health Link.

Within the past year, we have sent to our small business partners more than 900 marketing and promotional emails and social media messages; made over 330 phone calls; made 383 in-person connections; and referred more than 50 businesses. For greater exposure, DC Chamber newsletters and virtual convening announcements include the DCHL banner as a tagline directing businesses right to the DCHL website. We are also proud of the fact that three of the four DCHL carriers; Aetna, CareFirst BlueCross Blue Shield and Kaiser Permanente, are members of the DC Chamber. Each of them works with us to inform small businesses of both the changing commercial health insurance landscape and accompanying market trends.

Every month, the DC Chamber also hosts a new member orientation providing an opportunity for DCHL representatives to address more than 300 new Chamber members during the last fiscal year alone. The Chamber also hosted a series of Employer Advocacy Program webinars in which the DCHL educated dozens of attendees on the benefits of providing health coverage to employees. We also hosted the DCHL at our Business After Business Networking event.

The DC Chamber's ongoing small business partnership with DCHL includes outreach and enrollment campaigns designed to inform small business owners about the array of plans offered by the Exchange that will help choose high-value

plans, provide enhanced employee benefits, and offer healthcare options that are comparable to the coverages large employers offer their employees.

The DC Chamber hosts more than two dozen events each year to promote DCHL to not only our own members, but other DC small businesses as well. I am especially excited to announce that this year, we are combining three National Small Business Week events hosted separately by DC Health Link (POWERUP DC), the DC Chamber of Commerce (our upcoming Small Business Summit), and DISB's and DSLBD's combined Small Business Expo into one major collaborative event! The "DC Small Business Summit and Expo: POWERUP for Success," is designed to collectively celebrate the invaluable contributions DC small businesses make to strengthen our economy and community.

The DCHL is also conducting targeted small business outreach focused on bridging the gap small business employees face as they transition from employer-sponsored health coverage to coverage in the private or public sectors due to changes in employment status. DCHL Assisters are working with small businesses to support DC resident employees who are losing or have lost their DCHL small group health coverage to help them enroll in a DCHL individual policy, or apply for Medicaid coverage to ensure they remain covered during this period in their lives.

The DC Chamber is committed to both continuing our partnership with DC Health Link and providing a robust choice of high-value services to our businesses and their employees, including small business health insurance through the DCHL. We encourage the Committee to continue to support the work of the DC Health

Benefit Exchange Authority and its efforts to address the healthcare needs of residents and employers in the District of Columbia.

As the Committee reviews the budget priorities of agencies under its purview, we would like to underscore the importance of working to ensure affordable coverage options, as well as a range of plan choices for our local businesses to choose from. For small employers, stability and affordability are paramount considerations. We ask that you and the members of the Committee work to ensure the Exchange has funding required to support its outreach, education, and enrollment initiatives for individual residents and the District's job creators.

We look forward to continuing to work with the DC Health Benefit Exchange Authority to improve and maintain an affordable health insurance program for the District's businesses and families. I would be happy to answer any questions you may have.

Thank you for the opportunity to testify today.

Angela Franco

Center on Budget and Policy Priorities

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April 8, 2024

The Affordable Care Act Enhanced Health Insurance Access, Affordability, and Consumer Protections

Testimony of Claire Heyison, Senior Policy Analyst for Health Insurance and Marketplace Policy, Center on Budget and Policy Priorities, Before the Council of the District of Columbia Committee on Health

Good morning Chairperson Henderson and members of the Committee, and thank you for the opportunity to testify before you this morning.

I am Claire Heyison, Senior Policy Analyst of Health Insurance and Marketplace Policy at the Center on Budget and Policy Priorities, a nonpartisan research and policy institute in Washington, D.C. I also recently joined the DC Health Benefit Exchange Standing Advisory Board. In this testimony, I will discuss major provisions of the Affordable Care Act, or ACA, that improved health care access and enhanced consumer protections. I believe these benefits are important to highlight as talk of repealing the ACA has resurfaced.

The ACA substantially improved the individual and group health insurance markets, creating nationwide protections for people with pre-existing conditions and setting minimum standards for plan benefits. Prior to the ACA, insurers in the individual market could refuse to sell health insurance to people with pre-existing conditions, such as diabetes, HIV, or even pregnancy.[1] When people with pre-existing conditions *were* able to purchase coverage, insurers could charge them higher premiums, exclude services related to their pre-existing condition or rescind coverage if a person developed a health condition that the insurer determined to be related to a pre-existing condition.[2]

The ACA prohibited the widespread use of these practices. It also prohibited insurers from charging enrollees for preventive care, required plans to let dependent children stay on their

[1] Karen Pollitz, "Pre-existing Conditions: What Are They and How Many People Have Them?," KFF, October 1, 2020, https://www.kff.org/policy-watch/pre-existing-conditions-what-are-they-and-how-many-people-have-them/.
[2] Sarah Lueck, "Eliminating Federal Protections for People with Health Conditions Would Mean Return to Dysfunctional Pre-ACA Individual Market," CBPP, October 5, 2020, https://www.cbpp.org/research/health/eliminating-federal-protections-for-people-with-health-conditions-would-mean-return.

parents' health plan until age 26, and required most plans in the individual market to cover ten Essential Health Benefits.

The ACA also incentivized states to expand their Medicaid programs to people with low incomes, which reduced uninsurance dramatically. Prior to the ACA, Medicaid was only available to people with very low incomes who fall into specific groups, like pregnant people and people with disabilities. Many people with low incomes who did not have health insurance through their jobs went without health insurance. This is still the case in the 10 states that have not yet expanded Medicaid.[3]

Finally, the ACA created marketplaces where individuals and small businesses can compare and purchase health plans. It also provides federal subsidies that make coverage more affordable for people with low and moderate incomes. The 2021 American Rescue Plan Act made marketplace coverage more affordable than ever and drove record enrollment in the ACA marketplaces, especially among Black and Hispanic individuals.[4] These affordability improvements were extended by the Inflation Reduction Act, but will expire in 2025 unless Congress takes action to extend them.

Improvements made by the ACA have helped millions of people obtain health insurance and driven gains in health outcomes. This important legislation must be protected.

Thank you again for your time.

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[3] Jennifer Sullivan, Allison Orris, and Gideon Lukens, "Entering Their Second Decade, Affordable Care Act Coverage Expansions Have Helped Millions, Provide the Basis for Further Progress," CBPP, March 25, 2024, https://www.cbpp.org/research/health/entering-their-second-decade-affordable-care-act-coverage-expansions-have-helped.

[4] Anu Warrier et al., "HealthCare.gov Enrollment by Race and Ethnicity, 2015-2023," Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 22, 2024, https://aspe.hhs.gov/reports/marketplace-enrollment-race-ethnicity-2015-2023.

Carlos Duque

Good morning, esteemed members of the DC Council Committee on Health. My name is Carlos Duque, and I am the director of Amazing Life Games Preschool in Washington, DC.

I am honored to have the opportunity to speak before you today about the invaluable assistance provided by HealthCare4ChildCare.

HealthCare4ChildCare has been a game-changer for my school and our teachers! This program has simplified the process of obtaining and managing health insurance and made it significantly more affordable!

The financial assistance provided by HealthCare4ChildCare has allowed us to offer comprehensive health coverage to our teachers without compromising the quality of care we provide our children.

By alleviating the financial burden of healthcare costs, HealthCare4ChildCare has empowered our teachers to prioritize their health and well-being, resulting in a happier and more productive workforce.

Furthermore, the peace of mind knowing that they have access to quality healthcare coverage has allowed our teachers to focus more on their work, ultimately benefiting the children under our care.

In addition to the direct benefits to ALG and our teachers, HealthCare4ChildCare plays a crucial role in strengthening the childcare industry. By ensuring that childcare providers have access to affordable healthcare coverage, this program contributes to the stability and sustainability of childcare businesses, ultimately benefiting the families and children who rely on our services.

I am immensely grateful for the support provided by HealthCare4ChildCare. This program has made a significant financial difference for my school and teachers and has also played a vital role in improving access to healthcare in the childcare industry.

I urge the Committee to continue supporting and funding initiatives like HealthCare4ChildCare, as they are instrumental in building a healthier and more prosperous community for all.

Thank you for your time and attention.

LCHC Leadership Council for Healthy Communities

Testimony of
Floyd May
Program Manager
Leadership Council for Healthy Communities (LCHC)

Before the

Council of the District of Columbia
Committee on Health and Human Services
Chairperson, Councilmember Christina Henderson

FY24 Budget Oversight Hearing

DC Health Benefit Exchange Authority

Monday, April 8, 2024

9:30 a.m.

Via WebEx

Good morning Chairperson Henderson and members of the DC Council Committee on Health, I am Floyd May, Executive Director for Leadership Council for Healthy Communities (LCHC). It gives me great pleasure to provide testimony at this hearing for LCHC, an organization of clergy leaders, medical professionals, public and community leaders working together to help African Americans and other communities of color eliminate health disparities and promote healthy communities through comprehensive health programs.

LCHC has had the privilege of serving as an Assister Organization for the Health Benefit Exchange (DCHBX) since its inception. We recognize the great work the Exchange is doing for DC residents in providing health insurance through DC Health Link. LCHC has worked diligently to help District residents gain and maintain health insurance coverage and, recently, during Open Enrollment 11, has placed special emphasis on Medicaid Unwinding and Healthcare for Childcare (HC4CC).

When DCHBX launched the HealthCare4ChildCare program, LCHC Assisters visited OSSE licensed child development centers and homes to enroll childcare workers and/or childcare sites in health insurance plans and provide information on health plan options through DC Health Link. Many childcare facilities had never been able to afford health insurance benefits for their workers prior to the HC4CC program, and it was a priority for LCHC to ensure that as many early educators as possible

gained access to these life-changing and life-saving healthcare benefits. Additionally, to inform HC4CC workers about their eligibility for health insurance, calls and emails were made to over 75 childcare workers and or childcare providers. We helped staff Virtual One Touch events on Saturday mornings and weekday evenings to assist health care workers at times that were more convenient for them to enroll and get information to make informed decisions about their health insurance options.

Special emphasis has also been placed on Medicaid Unwinding to provide assistance to persons who may be losing Medicaid coverage to renew their Medicaid or assist them in enrolling in other healthcare plan options with DC Health Link. Over 100 calls and over 90 emails went out to people for this Medicaid Unwinding effort. A total of 285 Consumers were recorded on the HBX Consumer Tracking report, of which 176 were enrolled in Medicaid, 44 for Medicaid Renewal, 3 QHPs, 6 in Alliance and 5 for QMB. The additional 51 Consumers were provided assistance without an action enrollment.

LCHC also engaged in a robust outreach effort to be accessible and provide opportunities for people to enroll in health insurance plans or obtain information that would allow them to make informed decisions. LCHC Assisters were assigned weekly throughout the year at 3 locations – DOES Backus Campus on Tuesdays, Wednesdays and Thursdays:

Martin Luther King, Jr. Library on Tuesdays, Wednesdays and Saturdays and Preventive Measures Health Clinic Monday through Thursday. LCHC is also uniquely positioned to accommodate requests from DCHBX to provide tabling at other outreach special events/activities including the Mayor's Career Job Fair, DC Open Streets, the Mayor's DC Early Education Expo, the Mayor's Civic Learning Day at MLK Library, the DC city-wide Medicaid Renewal Fair at Dorothy Heights Library and the Mayor's Maternal and Infant Health Summit. LCHC Assisters also provided participation at 4 health fairs, 7 events at faith institutions, 3 vaccination pop-up clinics and a barber shop. Resource materials and information were provided at an additional 2 beauty salons and 4 barber shops. We also arranged to have stickers placed on 300 boxes at a pizza shop and over 500 pamphlets were distributed at several restaurants throughout the city.

LCHC's creative outreach efforts provided widespread opportunities to enroll persons in health insurance and educate audiences on the importance of being insured. Importantly, as a faith-based organization, we serve as a trusted community resource where DC residents know they can access health education, resources, and support. We strongly believe that we can transform the community through the power of faith, and we are transforming the health of DC's underserved communities through access to health care.

We commend the leadership and staff of the Health Benefit Exchange in this critical work to help improve the health of individuals and community health throughout the District of Columbia.

Thank you.

Respectfully submitted,

Floyd May
Executive Director
Leadership Councill for Healthy Communities

Testimony of Anne Gunderson, Senior Policy Analyst
At the Committee of the Whole Fiscal Year 2025 Budget Hearing for
the Health Benefits Exchange
April 8, 2024

- Chairperson Henderson, members of the Committee, thank you for the opportunity to testify. My name is Anne Gunderson, and I am a Senior Policy Analyst at the DC Fiscal Policy Institute (DCFPI) and a member of the Under 3 DC Coalition (U3DC).
- Despite being called a budget of "shared sacrifice," Mayor Bowser's proposed fiscal year 2025 budget and financial plan takes an ax to transformative investments in residents who struggle to get by, like the Pay Equity Fund, while prioritizing the wealthiest businesses.
- Eliminating the Pay Equity Fund will decimate the early education sector. Not only does the Mayor's approach undermine her purported "economic comeback" vision, but it also backtracks on DC's commitment to Black and brown educators fueling a sector that all other businesses rely on.
- Over 4,000 early childhood educators, most of whom are long underpaid Black and brown women, have received boosted income since the launch of the Pay Equity Fund, and over 1,000 educators and their families have been covered by HealthCare4ChildCare (HC4CC).
- Health insurance is a critical component of compensation. When the Mayor eliminated the Pay Equity Fund from her budget, she also eliminated HealthCare4ChildCare, which makes free or low-cost health care coverage available to child care workers who live in the District and non-District child care workers whose employers purchase coverage through the DC Health Benefit Exchange (DCHBX).
- The Exchange has been working tirelessly to get 1,470 employees of OSSE-licensed facilities enrolled in HC4CC coverage. Including dependents, this represents a total of 1,811 covered. They have shown commitment to providing the best healthcare options for this program by upgrading plans from Silver level to Gold level, which reduced deductible and out-of-pocket costs for enrollees. This change helped encourage more facilities to enroll.
- Much has been said about the severe salary cuts educators will be faced with if the Pay Equity Fund is eliminated, but losing HealthCare4ChildCare will be just as devasting, especially for those educators who are gaining access to healthcare for the first time through this program.
- If the Council restores funding for the Pay Equity Fund, it is critical that it includes the cost of restoring HealthCare4ChildCare. Excluding health care benefits as part of the compensation program would not only violate the spirit of the Birth-to-Three law, but it could cause some workers to be worse off in the end if their total wage increase fails to outstrip any increased cost in health care coverage that they face due to higher wages. Higher costs could be a result of losing Medicaid eligibility or facing a higher premium through employer-sponsored insurance or through the marketplace.
- Losing funding for the Pay Equity Fund would devastate educators who took DC leaders by your word that this program would provide professional wages and affordable healthcare in the long-term.
- We cannot cut our way to prosperity. DCFPI is asking the Council to restore all funding to the Pay Equity Fund and HealthCare4ChildCare to save the District's early childhood system.
- I appreciate the Councilmembers who have spoken in defense of the Pay Equity Fund since the release of the Mayor's budget. Your support means everything.
- Thank you for the opportunity to testify. I'm happy to take questions.

Mary's Center
Quality healthcare. Stronger communities.

Testimony of Dennis Angel
In person Assister

2333 Ontario Road, NW
Washington, DC 20009

Before the
DC Council Committee on Health

Chairperson, Councilmember Christina Henderson

Monday, April 08, 2024 – 9:30 am
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington DC 20005

Good morning, Chairperson Henderson and Members of the Committee. My name is Dennis Angel, an In-Person Assister at Mary's Center, a Federally Qualified Health Center with multiple locations in the DC metropolitan area. Our team at Mary's Center has two In-Person Assisters who work to implement our Health Benefits Exchange program. Our partnership with the Health Benefits Exchange Authority has been going on for nearly 11 years now. As an In-Person Assister, I have witnessed firsthand the positive impact our team has on DC residents by helping them access health insurance providers through the DC Health Link, which is the Affordable Care Act health insurance marketplace in DC.

Our two In-Person Assisters helped 2,266 DC residents and their families obtain health insurance between January 1 and December 31, 2023. Our enrollment success in 2023 was

Mary's Center
Quality healthcare. Stronger communities.

driven by our commitment to providing culturally specific outreach services and meeting residents where they are. We conducted outreach events in English and Spanish, both in-person and virtually, to educate our community about health insurance benefits and enrollment processes. We are present in the community during evenings and weekends, and we also host indoor and outdoor community events. Our dedication and tenacity to maximize opportunities for uninsured DC residents to enroll in health insurance is a testament to Mary's Center's Health Benefits Exchange program's perseverance to ensure the highest percentage of residents obtain health insurance coverage. The DC residents we serve express their gratitude for providing culturally specific services in their native languages, especially in increasing health insurance literacy and enrolling in qualified health plans.

We're grateful for the incredible partnership and leadership of the DC Health Benefit Exchange. Their unwavering support has ensured that our staff is well-trained and equipped to excel in their roles. With their help, we've been able to identify and organize events that effectively cater to those who are still without insurance. Thank you, DC Health Benefit Exchange, for your invaluable contributions to our cause!

Thank you for the opportunity to testify. I am happy to answer any questions you may have.

TESTIMONY OF SIA BARBARA FERGUSON KAMARA

DC Early Learning Collaborative

AT THE FY 2025 BUDGET OVERSIGHT HEARING

ON THE D.C. Health Benefit Exchange Authority

COMMITTEE ON HEALTH, Chairperson Christina Henders

Good morning, Chairperson Henderson, other Committee members, and staff of the DC Council Committee on Health. I am Sia Barbara Kamara, a long time Ward 4 resident and the Chief Strategy Officer for the DC Early Learning Collaborative, Inc. (DCELC), an early childhood advocacy organization that was instrumental in the passage of the Pre-K Expansion and Enhancement Act of 2008, as well as the Birth to Three for All DC Act of 2018. I am also a member of the DC Association for the Education of Young Children and a member of the executive committee of the Under Three DC Coalition.

I am here to testify in strong support of restoring full funding for the HealthCare4ChildCare Program managed by the DC Health Benefit Exchange (DCHBX). Washington, DC leads the nation in early childhood education on multiple fronts, including the provision of infant/toddler and universal Pre-K programs, pay equity, and now, HealthCare4ChildCare benefits. None of this would have been possible were it not for the vision and leadership of the DC Council, for which we are most appreciative. We are also grateful for your passionate support of our early educators and dedication to restoring the Pay Equity Fund and, through it, the HealthCare4ChildCare program.

The Early Learning Collaborative believes that a healthy early childhood workforce is pivotal to providing quality care for children. A healthy early childhood workforce contributes to the District’s educational improvement initiatives, its workforce development efforts, and the city’s overall economic

vitality. For many early educators, the launch of the HealthCare4ChildCare program represented the *first time* that had access to healthcare benefits. Furthermore, it represented the first time that this workforce, most of which are women of color, were able to gain access to comprehensive health coverage for their children and families.

This program has been a lifeline for a population that everyone agrees is essential but is all too often left behind in our city's economic progress. Healthcare coverage is the difference between catching medical issues early verses facing a late-stage diagnosis, financial security verses possible bankruptcy from medical debt, and the mental security of knowing that, should you or your loved one face a health emergency, you have options and access to care. The impressive growth of the HealthCare4ChildCare program —which more than doubled over the past year— shows that our early educators want and need this benefit, that trust was built and that the District government values their wellness and health. Now is the time to show them that their trust was not misplaced. That, even during a difficult budget year, the District prioritizes early childhood educators and will continue to invest in stability for young children.

HealthCare4ChildCare is a groundbreaking national model in how to strategically provide health benefits to the childcare workforce. We applaud Mila Kofman, executive director, and the entire DC Health Benefit Exchange team for their outstanding work to bring this long overdue benefit to early childhood educators. They are a sterling example of how public servants, collaborating with key partners, can unpack free and low-cost healthcare benefits for thousands of childcare professionals in Washington, DC. I thank you for working to fully restore this program and the entirety of the Pay Equity Fund.

Julie Lujan- Lanier Lullabies CDC & Julie Lujan's CDH

Testimony of Julie Lujan

Owner of Lanier Lullabies CDC and Julie Lujan's CDH

Council of the District of Columbia Committee on Health

Monday, April 8, 2024

Greetings, Committee Chairman Henderson and members of the Committee,

Thank you for allowing me to speak today. My name is Julie Lujan. I am the owner of 2 childcare facilities in ward 1, Julie Lujan's Child Development Home and Lanier Lullabies Child Development Center. I am also a mother of 4 who lives in Adams Morgan. Since 2007 I have provided care for over 260 children and jobs for 51 employees, some of whom I have employed for over 10 years. I am writing today to encourage you to HealthCare4ChildCare and the Pay Equity Fund. I have experienced the power of this program on the well-being of the teachers, their families, my early learning programs and me personally.

I have always been a small business owner and been faced with the crippling expense of finding individual health insurance. Believe me, with the Affordable Care Act, the opportunity of just having an option to purchase health insurance for my own family was monumental. Just knowing I could purchase insurance regardless of enormous costs was a huge relief. I paid around $3000 month for health insurance for my family for decades. Like many people, my family is faced with multiple health issues that could easily bankrupt us with a single unexpected medical bill. But, we all know that the health insurance system in the US is broken. But Healthcare4childcare was a step towards fixing the broken system and thinking outside of the box.

When I first opened my home daycare, I didn't realize that my role would not only be transformative to the children and families I cared for but also the lives and growth of the early childhood professionals that worked with me. Please understand that I said they worked with me, not for me. Over the last 17 years we have worked together as equals at my facilities, no job more important than another. We have supported each other and I have worked hard to create a work environment where everyone feels valued, has a sense of stability, flexibility and that their opinions and insight are important to me and the families we serve. We had made sacrifices for each other, worked extra hard when one of us needed time off to tend to our families or own personal health issues and closed for business to participate in protests and rallies concerning immigration and women's rights. We rose to the challenge of providing care during the pandemic, pushing past our own fears for ourselves and our families, fueled with the energy and recognition we were receiving because of our crucial role of the economy. We did all of that without the stability of our own health insurance.

When I heard the first whisper of the chance childcare providers would be offered health insurance, I thought for sure it was too good to be true. Could there really be a program that offers free health insurance premiums to residents working in licensed child development centers and homes? The significance of this cannot be overstated. Imagine being a dedicated early childhood professional, passionate about nurturing and educating young minds but constantly burdened by the fear of unaffordable healthcare. Before HealthCare4ChildCare, most of us in the early care and education workforce faced this very struggle. We were forced to make difficult choices, often sacrificing their own well-being and that of their families in order to make ends meet. It is an exhausting way to live. But with the introduction of HealthCare4ChildCare, a support system was created for us. But with HC4CC it alleviated the financial burden that once hindered our ability to seek necessary medical care in a timely manner. This newfound security and peace of mind have profoundly impacted the overall well-being of the early care workforce. I have seen and felt it in my facilities. I have seen my coworkers more relaxed and able to focus more on the task of caring and supporting the growth of babies and young children.

I encourage you to consider the profound impact of HealthCare4ChildCare on the early care and education workforce. By providing affordable health insurance, you are supporting the physical and mental well-being of our dedicated professionals and improve the quality of care provided to our children. Help us move forward, not backwards.

Thank you for your attention to this matter and your dedication to the well-being of the young children and those who serve them daily.

Kindly,

Julie Lujan

Testimony of Emma Mehrabi

Parent Member, Under 3 DC Coalition

Council of the District of Columbia Committee on Health

Monday, April 8, 2024

Greetings, Committee Chairman Henderson and members of the Committee,

Thank you for allowing me to speak today. My name is Emma Mehrabi. I live in Ward 5.and I am the proud parent of a child enrolled in Petit Scholars. My son, who is 22 months old and name is Ameen, has been enrolled since October 2023. I am here today to express my strong opposition to Mayor Bowser's proposed elimination of the Pay Equity Fund and Health4Childcare programs.

The mayor's proposed budget completely eliminates the Pay Equity Fund, which will cause serious harm to early educators, most of whom are Black and brown women. By permanently cutting pay and health benefits for more than 4,000 educators, the mayor will be single-handedly responsible for educators fleeing early education for higher paying jobs. Early educators may see their pay reduced by tens of thousands of dollars, returning many of their incomes to just a few dollars above the minimum wage.

I love that Petit Scholars provides my child with bonds with our early educators, the care, level of trust, and valuable educational enrichment programs cannot be understated. If any of these early educators were to leave because of these proposed, devastating cuts, not only would that sacred, trusted bond be broken between child and educator, but it would also mean a drain on the very fabric of our system. I love how gentle and caring they are with my son, and the montessori type of education is truly unparalleled. They speak Spanish, provide healthy, nutritious food, and do so many activities that I truly cannot understand how they do it all so well!

This cut deliberately breaks promises that the Mayor and DC Council made to early educators.

A healthy early education workforce, spending less for healthcare and being able to access high-quality care quickly, has transformed countless lives at programs that participate in the Healthcare4Childcare program.

Healthcare4Childcare is also funded through the Pay Equity Fund, so the Mayor's proposed elimination of the Pay Equity Fund is not just an attempt to steal early educators' pay, it is an attempt to take away their healthcare coverage. This is unacceptable and must be fully reversed. Thank you for your time.

GREATER WASHINGTON HISPANIC CHAMBER OF COMMERCE

COUNCIL OF THE DISTRICT OF COLUMBIA
Committee on Health

FY2025 Budget Oversight Hearing
Monday, April 8, 2024
9:00 am

Location
Virtual Meeting Platform

Good morning Committee Chairperson, Christine Henderson and members of the DC Council in Health. My name is Nicole Quiroga*, President and CEO of the Greater Washington Hispanic Chamber of Commerce* and I am here today to testify on behalf of DC Health Benefit Exchange Authority (DCHBX), the agency that manages and operates the award-winning ACA online health insurance marketplace, DC Health Link.

I am honored to offer my testimony regarding the invaluable partnership between the Greater Washington Hispanic Chamber of Commerce (GWHCC) and DC Health Benefit Exchange Authority. Since 2013, this collaboration has been instrumental in expanding health insurance enrollment services to individuals, families, small businesses and their employees in the District of Columbia.

Through a range of initiatives and partnerships with community-based organizations, federal and local government entities, GWHCC has extended the reach of DC Health Link's services within the Hispanic community and other communities of color in the District.

The Greater Washington Hispanic Chamber of Commerce (GWHCC) has been actively engaged in promoting access to quality, affordable health insurance through various initiatives and partnerships with DC Health Link:

- One Touch Enrollments Events: GWHCC collaborates with DC Health Link to hosts events facilitating enrollment in health insurance for DC residents, including those eligible for Medicaid, Alliance, and Cover-ALL DC. These events, conducted virtually and in-person have successfully enrolled 243 individuals and families in health plans.

- Hispanic Enrollment Week of Action: GWHCC participates in and supports the planning of an intensive week of hyper-local creative outreach and enrollment activities.

- Outreach to Small Business Owners: This year, GWHCC conducted 45 online informative sessions reaching approximately 2,250 small business owners to educate them about the benefits of health insurance through DC Health Link.

- Networking and Educational Events: Though online and in-person networking events, educational sessions, co-sponsored events, and the Annual Business Expo, GWHCC disseminates information and promotes health insurance awareness among resident and business owners.

- Communication efforts: GWHCC sent 20,473 emails, e-blast, and newsletters with DCHL information.

- POWERUP DC Small Business Summit: GWHCC collaborates with DC Health Link and other partners to host the annual POWERUP DC Small Business Summit, providing small businesses with resources, networking opportunities and insights into business trends and contracting opportunities.

DC Health Link emphasizes the importance of creative marketing strategies, bilingual staff, and easy enrollment process to support the Affordable Care Act's implementation and sustainability in the District of Columbia.

In conclusion, GWHCC supports the DC Health Benefit Exchange Authority and its FY 25 budget. We urge this Committee to do the same. We pledge to continue working alongside DC Health Link to ensure residents, families, small business owners, and their employees have access to high-quality, affordable health insurance.

Thank you for the opportunity to testify and stand ready to answer any questions you may have.

Nicole Quiroga
President and CEO
Greater Washington Hispanic Chamber of Commerce

Fiscal Year 2025 Budget Oversight Hearing on the Not-for-Profit Hospital Corporation (UMC)

Before the
Committee on Health
Council of the District of Columbia

The Honorable Christina Henderson, Chairman

April 8, 2024, 9:00 am.

Testimony of
Angell Jacobs
Chair, Fiscal Management Board
Not-for-Profit Hospital Corporation and
Deputy Chief Financial Officer and Chief of Staff
Office of the Chief Financial Officer

Glen Lee
Chief Financial Officer
Government of the District of Columbia

Good morning, Chairperson Henderson and members of the Committee on Health. I am Angell Jacobs, Chair of the Fiscal Management Board (Board) for the Not-for-Profit Hospital Corporation, commonly known as United Medical Center or UMC. I am pleased to appear before you today with CEO Dr. Jacqueline Payne-Borden and CFO Lilian Chukwuma to discuss the Fiscal Year (FY) 2025 budget of UMC.

During FY 2025, we will continue our mission of providing quality medical care to residents, while prudently and appropriately managing our resources. As indicated in my testimony during the performance oversight hearing, UMC experienced a significant reduction in DSH of $8 million in FY 2023. We will continue to closely monitor the impact of DSH on the FY 2024 and FY 2025 budgets, and if necessary, take appropriate action to remain in balance.

In December of 2021, the construction process for the new Cedar Hill Regional Medical Center began. Since that time, the hospital construction team has successfully reached all key project milestones to date. By December of this year, the work on the construction of the hospital will be largely complete. Subsequently, hospital staff at the new facility will spend the first quarter of 2025 executing the required activities to prepare for the hospital's first patients by March 2025.

As a result, FY 2025 will be the last year of operations for UMC. Our focus will be on ensuring the safe transition of patients to the new hospital as well as the complete and effective closure of UMC operations and facilities. To support the closure effort, UMC will onboard a project manager, experienced in hospital decommissioning, in the coming weeks. With these factors in mind, our FY 2025 budget request represents the resources required to accomplish the tasks outlined here.

I would now like to turn to our CEO, Dr. Jacqueline Payne-Borden, who will provide testimony on the FY 2025 budget, after which, the panel would be pleased to answer questions that you or the Committee may have.

PUBLIC OVERSIGHT HEARING ON
FY 2025 BUDGET
of the
THE NOT-FOR-PROFIT HOSPITAL CORPORATION

Testimony of Jacqueline Payne-Borden
Chief Executive Officer/Chief Nursing Officer
Not-for-Profit Hospital Corporation

Before the
Committee on Health
Council of the District of Columbia

The Honorable Christina Henderson, Chairperson

April 8, 2024, 9:00 a.m.
The John Wilson Building

Good morning, Chairperson Henderson, Councilmembers of the Committee on Health, and Council staff. My name is Jacqueline Payne-Borden and I have the privilege of serving as the Chief Executive Officer of the Not-For-Profit Hospital Corporation, commonly known as United Medical Center (UMC). I am joined at today's hearing by our CFO, Lilian Chukwuma.

I would like to thank you as always, Chair Henderson, for your dedication and support of the hospital and community. I also want to thank the Council and Fiscal Management Board as they continue to support UMC in sustaining the goal of providing safe and effective care to our deserving patients while upholding or exceeding standards of care. This goal will be maintained until the Cedar Hill Regional Medical Center is ready to receive patients.

Over the past 14 years, the District has provided millions of dollars in operating subsidies to the Not-For-Profit Hospital Corporation (NFPHC) for the ongoing support of the mission to provide affordable high quality health care for the residents of Wards 7 and 8. In FY2024 and FY2023, the District provided subsidies of $15 million and $22 million respectively to support the NFPHC and sustain the only hospital East of the Anacostia River. For Fiscal Year 2025, the District has committed $25.2 million subsidy to support the hospital until the proposed closure date by the second quarter of FY2025.

The FY 2025 Budget reflects total operating revenues of $68.7 million which includes the $25.2 million in District subsidy, and expenses of $68.5 million with an operating margin of $200 thousand. In addition to the FY25 budget, the UMC leadership team will continue to operate and manage FY24 funds within the parameters of our budget, being strategic in managing costs. Our

leadership team continues with reviewing contractual services to determine necessity, make adjustments or eliminate contracts as appropriate, as we transition towards closure.

As in FY24, there is no new capital budget for FY25. The hospital will rely on the balance of previous years' capital funding on hand to address any capital needs. Most of UMC's facility expenses will involve capitol-eligible repair and maintenance projects that will inevitably occur throughout the year. These repairs and routine maintenance deemed essential will be accomplished to mitigate the risk of potential high-cost emergency repairs. With the closure of UMC approximately a year away, we are being very careful to only spend capital funds on systems required to ensure that the hospital operations remain safe. I believe these funds will be sufficient to keep UMC up to code through closure barring any unpredictable issues.

Chair Henderson, our most important task over the next several months is the efficient, and dignified closure of this Ward 8 landmark healthcare facility that has served the community for approximately 58 years. We are close to hiring a consultant to assist with this task. Our goal is to have the consultant on board by sometime next month. A critical activity pertaining to the closure of UMC, is providing formal and regular communication primarily to our staff, as well as external stakeholders. An initial formal communication will be forthcoming. As we posture towards permanent closure, there will be ongoing analysis of operations and services to ensure we maintain accreditation and licensing standards. We are cognizant of the potential for increased staff attrition over the next 12 months; as such, we have engaged with supplemental agencies, both clinical and non-clinical, to meet any staffing challenges. In addition, we are cross-training employees to cover multiple roles as is feasible to promote flexibility, especially in the non-clinical areas. Leaders continue to encourage eligible staff via varied communication

methods to participate in the Voluntary Training Program facilitated by George Washington University Hospital/UHS in collaboration with the Department of Health Care Finance and UMC. Completion of this primarily online, self-paced, program will be a great benefit to staff should they apply for a position at Cedar Hill Regional Medical Center.

Conclusion

In closing, our leadership team is aware of the many potential challenges we might face during UMC's final year of operation. It is our intent Chair Henderson, to keep you and the Committee on Health fully informed of any relevant positives or challenges. We will remain accountable to the UMC Fiscal Management Board, Mayor, Council, hospital employees and patients. Our staff remains committed to upholding the mission and vision of the hospital by being an "efficient patient-focused, provider of high quality healthcare the community needs." This will be accomplished while keeping our budget balanced for FY24 and FY25.

In anticipation that this is our final Budget Oversight Hearing, on behalf of the hospital and patients, I extend our appreciation to all Mayors, Council Members and UMC Board members for the support and dedication to the only public hospital in Washington DC and the only hospital east of the Anacostia River.

I cannot appreciate our resilient and dedicated staff enough for all they do, also our patients, and the community for trusting UMC to run UMC. This concludes my testimony. My team and I welcome any questions you and your colleagues may have.

UMC

UNITED

MEDICAL CENTER

Budget for Fiscal Year 2025

Not-for-Profit Hospital Corporation

United Medical Center
Fiscal Year 2025
Contents

Introduction

Over the past 14 years, the District has provided millions of dollars in operating subsidies to the Not-for-Profit Hospital Corporation (NFPHC) for the ongoing support of the mission to provide affordable health care for the constituents of wards 7 and 8. In FY 2024 and FY 2023, the District provided subsidies of $15 million and $22 million respectively to support the NFPHC and sustain the only hospital East of the Anacostia River. The hospital has a proposed closure date by the second quarter of FY2025.

Executive Summary

The FY 2025 Budget presents patient activities for the period of October 1, 2024 through March 31, 2025 and other related activities through September 30, 2025 based on FY2024 reforecast information. The FY 2025 Budget reflects total operating revenues of $68.7 million which includes $25.2 million in District subsidy and expenses of $68.5 million with an operating margin of $200 thousand.

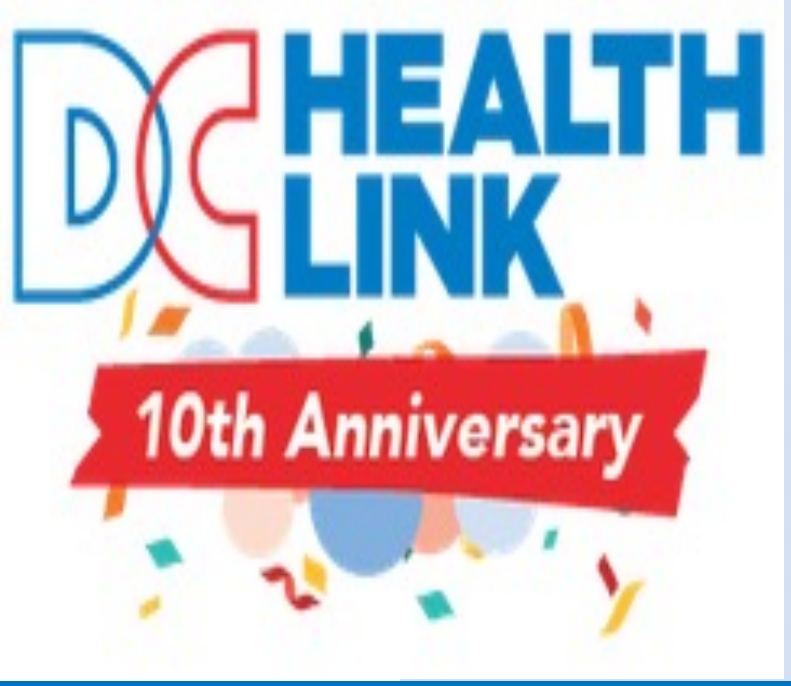
Operating Budget

Dollars in (000's)	FY 2025 Budget	FY 2024 Reforecast	FY 2023 Actuals
Operating Summary			
Total Revenues	$ 68,669	$ 102,756	$ 116,519
Total Expenses	68,469	101,514	114,913
Net Income / Loss	**$ 200**	**$ 1,242**	**$ 1,606**
Key Statistics			
Total Admissions	1,507	3,014	3,609
Average Daily Census	56	56	66
ED Visits	15,972	31,944	35,261
Other Outpatient Visits	4,334	8,668	22,293
Surgeries *	201	805	1,366

* FY2025 data is for Inpatient only.

Capital Budget

There is no Capital budget for FY 2025. The hospital will rely on the balance of previous years' capital funding on hand to address any capital needs before closure.



DC Health Benefit Exchange Authority

Mila Kofman, J.D., Executive Director

HBX Proposed Budget FY25

Budget Oversight Hearing

DC Council Committee on Health

Chairperson Councilmember Henderson

April 08, 2024

- ✓ Background
- ✓ Successes
- ✓ Proposed Budget

DC Health Link: 10 Years of Success

- HBX is responsible for DC Health Link – DC's Affordable Care Act online health insurance marketplace
- Last state to start IT build, **1 of 4 state marketplaces opened for business on time** (& stayed open) Oct 1, 2013
- **Funded** through assessment on health carriers

DC Health Link: 10 Years of Success

NEAR UNIVERSAL COVERAGE: nearly **97%** of DC residents covered

- ✓ Cut uninsured rate by half since DC Health Link opened for business
- ✓ DC ranks **#2** in U.S. for lowest uninsured

- ➢ **Cover 100,000 people** (private health insurance);
- ➢ **Cover 5,200+** District small businesses and non-profits
- ➢ **Have 900+** DC Health Link brokers providing free help to customers
- ➢ **Responsible for $670+ million** in annual premiums
- ➢ **Advocate for lowest possible premiums** and have helped residents, employers and their workers save millions of dollars in premiums

Health insurance with all ACA protections and equity-based benefit design

- **All ACA consumer protections**
- **Affordable coverage: More residents qualify for lower monthly premiums** because of Inflation Reduction Act. **Premiums as low as $13/month** for quality health insurance through DC Health Link.

  ✓HBX is working closely with other state-based marketplaces, federal partners, consumer and patient advocates, and others to advocate for Congress to make lower premiums permanent.
- **Standard Plans: Access to essential care** like primary care, specialists, mental and behavioral health, urgent care and generic Rx **without deductibles**.

Addressing Health Disparities Through Equity-Based Benefit Design In Standard Plans

DC Health Link changed its benefit design to **equity-based benefit design** removing financial barriers to care focusing on conditions which disproportionally impact communities of color in DC, e.g., heart disease is a leading cause of death for Black residents.

- ✓ **2023 plan year: No cost sharing for Type 2 Diabetes outpatient care and services.** No deductibles, no co-insurance, no copays for physician visits, lab work, eye exams and foot exams, supplies and insulin/Rx.
- ✓ **2024 plan year: Reduced to $5 cost sharing for outpatient pediatric mental and behavioral health care and services** including office visits with specialists, certain lab work and medication (e.g. reduced $45 copay to $5 copay). No limit on number of visits.
- ✓ **2025 plan year: No cost sharing for outpatient cardiovascular and cerebrovascular services including** office visits with family medicine or internal medicine doctor, generic Rx, laboratory tests and imaging services including CT scans and electrocardiograms.

A HISTORY OF SUCCESSFUL IMPLEMENTATION OF LOCAL AFFORDABILITY PROGRAMS

- ✓ Mayor Bowser's COVID relief for District employers and residents with health insurance premiums in arrears helped employers and residents maintain their health insurance during COVID ($18 million in premium relief)
- ✓ HealthCare4ChildCare providing free and lower cost health insurance for early child development facilities and workers.

SUCCESSFUL IMPLEMENTATION OF LOCAL AFFORDABILITY PROGRAMS: HealthCare4ChildCare

Small Group Enrollment

- **Licensed facilities doubled** from 94 to **198**
- **Employers more than doubled** from 61 to **141**
- **Employees doubled** from 516 to **1,096**
- **Employees and their dependents more than doubled** from 594 to **1,258**

Individual Marketplace Enrollment

- **Residents more than quadrupled** from 41 to **226**
- **Residents and their dependents more than quadrupled** from 62 to **361**

HealthCare4ChildCare covers 1,619 people*

**As of 3/26/24; growth from 1/2023 to 4/2024*

HBX PROPOSED BUDGET FY25

- PROCESS: Staff, Board Finance Committee, Standing Advisory Board (diverse stakeholders) & HBX Executive Board
- Organized to Reflect Function Areas
- Efficiency: Leverage DC gov't agencies; phase-out consultants and transition to FTEs, and reduce operational costs through partnership with the Massachusetts Health Connector
  - **$1,666,704 savings with MA partnership**
- FY25 PROPOSED BUDGET **$41,752,784:**
  - Funding $38,903,624 from health carrier assessments, $1,349,160 from MA, and $1,500,000 from investment income.
- Funded through an assessment on health carriers (projected assessment **0.825%** same as FY24).

ANNUAL ASSESSMENT ON HEALTH CARRIERS

Projected assessment for FY25 and historical actual assessment rates

To fund (FY)	Assessment Rate
FY25	**0.825%**
FY24	0.825%
FY23	0.800%
FY22	0.825%
FY19, FY20, FY21	0.900%
FY15, FY16, FY17, FY18	1.000%

BUDGET COMPARISON: FY24 & FY25

	FY24 APPROVED BUDGET	FY25 PROPOSED BUDGET	$ CHANGE	% CHANGE
AGENCY MANAGEMENT OPERATIONS	$6,365,078	$6,638,858	$273,781	4.12%
CONSUMER EDUCATION AND OUTREACH	$3,363,705	$3,366,786	$3,081	0.09%
PARTNERSHIPS AND MARKETPLACE OPERATIONS*	$13,768,917	$16,681,589	$2,912,672 *($2,249,770 call center costs increase)*	17.46%
HEALTH COVERAGE AND INNOVATION*				
IT (DCHealthLink.com)	$13,225,400	$14,285,511	$1,060,111	7.42%
AGENCY FINANCIAL OPERATIONS	$829,048	$780,040	($49,008)	-6.28%
TOTAL BUDGET	**$37,552,148**	**$41,752,784**	**$4,200,637**	**10.06%**

***FY24 PARTNERSHIPS AND MARKETPLACE OPERATIONS TOGETHER WITH HEALTH COVERAGE AND INNOVATION WERE IN MARKETPLACE INNOVATION, POLICY, AND OPERATIONS. FY25 APPROACH PROVIDES MORE TRANSPARENCY.**

BUDGET RECONCILIATION TO ASSESSMENT BUDGET

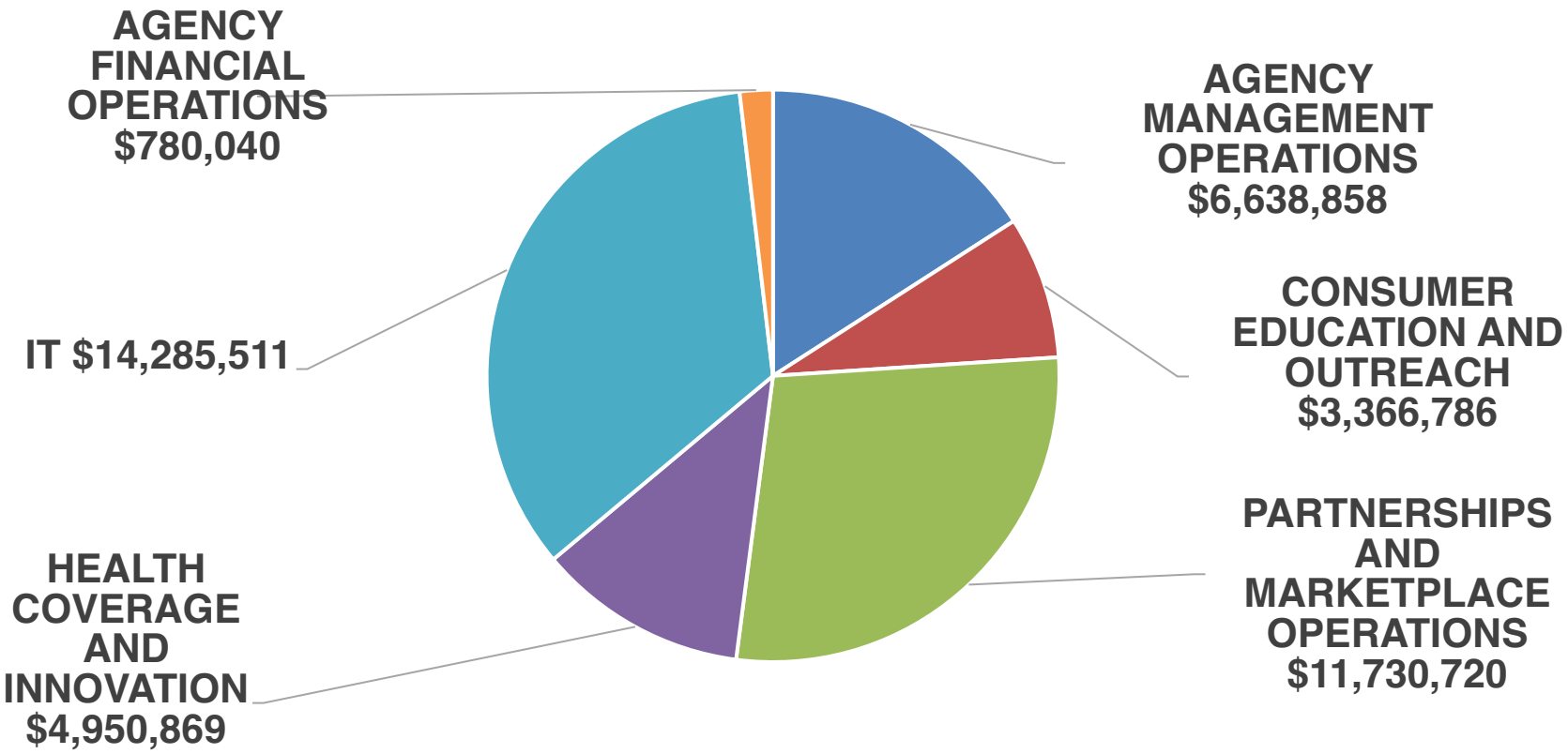
FY25 Proposed Budget	**$41,752,784**
Less:	
6.0 FTEs Budgeted for MA Health Connector	(811,260)
Admin Fees Budgeted for MA Health Connector	(260,300)
Contact Center Costs Budgeted for MA Health Connector	(165,600)
Mailing and Postage Fees Budgeted for MA Health Connector	(40,000)
Cloud Security for MA Health Connector	(72,000)
FY23 Investment and Interest Earnings	(1,000,000)
FY24 Estimated Investment and Interest Earnings	(500,000)
Net FY25 Budget for Assessment Calculation	**$38,903,624**

FY25 REDUCTION IN HBX OPERATING COSTS THROUGH MA HEALTH CONNECTOR PARTNERSHIP

Category	FY25 Budget
Personnel – 6.0 FTEs	811,260
Admin Fees	260,300
Premium Aggregation*	317,544
Contact Center Fees	165,600
Mailing and Postage	40,000
Cloud Security	72,000
Total	**$1,666,704**

* SAVINGS ALREADY REFLECTED IN FY25 PROPOSED BUDGET

PROPOSED FY25 BUDGET BY PROGRAM



FY25 BUDGET FOR ASSESSMENT: $38,903,625

PARTNERSHIPS AND MARKETPLACE OPERATIONS (PMO)

PROPOSED FY25 BUDGET: $11,730,720

FY25 PERSONNEL SERVICES BUDGET FOR 35.8 FTEs: $4,677,498

NON-PERSONNEL SERVICES (NPS): $7,053,222:

- CONTACT CENTER: $5,233,209 (cost allocated share only)
- PLAN MANAGEMENT: $726,750 (cost allocated share only)
- S.H.O.P.: $924,622
- PERFORMANCE AND STRATEGIC MANAGEMENT: $168,641 (cost allocated share only)

HEALTH COVERAGE AND INNOVATION (HCI)

PROPOSED FY25 BUDGET: $4,950,869

FY25 PERSONNEL SERVICES BUDGET FOR 24.45 FTEs: $3,406,351

NON-PERSONNEL SERVICES (NPS): $1,544,518:

- CONTACT CENTER: $923,508 (cost allocated share only)
- PLAN MANAGEMENT: $128,250 (cost allocated share only)
- ELIGIBILITY AND ENROLLMENT: $463,000
- PERFORMANCE AND STRATEGIC MANAGEMENT: $29,760 (cost allocated share only)

CONTACT CENTER
(TOTAL COST BELOW IS 85% PMO AND 15% HCI)

PROPOSED NPS FY25 BUDGET: $6,156,717
(FY24 BUDGET: $3,906,947)

- CONTACT CENTER SERVICE CONTRACT: $5,562,737 (FY24 $3,504,726)
- SALESFORCE LICENSES : $210,600 (FY24 $173,021)
- SALESFORCE DEVELOPMENT AND MAINTENANCE: $124,800
- MICROSOFT OFFICE 365 LICENSES: $18,000
- AMAZON CONNECT (TELEPHONY): $98,280 (FY24 $84,000)
- TOLL FREE LINE: $35,700
- ADMIN (COURIER SERVICE, EQUIPMENT, COMPUTER REFRESH, SUPPLIES): $52,000
- LANGUAGE LINE: $54,600

PLAN MANAGEMENT
(TOTAL COST BELOW IS 85% PMO AND 15% HCI)

PROPOSED NPS FY25 BUDGET: $855,000
(FY24 BUDGET: $831,600)

- ACTUARIAL SERVICES: $175,000
- DOCTOR DIRECTORY, HEALTH PLAN MATCH, PRESCRIPTION DRUG FORMULARY LOOKUP TOOL, DENTAL PLAN MATCH: $680,000 (FY24 $656,600)

PERFORMANCE AND STRATEGIC MANAGEMENT
(TOTAL COST BELOW IS 85% PMO AND 15% HCI)

PROPOSED NPS FY25 BUDGET: $198,400
(FY24 BUDGET: $190,594)

- INTERNAL SURVEY SOFTWARE: $500
- BROKER TRAINING: $25,000
- EMMA EMAIL TOOL: $37,900
- ADMIN (POSTAGE, TRAINING, SUPPLIES AND EQUIPMENT): $135,000

PARTNERSHIPS AND MARKETPLACE OPERATIONS (PMO): SMALL BUSINESS MARKETPLACE (S.H.O.P.)

PROPOSED NPS FY25 BUDGET: $924,622
(FY24 BUDGET: $899,822)

- PREMIUM AGGREGATION: $504,822*
- CONSULTING SERVICES: $250,000
- MAILING AND POSTAGE: $124,800**
- TRANSLATION: $25,000
- RETURNED MAIL SERVICE: $20,000

**REFLECTS SAVINGS OF $317,544 FROM MA HEALTH CONNECTOR PARTNERSHIP*
***INCLUDES $40,000 TO BE REIMBURSED BY THE MA HEALTH CONNECTOR*

HEALTH COVERAGE AND INNOVATION (HCI): ELIGIBILITY AND ENROLLMENT

PROPOSED NPS FY25 BUDGET: $463,000
(FY24 BUDGET: $463,000)

- MOA WITH OFFICE OF ADMINISTRATIVE HEARINGS FOR ELIGIBILITY APPEALS: $6,000
- NOTICE PRINTING/MAILING: $180,000
- AMHARIC/SPANISH TRANSLATION OF NOTICES: $27,000
- CONSULTING SERVICES: $250,000

CONSUMER EDUCATION AND OUTREACH

PROPOSED FY25 BUDGET: $3,366,786
(FY24 BUDGET $3,363,705)

- PERSONNEL SERVICES FOR 7 FTEs: $1,101,937
- NON-PERSONNEL SERVICES: $2,264,849 (same as FY24)
  - OUTREACH AND ENROLLMENT (DCCC, GWHCC, RAMW) AND NAVIGATORS/ASSISTERS: $1,050,000
  - OUTREACH AND MARKETING: $1,092,050
  - HEALTH INSURANCE LITERACY: $90,000
  - DATA RESOURCES: $25,000
  - ADMIN (OFFICE SUPPLIES, COMPUTER REFRESH): $7,799

IT (DCHealthLink.com)

PROPOSED FY25 BUDGET: $14,285,511
(FY24 BUDGET: $13,225,400)

- PERSONNEL SERVICES FOR 36.5 FTEs: $6,075,092
- NON-PERSONNEL SERVICES BUDGET: $8,210,419 (FY24 BUDGET $7,491,537)
    - IT CONSULTANTS: $5,661,789
    - SOFTWARE: $1,744,372
    - EXTRA CARE: $535,500 (additional resources post-deployments for quicker ticket resolution)
    - MICROSOFT OFFICE 365 LICENSES: $45,000
    - OCTO: $125,910
    - ADMIN (OFFICE SUPPLIES, TRAINING, PROFESSIONAL SERVICE, COMPUTER REFRESH): $97,848

AGENCY MANAGEMENT PROGRAM (AMP)

PROPOSED FY25 BUDGET: $6,638,858
(FY24 BUDGET $6,365,078)

- PERSONNEL SERVICES FOR 21.25 FTEs: $4,328,376
- NON-PERSONNEL SERVICES BUDGET: $2,310,483
  - FIXED COST (INCLUDES RENT & TELEPHONE): $1,672,160
  - MOA WITH DCHR FOR HR SUPPORT SERVICES & SUITABILITY STUDIES: $110,725
  - MOA WITH DCHR FOR CAPITAL CITY FELLOWS: $80,198
  - MOA WITH DISB FOR ASSESSMENT SERVICES: $50,000
  - MOA WITH CONTRACT APPEALS BOARD: $5,000
  - MOA WITH DSLBD: $700
  - LEGAL EXPENSES (CONSULTANTS, WESTLAW, ETC): $44,650
  - EMPLOYEE TRAINING (INCLUDING SOCIAL JUSTICE INITIATIVE TRAINING): $150,000
  - MEMBERSHIPS & SUBSCRIPTIONS (INCLUDING NASHP): $32,000
  - CONSULTING SERVICES: $20,000
  - ADMIN (COMPUTER REFRESH, EQUIPMENT, TRAVEL, OFFICE SUPPLIES): $145,049

AGENCY FINANCIAL OPERATIONS (AFO)

PROPOSED FY25 BUDGET: $780,040
(FY24 BUDGET: $829,048)

- PERSONNEL SERVICES FOR 3 FTEs: $614,507
- NON-PERSONNEL SERVICES: $165,533
  - AUDITING SERVICES (INCLUDING ANNUAL COMPREHENSIVE FINANCIAL REPORT AND SMART AUDIT): $150,000
  - EMPLOYEE TRAINING AND TRAVEL: $7,000
  - ADMIN (COMPUTER REFRESH, SUPPLIES): $8,533

HBX Awards and Recognition

✓**Won 2019 Sustainability and Equity Award:** Amazon Web Services (AWS) City on a Cloud international competition

✓**Featured in the Fall 2019 AWS City on a Cloud International Announcement For Applications:** https://aws.amazon.com/stateandlocal/cityonacloud/

✓**Won 2018 & 2016 Best Practices in Innovation:** Amazon Web Services (AWS) City on a Cloud international competition

✓**Ranked #1 for consumer decision support tools (ranking of State-Based Marketplaces and Federal Exchange 2018 and 2017)**

✓**Five PR News Awards in 2019 and 2018**

✓**2017 AWS IT case study on cloud solutions:** https://aws.amazon.com/solutions/case-studies/DC-HBX/

✓**First in the nation SBM partnership:** Selected by the Massachusetts Health Connector to provide IT solution and on-going operations support for the MA SHOP (Feb 2017)

DC HEALTH LINK
10th Anniversary

greaterwashington
hispanic chamber of commerce

RAMW
RESTAURANT ASSOCIATION
METROPOLITAN WASHINGTON

DC Chamber of Commerce
DELIVERING THE CAPITAL

NABIP
Shaping the *future* of healthcare

ATTACHMENT
I

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH

ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Department of Behavioral Health

And

DC Health

ON

Wednesday April 10, 2024, 9:30 A.M.
Hybrid in Room 500 and Virtual via Zoom
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Department of Behavioral Health

In-Person

1. Anne Amber Rieke, Children's Law Center
2. Kerry Savage, Senior Director of Policy and Advocacy, PAVE
3. Jaclyn Verner, Supervising Attorney, Disability Rights DC at University Legal Services
4. Kristin Ewing, Policy Counsel, DC Appleseed Center for Law and Justice
5. Leonard Stevens, Public Witness

6. Ann Chauvin, Executive Director, Woodley House
7. Rachel White, Senior Youth Policy Analyst, DC Action
8. David Freeman, PsyD, Senior Director, Community Connections
9. Marie Morilus-Black, CEO, MBI Health Services LLC
10. Johnny Bailey, Hot Spot Manager, HIPS
11. Brianne Dornbush, Executive Director, District Bridges
12. Patrick Canavan, Capital Integrated Care, LLC
13. Dario Martinez, Director of Community Navigation, District Bridges
14. Fredericka Ford, Public Witness
15. Jamese Johnson, Youth, DC Doors
16. Lanai Buskey, Youth, DC Doors
17. Amaya Cook, Youth, DC Doors
18. Rob Hofmann, State Policy Manager, American Atheists

Virtual

19. Mark Robinson, FMCS, Inc.
20. Nicole Travers, Senior Director of School Support & Program Data, DC Charter School Alliance
21. Hilary K., Public Witness
22. Tifphane Riley, Deputy Director, Wanda Alston Foundation
23. June Crenshaw, Executive Director, Wanda Alston Foundation
24. Dominique Moore, PAVE
25. Quiana Lamons, PAVE
26. Simone Scott, PAVE

27. Andrea Jones, PAVE

28. Katrice Fuller, PAVE

29. Mark LeVota, Executive Director, District of Columbia Behavioral Health Association

30. Shane Sullivan, Harm Reduction Coordinator, HIPS

31. Laura Mainzinger School-Based Mental Health Therapist, Latin American Youth Center

32. Gregory Anthony Dear Jr, Public Witness

33. Patricia Quinn, Vice President, DC Primary Care Association

34. Jamila White, Public Witness

35. Elizabeth Mohler, Social Services Department, Latin American Youth Center

36. Sarah Goldman, Public Witness

37. Andrew Robie, MD, Chief Medical Information Officer and Vice President of Population Health, Unity Health Care, Inc.

38. Philip Carpenter, Public Witness

39. Seojin Kim, Public Witness

40. Carmen Brito, Public Witness

41. Christy Respress, President & CEO, Pathways to Housing DC

42. Will Doyle, Vice President of Housing First, Pathways to Housing DC

43. Shannon Walsh, Clinical Director, Pathways to Housing DC

44. Joel Cohen, Psychiatrist, Pathways to Housing DC

45. Nyla Anderson, Youth Advocate, Young Women's Project

46. Nadia Gold-Moritz, Executive Director, Young Women's Project

47. Denzel McKinley Ibilunle, Youth Advocate, Young Women's Project

48. Michael Massey, Public Witness

49. Betty Gentle, Senior Advocacy and Community Engagement Specialist, SOME, Inc.

50. Dr. David Freeman, PsyD

51. Ayominde Miller-Aganyemi, Youth Advocate, Young Women's Project

52. Morgan Smith-Davis, Youth Advocate, Young Women's Project

53. Tyesha Andrews, PAVE

54. Sharnetta Boone-Ruffin, PAVE

55. Takia Shire, PAVE Parent Leader

56. Katrice Fuller, PAVE

57. Karla Reid-Witt, PAVE

58. Sarah Venable, SPACEs In Action

59. Carolyn Babendreier, Public Witness

60. Judy Ashburn, Program Director, Samaritan Inns

DC Health *(12 noon or immediately following the DBH budget hearing)*

In-Person

61. Mary Katherine West, Program Manager for Early Childhood, DC Action

62. Leah Castelaz, Policy Attorney, Children's Law Center

63. Alexander Moore, Chief Development Officer, DC Central Kitchen

64. Fernanda Ruiz, Public Witness

65. Rachel Johnston, Chief of Staff, DC Charter School Alliance

66. Sarah Buckley Fernanda Ruiz, Public Witness

67. Deja Williams, SPACEs In Action

68. Hope Joyner, Organizer, SPACEs In Action

69. Destynee Bolton, Childcare Organizer, SPACEs In Action

70. Dean Brenner, Chairman, National Capitol Area Chapter Board, Alzheimer's Association

71. Camila Perez, Family Support Worker , Mary's Center

72. Shellie Bressler, Secretary, DC Tobacco Free Coalition

73. Deja Williams, Health Equity Organizer, SPACEs In Action

74. Kristin Ewing, Policy Counsel, DC Appleseed Center for Law and Justice

75. Jacqueline Bowens, President & CEO, DC Hospital Association

76. Nathaniel Beers, Executive Vice President of Community and Population Health, Children's National Hospital

Virtual

77. Carrie Stoltzfus, Executive Director, Food & Friends

78. Casey Dyson, Food & Friends, Inc.

79. Travis Ballie, Public Witness

80. Peter Wood, ANC 1C03

81. Micaela Deming, Policy Director DC, Coalition Against Domestic Violence

82. Abayea Pelt, Senior Director of Maternal and Child Health, Community of Hope

83. April Weeden, Director, Perinatal Services, Community of Hope

84. Stephanie Maltz, Public Witness

85. Luis Chavez, Director of Operations and Community Engagement, The Family Place

86. Teresa Williams, Public Witness

87. Melody Webb, Executive Director, Mothers Outreach Network

88. Camelia Belt, Public Witness

89. Kowshara Thomas, Executive Director, Joseph's House

90. Hugh Mighty, SVP of Health Affairs, Howard University Hospital’s Centers of Excellence

91. Ruth Pollard, President and CEO, DC Primary Care Association

92. Ryan Buchholz, MD, Chief Medical Officer, Unity Health Care, Org.

93. Juanita Blassingame, Market Champion, FRESHFARM

94. Kimberly Price, Market Champion, FRESHFARM

95. Marie Brown, Market Champion, FRESHFARM

96. Hugo Mogollon, Executive Director, FRESHFARM

97. Alex Baca, D.C. Policy Director, Greater Greater Washington

98. Heidi Ellis, Coordinator, DC LGBTQ+ Budget Coalition

99. Lily Horn, Public Witness

100. Chyna Holloway, Public Witness

101. Clementine Kovacs, Youth Advocate, Young Women's Project

102. Felix Hernandez, Public Witness

103. Kimberly Price, Market Champions , Fresh Farm

104. Kaitlyn Wilson, Public Witness

105. Janet Phoenix, Campaign to Reduce Lead Exposure & Asthma

106. Nia Bodrick, Pediatrician, DC Chapter of the American Academy of Pediatrics

107. Amanda Quiroz-Guajardo, Public Witness

108. Yasmina Konate, Youth Advocate, Young Women's Project

109. Brooklynne Payne, Youth Advocate, Young Women's Project

110. Julienne Summer Sardona, Youth Advocate, Young Women's Project

111. Gloria Gomez, Public Witness

112. Zainab Kamara, Public Witness

113. Ana Lemus, Public Witness

114. Wayne Goodwin, Public Witness

115. Geoff Gilbert, Legal & Technical Assistance Director, Beloved Community Incubator

116. Felix Macaraeg, Public Witness

117. Carolyn Babendreier, Public Witness

Testimony on

FY 2025 Budget Oversight

of the Department of Behavioral Health

Committee on Health

April 10, 2024

Thank you, Chair Henderson and Council staff.

My name is Will Doyle and I am the Vice President of Housing First at Pathways to Housing DC. My role includes responsibilities for our programs under DBH, namely ACT and Community Support Services, as well as the Court Urgent Care Clinic at the DC Superior Court.

I want to focus my comments on the Court Urgent Care Clinic, which DBH has proposed to completely eliminate in its FY25 budget despite the significant demand for its services and the key role it plays at the DC Superior Court. The Court Urgent Care Clinic was founded by DBH in 2008 and Pathways to Housing DC has been providing services there since 2012.

The Court Urgent Care Clinic is unique as staff provide same day mental health and substance use assessment and treatment at the DC

Superior Court. For those experiencing a mental health crisis, whether a child or an adult, Clinic staff provide immediate access to assessments for involuntary hospitalization, avoiding escalation and incidents at the DC Superior Court. Clinic staff also provide immediate assessments, transportation, and access to inpatient substance use treatment, avoiding gaps that often prevent successful entry into treatment.

When unaddressed chronic behavioral health needs are displayed in the DC Superior Court, the Court Urgent Care Clinic supports individuals in connecting to ongoing community based services. However, there are multiple steps to that process, so Clinic staff provide short term behavioral health services until that connection can be completed. This is a key role, as without ongoing support, most will not successfully connect for services, contributing to continued engagement with the criminal justice system at great expense to DC government.

The Court Urgent Care Clinic is on pace for 630 unique referrals, 762 assessments, and 3,878 follow up visits for the year ending September 30, 2024. If the Clinic is eliminated as planned, the need for its services will not go away, they will simply be unaddressed. These are individuals who are not adequately accessing behavioral health services elsewhere and are doing so due to the unique location and services of the Court Urgent Care Clinic. An individual stranded in DC would not have received assistance in returning to California, but would be adding to the burden on our

criminal justice and homeless services systems. A 17 year old experiencing psychosis would not have been connected to emergency services, but would have returned to wandering downtown DC, likely a future victim due to her significant vulnerability. Many others would be denied timely and appropriate behavioral health services that lead to stability and engagement in ongoing services. Without the Court Urgent Care Clinic we will see increased use of 911, Fire and Emergency Medical Services, the Metropolitan Police Department, the DBH Community Response Team, CPEP, and the Department of Corrections. Do they have money to spare in their FY25 budgets to cover increased demand?

I urge you to focus on the many DC residents whose needs will not be met if the Court Urgent Care Clinic is eliminated and restore funding for this crucial community resource.

I am providing additional information regarding the scope of the Court Urgent Care Clinic to ensure that the Committee on Health has full information when considering the need for its services. The attached excerpt from our Human Care Agreement outlines this thoroughly. I want to specifically highlight C.2.1 f) & g), which focus on the intent to provide ongoing services:

f) Provide on-going mental health treatment and aggressive case management services to individuals who prefer to receive their services at the UCC; and to g) Provide care coordination and

intervention management services for high utilizers of D.C.'s behavioral health and criminal justice systems.

Additionally, C.5.5 states:

The clinical staff shall provide continued clinical services to consumers who either do not have a viable relationship with a community provider and/or prefer to remain with the CUCC. It is anticipated that these individuals will be seen by the CUCC for the duration of their court supervision or for approximately 60-90 days. This period may be extended on a case-by-case basis, and if clinically indicated.

Regarding utilization, C.7.1 c)1) states:

A minimum of 600 clients identified with mental health needs, with 50 individuals being served at any one time.

As indicated above, the Court Urgent Care Clinic is on pace for 630 unique referrals for the year ending September 30, 2024, showing that we are currently exceeding this utilization number. The Clinic is consistently serving 80 to 95 clients through ongoing intensive case management and clinical services. We have also observed additional demand for services that could be provided with increased investments in office space and staffing, given a required client-to-staff ratio of 20:1 or less (C.5.3). In fulfilling the mandate to provide ongoing services, the Court Urgent Care Clinic is on pace to complete 3,878 follow up visits for the year ending September 30,

2024. In no way is the Court Urgent Care Clinic currently overstaffed or over resourced in relation to the current utilization of services.

Clinic staff provide a unique role that will not be replaced as particularly related to care coordination for high utilizers/Familar Faces (C.5.7, C.6.7 & C.6.8) and facilitating Community Integration Team meetings (C.5.8 & C.6.9). Without these needed interventions, DC will incur increases in costs in its emergency, crisis, and criminal justice systems.

Our HCA also requires that we "further develop the operational elements of the CUCC that meets the needs of the Superior Court divisions and DBH" (C.6.10) and "make the required service and operational adaptations in the project" (C.6.11). Pathways to Housing DC has therefore assessed the changing needs and adapted services accordingly in collaboration with DBH. Changes in staffing and the distribution of services firmly remain within the scope of the Human Care Agreement.

The expectation is that individuals "will have complex needs and may be difficult to engage in services" (C.6.13.1). Our success in overcoming these barriers is grounded in being onsite at the DC Superior Court with flexibility and immediate access. There is simply no substitute for this effective model in meeting the needs at the DC Superior Court.

Rather than having the capacity to provide services in place of the Court Urgent Care Clinic, CSOSA is the biggest referral source, accounting for 44% of referrals from July 2023 to March 2024. DBH may suggest that given their dependence on the services of the Court Urgent Care Clinic, CSOSA should fund or directly provide these services. Regardless, the clients served by the Court Urgent Care Clinic are DC residents who "have a need for mental health, substance abuse, and housing assessment services" (C.2). A decision to uphold DBH's proposed elimination of the Court Urgent Care Clinic is in direct conflict with Mayor Bowser's intended principle of "preserving programs and services that protect the health and safety of our community" and instead reflects whose needs we prioritize (https://tinyurl.com/ydpztbnw).

Will Doyle, LICSW
Vice President of Housing First
Pathways to Housing DC
wedoyle@pathwaysdc.org

SECTION C: HUMAN CARE SERVICE DESCRIPTION AND SCOPE OF SERVICES

C.1 BACKGROUND

C.1.1 The D.C. Superior Court has long stated there are many defendants with criminal cases and other individuals who utilize the Court's services that are in need of behavioral health services and supports. Based on this need, the DBH established a CUCC located at the D.C. Superior Court. A significant number of individuals who come before the Court are homeless and have a mental illness and/or co-occurring substance abuse problem. Over CUCC's existence, nearly thousands of individuals have received services at this site. This includes behavioral health screening and assessment, medication management, and care coordination services. As a result, many of these individuals have been diverted from the criminal justice system, received immediate access to substance abuse and mental health screening and assessment, and linked to on-going treatment services provided by DBH's provider network.

C.1.2 DBH is interested in continuing its close working relationship with the court system to address the needs of individuals with mental health and substance abuse challenges in an easily assessable service environment located within the D.C. Superior Court. The service delivery model will encompass a person-centered, trauma-informed approach to treatment, with a primary emphasis on stability and recovery, as well as coordination of activities with multiple providers and service systems.

C.2 SCOPE

DBH is seeking a Provider to operate a Free-Standing Mental Health Clinic that will function as an Urgent Care Clinic at the D.C. Superior Court (CUCC), which is located at 500 Indiana Avenue, NW, Washington, D.C. 2000l. The population of focus for the CUCC will be persons who have contact with the court system and have a need for mental health, substance abuse, and housing assessment services. The primary focus will be on individuals involved with the Superior Court's Criminal and Family Court Divisions; however, other Superior Court divisions, D.C. Court Services and Offender Supervision Agency (CSOSA), and D.C. Pretrial Services Agency (PSA) are also authorized to make referrals to the CUCC. In addition, the successful Provider will provide ongoing support and services to the Mental Health Community Court (MHCC) diversion program.

The mission of the CUCC is to identify and provide immediate services to persons in need of mental health and/or substance abuse assistance who become involved with the Court as a result of criminal, civil, probate, and/or family proceedings and to connect them to appropriate mental health, substance abuse, and housing services. Anyone who is directly or indirectly involved with the court, adults/juveniles, housed/unhoused, those with matters before the criminal, civil, family, probate courts, are eligible to receive services. Based on many years of program operation, the principal recipients in need of this service are adults who walk-in for assessment and short-term care, as well as a small number of juveniles who are court-ordered for emergency evaluation. The ultimate objective is to support D.C. residents who are court involved, minimize recidivism within the criminal justice system, augment justice diversion programs, and triage the behavioral health needs of the consumers served there so they will be connected to appropriate long-term care.

C.2.1 The specific objectives of the CUCC are to:

a) Identify the behavioral health, housing, and support service needs of individuals who come in contact with the criminal, civil, probate, and/or family legal system who require on-going treatment services.

b) Conduct behavioral health screening, assessment, and referral services.
c) Conduct housing needs assessments and make referrals to services.
d) Provide urgent care triage and treatment services to stabilize individuals identified by the Court.
e) Refer identified individuals to appropriate community-based or residential treatment services.
f) Provide on-going mental health treatment and aggressive case management services to individuals who prefer to receive their services at the UCC; and to
g) Provide care coordination and intervention management services for high utilizers of D.C.'s behavioral health and criminal justice systems.

C.2.2 The CUCC will be funded by DBH. Space for the project will be provided by the D.C. Superior Court.

C.3 APPLICABLE DOCUMENTS

The following documents are applicable to this procurement and are hereby incorporated by this reference:

Item No.	Document Type	Title	Date
1	Chapter 34, Title 22A of D.C. Municipal Regulations https://dbh.dc.gov/node/1246426	Mental Health Rehabilitation Services (MHRS) Contractor Certification Standards	2001
2	HIPPA Law, Public Law 104-191 https://dbh.dc.gov/node/136223691	Health Insurance Portability and Accountability Act of 1996	1996, as amended
3	DBH Privacy Policies and Procedures https://dbh.dc.gov/node/285782	DBH Privacy Policies and Procedures	2000
4	Code of Federal Regulations, Title 42, Chapter l, Subchapter A, Part 2 https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2	Public Health, Section 2.1-2.67, part 2, Confidentiality of Alcohol and Drug Abuse patient Records	2002
5	D.C. Law 13-146, D.C. Official Code §7-3001 et seq. https://code.dccouncil.gov/us/dc/council/laws/13-146	District of Columbia Substance Abuse Treatment and Prevention Act of 1989	1990, as amended
6	D.C. LAW 80-80, D.C. Official Code §44- 1201 et sea. https://code.dccouncil.gov/us/dc/council/code/titles/44/chapters/12	District of Columbia Substance Abuse Treatment and Prevention Act of 1989	1990, as amended

7	DBH Transmittal Letter -Reporting Major Unusual Incidents (MUIs) and Unusual Incident (UIs) http://dbh.dc.gov/node/243632	Reporting Major Unusual and Unusual Incidents	2012
8	DBH Electronic Health Records https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/115.6A%20TL-338.pdf	Policy No. 115.6A	1/23/23
9	Chapter 22-A30 Free Standing Mental Health Clinic - DCRegs	Free Standing Mental Health Clinic standards	Recent

C.3.1 The Provider shall meet all applicable certification requirements specified in proposed modifications to Chapter 34 of Title 22A of the D.C. Code of Contractor Certification Standards.

C.4 PROVIDER MINIMUM QUALIFICATION REQUIREMENTS

The Provider shall meet or exceed the following minimum requirements:

C.4.1 The Provider must have a minimum of 2 years of experience in establishing and managing Free-Standing Mental Health Clinics.

C.4.2 The Provider must be certified by DBH to provide MHRS

C.4.3 The provider shall provide proof that it has been awarded a contract by a local, state, or federal agency to perform mental health and substance use assessments and treatment, to perform to perform housing need assessments and referrals, and/or to perform brief therapeutic interventions for individuals who are involved in the justice system.

C.5 GENERAL STAFFING REQUIREMENT

The Provider shall meet or exceed the following staffing requirements:

C.5.1 The staffing pattern of the CUCC shall include a team comprised of mental health and substance abuse clinicians, as well as certified peer support and administrative personnel. The staffing pattern shall be sufficient to provide services to a minimum of 600 individuals per year.

C.5.2 The Provider shall ensure one or more CUCC staff are qualified to conduct FD-12s, either permitted by law (i.e., psychiatrist or psychologist) or certified by DBH as an Officer Agent.

C.5.3 The CUCC staff-to-client ratio should be no greater than 20:1 to ensure that the required intensive follow-up activities required linking the consumer to a mental health provider or substance abuse treatment facility can be conducted.

C.5.4 The clinical staff shall be responsible for conveying diagnostic assessment results, clinical compliance, treatment referral information, and other information to the Courts, PSA, and/or CSOSA.

C.5.5 The clinical staff shall provide continued clinical services to consumers who either do not have a viable

relationship with a community provider and/or prefer to remain with the CUCC. It is anticipated that these individuals will be seen by the CUCC for the duration of their court supervision or for approximately 60-90 days. This period may be extended on a case-by-case basis, and if clinically indicated.

C.5.6 The Provider shall employ staff at the CUCC who are trained in conducting housing needs, assessments, and are knowledgeable about housing referral resources in the District.

C.5.7 This provider shall possess 4 years of experience in conducting housing need assessments.

C.5.7 The Provider shall employ staff to conduct care coordination and care management activities for the high utilizer/Familiar Faces portion of this contract.

C.5.8 The Provider shall employ staff that can convene and facilitate a Community Integration Team meeting and conduct a root-cause analysis to identify individual's behavioral health and criminogenic risk/needs, as well as to identify patterns contributing to their justice involvement.

C.5.9 Key Personnel Requirements

The Provider shall ensure staff be qualified mental health professionals in accordance with Chapter 34, Title 22A of the D.C. Municipal Regulations who shall provide immediate access to services including, but not limited to: medication, prescriptions, therapy, assertive case management, and on-site supports before they leave the courthouse. In some situations, the individual may be in active treatment with a DBH certified provider. In these cases, the CUCC staff will work with the individuals to ensure linkage to the current provider. In instances in which the person is not enrolled with a community mental health provider, the CUCC will provide all necessary services to ensure clinical stabilization and a smooth transition to the community mental health provider.

At minimum, the Key Personnel are listed below, and each candidate must meet the following minimum requirements:

C.5.9.1 Clinical Director/Team Lead (Key Personnel)

The staff team shall be led by a licensed mental health clinician (i.e., Licensed Psychiatrist, Licensed Psychologist, or Licensed Social Worker). The Director/Team Lead shall possess 5 years of experience and 2 years of supervisory experience and shall be responsible for the overall supervision and management of the CUCC. The staff team leader (Clinical Director) shall be the primary point of contact to the Contract Administrator.

C.5.9.2 Licensed Psychiatrist (Key Personnel)

The Licensed Psychiatrist shall be available five days per week, during the Court's operational hours, to see individuals referred for service within 90 minutes of presenting at the CUCC. The psychiatrist shall possess an American Board of Psychiatry and Neurology Adult Psychiatry Certification with a minimum of 3 years post-licensure, professional experience. In addition, the psychiatrist shall possess an American Board of Psychiatry and Neurology in Child/Adolescent Psychiatry and/or, at minimum 3 years of post-licensure, professional experience conducting juvenile psychiatric assessments. The psychiatrist shall possess and maintain a valid license to practice issued by D.C. Health. If not, a Child/Adolescent Psychiatrist must be contracted and available to provide these evaluations.

C.5.9.3 Intake Administrator or Coordinator (Key Personnel)

The Intake Administrator or Coordinator shall support the CUCC's operation as well as support those individuals who present as a walk-in or present for scheduled appointments. This individual shall possess 2 years of experience in an administrative/medical intake role.

C.5.9.4 Substance Abuse Staffing Requirement (Key Personnel)

a). **Certified Addiction Counselors (CACs)** The CUCC shall employ two CACs to provide substance abuse screening, assessment, and referral services. The staff shall have the capacity to conduct the Global Appraisal of Individual Needs (GAIN) assessment. The GAIN is a standardized assessment for use in substance abuse diagnosis, placement, treatment planning, outcome monitoring, economic analysis, and/or program planning. CACs shall possess and maintain a valid license to practice issued by D.C. Health and have 2 years of relevant professional experience.

C.5.9.5 Licensed Social Worker (Key Personnel)

The CUCC shall staff one Mental Health Professional with a license to independently practice social work (i.e., LICSW) issued by D.C. Health, and 2 years of relevant social work experience.

C.5.9.6 Certified Peer Staffing / Outreach Specialist Requirement (Key Personnel)

The CUCC shall be staffed with at least one Certified Peer Specialist, Certified Peer Recovery Coach, or Certified Forensic Peer Specialist. This individual(s) shall be certified by DBH or other equivalent national certifying entity as being a Certified Peer Specialist. This individual shall possess 2 years of relevant experience.

C.6 PROVIDER RESPONSIBILITIES

The Provider must demonstrate capability to operate a Free-Standing Mental Health Clinic and provide approach to meet the following requirements:

C.6.1 Possess the capability to bill Medicaid under the structure of the Free-Standing Mental Health Clinic regulatory parameter under Chapter 30.

C.6.2 Demonstrate ability to enroll uninsured, eligible, individuals into Medicaid.

C.6.3 Possess 3 years of experience working with individuals with behavioral health needs that are involved in the legal system and who will be able to operate the CUCC. The provider must be able to collaborate effectively with Court personnel, criminal justice agencies (e.g., PSA and CSOSA), and community-based service providers.

C.6.4 Possess the expertise and resources to identify, assess, support, and develop relationships with individuals who come into contact with the legal system and require behavioral health services.

C.6.5 Demonstrate a commitment to the principles of person-centered, trauma-informed, recovery-focused services and peer support services, and demonstrate how these principles will be operationalized within the scope of their work.

C.6.6 Provide specific services to include, but not limited to:

- Assessment and diagnosis of mental health and co-occurring disorders; substance abuse screening.
- Housing needs assessments.
- Provision of immediate mental health clinical interventions as required.
- Coordination with existing service providers, if necessary
- and linkage to sustainable community-based treatment and resources.

C.6.7 Serve as a care management coordinator for individuals who are identified high utilizers of behavioral health services and who have the highest arrest rates (i.e., "Familiar Faces") in the District of Columbia.

C.6.8 Employ an evidenced-based care management model that provides individualized support and referrals to resources, facilitates communication, and maintains monitoring of the resources with which the Familiar

Faces are connected.

C.6.9 Convene a Community Integration Team meeting of individuals directly involved in the care of identified those as a familiar face and shall facilitate a root-cause analysis and utilizing tools and techniques that will identify actions to mitigate an individual's risk of recidivating. The root-cause analysis will be the framework for analyzing a person's behavioral health and criminogenic risk/needs and identify patterns contributing to their justice involvement.

C.6.10 Monitor and identify effective elements of the CUCC. The data and experience derived through this self-monitoring will be used to further develop the operational elements of the CUCC that meets the needs of the Superior Court divisions and DBH.

C.6.11 Utilize the Plan, Do, Study, Act continuous quality improvement model, as the framework for developing and implementing strategies for practice improvement. This will include a plan to evaluate the effectiveness of the CUCC, collect and analyze service data for all individuals seen in the clinic and make the required service and operational adaptations in the project in collaboration with DBH and the D.C. Superior Court.

C.6.12 The Provider shall have the capacity to bill Medicaid for all appropriate reimbursable services including mental health rehabilitation services (MHRS), Medicaid fee for service, and/or the Managed Care Organizations (MCOs).

C.6.13 REFERRAL, REPORTING AND DATA REQUIREMENTS

C.6.13.1 Identification and Referral Process

It is estimated that individuals eligible for this service will have complex needs and may be difficult to engage in services. The Provider, in conjunction with DBH and judicial stakeholders (e.g., U.S. Attorney's Office, D.C. Office of the Attorney General), shall develop a system to identify persons moving repeatedly through the court system. This will include individuals known by the Courts as possibly being in need of behavioral health services with an emphasis on the following priority populations:

a) Persons with a history of multiple arrests.
b) People who have a history of involuntary detention within the mental health system (FD-l2s); including involvement with DBH's Comprehensive Psychiatric Emergency Program (CPEP);
c) Actively psychotic individuals.
d) Individuals actively abusing alcohol or other drugs.
e) Mentally ill persons with a history of being unhoused; and
f) Other criteria to be identified through this contract's data collection plan.

C.6.13.2 The Provider shall describe a clear process for receiving referrals from the D.C. Superior Court courtrooms, PSA, CSOSA, and other referral sources. Existing mechanisms and processes for referral may exist but it is the Provider's responsibility to conduct ongoing reviews of these processes to determine if improvements can be made.

C.6.13.3 Though unlikely, the CUCC staff shall be prepared to respond to individual courtrooms to perform screenings, assessments, and referrals for individuals who may not be permitted to walk into the CUCC office area. The in-courtroom or in-courtroom detention cell evaluations can be conducted in person or virtually with authorization of the presiding judge and/or U.S. Marshals. The Provider's staff must always employ the best standards of health care assessment in the given circumstances.

C.6.13.4 All individuals who require substance abuse treatment based upon the results of the screening

performed at the CUCC shall be transported from the CUCC to the substance abuse provider on the same day unless the person refuses treatment.

C.6.14 Reporting of Client Records

C.6.14.1 The Provider shall use and maintain an Electronic Health Record (EHR) system that collects uniform information that meets the following criteria specified in DBH Policy 115.6 ("DBH Electronic Health Records"). Specifically:

a) Represents the person's health history,
b) Provides a method for clinical communication and treatment planning among providers and practitioners serving the person,
c) Serves as a legal document describing the healthcare services provided, and
d) Serves as a source of data for the behavioral health services and outcomes that the network provider renders.

C.6.14.2 The Provider shall ensure, as specified in DBH Policy 115.6, they.

a) Create written user access protocols for appropriate access to personal health information, and that require managerial approval before any person is granted access to the EHR.
b) Establish administrative safeguards including safeguards against staff who fail to comply with security procedures, procedures to regularly review records if information systems activity, procedures for the authorization and/or supervision of staff who work with the EHR, and procedures for terminating staff access to the EHR.
c) Establish physical safeguards that address access, business continuity, physical access, medic movement, media final disposition, and data exchange, and.
d) Institute technical safeguards including data integrity, authentication, and data transmissions.

C.6.14.3 The Provider shall maintain a clinical record for each person who presents with a mental health issue. The record shall include at a minimum, but is not limited to:

a) Psychiatric/mental health assessment.
b) Psycho-social/family history;
c) Case management assessment.
d) Current medications.
e) Treatment plan and progress notes for all individuals who receive mental health treatment and support services at the CUCC.

C.6.14.4 The Provider shall maintain a detailed record of Community Integration Team meetings. The record shall include at a minimum, but is not limited to:

a) Meeting attendees.
b) Reason for referral.
c) Pertinent psychosocial and behavioral health history.
d) Root-cause analysis.
e) Identification of criminogenic risk factors and risk mitigation factors.
f) Proposed treatment or action plan for the consumer and involved agencies to reduce the consumer's justice involvement.

C.6.15 Data Collection and Evaluation Plan

During the first year of the HCA and every option year, the provider shall conduct both a process and outcome evaluation of the project. This assessment should be designed to gather information about process or effort-operations, service delivery and resources required to conduct the project and effectiveness-the impact of the project on the population served. Each application must include an evaluation and data collection plan that meets the criteria described below. The process and outcome evaluations shall be submitted to DBH by January15th each year documenting events that occurred in the preceding year.

C.6.15.1 The Provider shall document the process/effort of evaluation, the resources required to design and implement each aspect of the CUCC and the procedures used to conduct activities. The key evaluation questions that will be answered are:

a) What services are provided, to whom and by whom?
b) To what extent are the activities related to the identified needs/problems they were designed to address?
c) What is the process by which services are delivered?
d) What worked, what did not work, and why?

C.6.15.2 The outcome evaluation shall capture the contract's impact on the population of focus. The key evaluation questions that will be answered are:

a) How many people were identified through the CUCC?
b) How many of the people identified received services at the CUCC?
c) How many of the people served through the CUCC were repeat offenders?
d) How many of the people served through the CUCC were unhoused?
e) How many individuals served by the CUCC are actively engaged in treatment six months following referral? [Note: The successful applicant will be able to extract these data from DBH's billing system.)

C.6.15.3 The minimum data set of information that shall be collected includes:

a) Demographic data for all arrestees who accept mental health services
b) Principal diagnosis and including co-occurring disorders
c) Previous mental health and substance abuse treatment, including the number of FD-12s the individuals have had
d) Current charges
e) Previous arrests and judicial dispositions
f) Number of arrestees screened for both substance use/abuse and mental health need
    1. Number in court holding cell evaluations
    2. Number referred from each Court division
g) Number who refused screening
h) Number enrolled with a mental health provider when arrested
i) Number determined to be actively linked with a community provider or Core Service Agency (CSA) at time of screening and referred for continuing care
j) Number determined not to have an active working relationship with a CSA and referred to CUCC
k) Number whose involvement with treatment with CUCC has a positive effect on judicial disposition
l) Number whose involvement with treatment with a community provider has a positive effect on judicial disposition
m) Number who began services with CUCC and referred to CSA whose involvement with

treatment has a positive effect on their judicial disposition

n) Number of people who are referred to housing referral sources
o) Number of people who were offered but refused housing resources
p) Number referred and enrolled in a substance abuse treatment facility
q) Number who were previously in an inpatient substance treatment facility
r) Number who refuse substance abuse treatment

C.6.15.4 The Provider shall develop in coordination with DBH and the Court, the data collection component, to allow for analysis of data that are systemic, comparable, and relevant to needs of the contract and its stakeholders.

C.6.15.5 The Provider shall have the capacity to bill Medicaid for all appropriate reimbursable services including mental health rehabilitation services (MHRS), Medicaid fee for service, and/or the Managed Care Organizations (MCOs).

C.6.16 Hours of Operation

The hours of operation shall be from 8:30 a.m. to 5:00 p.m., Monday through Friday, when the Court is open.

C.7 ADDITIONAL REQUIREMENTS

C.7.1 DBH requires the following outcomes for the HCA:

a) Demonstrate the effectiveness of identifying, engaging, and treating clients in a courthouse setting.
b) Demonstrate the degree to which individuals can begin treatment at a setting located in the courthouse and be successfully transitioned to a community-based provider.
c) Annual benchmarks for this project include:
    1) A minimum of 600 clients identified with mental health needs, with 50 individuals being served at any one time;
    2) All clients screened for substance abuse disorders;
    3) One hundred percent of the individuals who screen positive and consent to treatment are enrolled with a substance abuse provider;
    4) Demonstrated value of the CUCC by judges and others involved with the judicial system; and
    5) Report on client satisfaction with the service.

C.7.2 The Provider shall conduct a minimum 3 Community Integration Team meetings per month involving care coordination of individuals identified as Familiar Faces, as described in C.6.7 through C.6.9

C.7.3 The Provider shall provide an average of 25 individuals per week who are identified, referred, and evaluated by CUCC staff, and the clinic shall have an active caseload of at least 100 persons at all times.

C.7.4 DBH requires the Provider to be present for and facilitate the running of at minimum quarterly stakeholder meetings. These meetings will be conducted virtually.

C.7.5 The Provider will provide summary data and utilization reports on the metrics identified in C.6.15 monthly to DBH Contract Administrator as well during these quarterly at the stakeholder meetings.

***** END OF SECTION C *****

DISABILITYRIGHTSDC

TESTIMONY FOR BUDGET HEARING REGARDING THE PROPOSED FISCAL YEAR 2025 BUDGET FOR THE DEPARTMENT OF BEHAVIORAL HEALTH (DBH)
COMMITTEE ON HEALTH

Jaclyn Verner, Supervising Attorney

April 10, 2024

Disability Rights DC at University Legal Services (DRDC) appreciates the opportunity to submit written testimony regarding the Department of Behavioral Health's (DBH's) proposed budget for FY25. DRDC is the designated protection and advocacy program for people with disabilities in the District of Columbia. Pursuant to our federal mandate, DRDC advocates for hundreds of DC residents with mental illness each year. I would also like to thank the DC Bar Foundation for supporting DRDC's efforts to address housing barriers experienced by District residents living with mental illness.

Our testimony is focused on four areas: 1) the Personal Needs Allowance increase for Mental Health Community Residential Facility residents, 2) the need for DBH's Office of Data, Quality, and Compliance to be adequately resourced and resume its own independent investigations of deaths and serious incidents of abuse and neglect at St. Elizabeths Hospital, 3) our concerns about the proposed

budget reduction for community support services, and 4) the service gap for District residents living with traumatic brain injury.

Last year, our testimony focused on the necessity of DBH increasing the monthly personal needs allowance (PNA) for individuals residing in DBH-certified Mental Health Community Residential Facilities (CRFs), as the Department of Health Care Finance (DHCF) and the Department on Disability Services (DDS) had recently implemented an increase in the PNA for District residents with disabilities living in other care settings, but DBH and DHCF had not taken action to do the same for individuals residing in CRFs. This year, DHCF announced that, beginning in January 2024, the monthly PNA in CRFs increased from $100 to $134.16 for individuals[1], and will continue to increase on an annual basis along with the Cost of Living Adjustment (COLA).[2] DRDC would like to thank the Council, DBH, and DHCF for addressing this and implementing this much needed change. DRDC now urges the Council, DBH, and DHCF to ensure that all representative payees of CRF residents have been notified of this change, as the only public announcements of this change that DRDC is aware of were provider transmittals, and not all CRF residents who have a representative payee are served by a payee who is a provider. It is important for the District to do additional

[1] For couples, DHCF announced the PNA increased to $268.32.
[2] DHCF transmittal #24-04, https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2024-04%20-%202022%20Retroactive%20Payment%20of%20State%20Supplement%20and%20January%202024%20Payment%20Levels.pdf.

outreach to ensure that all CRF residents and payees are informed of this monthly increase.

Next, DRDC would like to stress the importance of DBH's accountability division being adequately resourced and of this division resuming its own independent investigations of deaths and serious incidents of abuse and neglect at St. Elizabeths Hospital. In February 2024, DRDC released a report to the public titled *Abuse and Neglect: The Need for Accountability at St. Elizabeths Hospital,* https://www.uls-dc.org/media/1339/need-for-accountability324.pdf.[3] The report details that in 2023, DBH's then Office of Accountability informed Disability Rights DC that, in order to be efficient with resources, they would no longer conduct separate, independent investigations of St. Elizabeths Hospital. Prior to this change in practice, DBH's Office of Accountability completed detailed, thorough investigations of deaths and serious incidents of abuse and neglect at St. Elizabeths Hospital, as is required by DBH Policy.[4] DBH's Office of Accountability investigation findings have been critical in not only substantiating allegations of abuse and neglect, but also provide meaningful recommendations to improve care and treatment practices and to keep patients safe. This newly announced practice not only violates DBH's own policy requiring DBH's Office of Accountability to conduct investigations of deaths and other serious incidents, but

[3] See attached report.
[4] DC Department of Behavioral Health Policy 480.1A (5c)(1), (5c)(7) (May 3, 2019).

it will also certainly result in placing all individuals in care at St. Elizabeths Hospital at risk.

The importance of independent agency investigations of deaths, injuries, and allegations of serious abuse and neglect cannot be overstated. St. Elizabeths' incident management personnel can and have completed adequate investigations for many incidents. However, as described in detail in our report, the St. Elizabeths "Incident Report Summaries" of multiple serious incidents, including a death, were not adequate investigations. Because of its expertise and independence in conducting detailed investigations related to behavioral health abuse and neglect, and its ability to independently identify staff deficiencies, it is critical that DBH's accountability division under its Office of Data, Quality, and Compliance follow its own policies and investigate these more serious incidents. We urge the District to ensure the accountability division under DBH's Office of Data, Quality, and Compliance is adequately resourced and that it resumes adhering to DBH policy and conducting its own investigations at St. Elizabeths Hospital.

Next, DRDC has serious concerns with what appears to be a proposed reduction in local funding for community support services. DBH's proposed budget includes an $11.6 million reduction "in community support benefits and restriction of audio only service modality."[5] Although there is not clear language in

[5] DC OCFO Budget Volume 4, page E-35.

the proposed budget as to whether DBH intends to drastically reduce the community support workforce with no clear replacement for these services, whether DBH intends to restructure the community support benefit, or whether DBH intends to make some other drastic change unknown to the public, we have serious concerns with this proposed reduction. Community support services as currently implemented are not perfect and leave much to be desired. However, the elimination of, or even a significant reduction of, these services without an effective, well-established alternative will be devastating to thousands of DBH consumers. Because no formal case management benefit exists in the DBH service array, many consumers are reliant on their community support workers to assist them with connecting to other needed supports, such as resources to address homelessness or housing instability, and lack of income. For many consumers who are not receiving Assertive Community Treatment (ACT) or Community Based Intervention (CBI) services, their community support worker is often the individual at the CSA who is most present in their life. We urge the Council to further examine this proposed reduction and consider its potential significantly harmful impact.

Finally, DRDC would like to again bring to the Council's attention the District's lack of targeted services for individuals with traumatic brain injury (TBI). In addition to representing individuals with severe and persistent mental illness, DRDC also represents a number of individuals with traumatic brain injury

each year. In addition to engaging in individual advocacy on behalf of these clients, DRDC participates in a TBI working group alongside other advocates and service providers in the District. What continues to remain clear is that there is a gap in community based services for individuals with traumatic brain injury.

In 2016, our TBI working group conducted a survey on the incidence of TBI among adult consumers of community behavioral health services in DC. Participants of this survey were 159 consumers from four different Core Service Agencies who were administered a TBI screening tool at the time of intake. We found that approximately 50 percent of the adult community behavioral health population surveyed had a history of TBI. Yet, almost none had been diagnosed with one.[6] Further, TBI is prevalent among District residents experiencing homelessness, with a 2010 survey of 199 DC residents experiencing homelessness showing that nearly two-thirds had a TBI.[7]

Currently, as we have consistently reminded DBH and DHCF over the years, TBI is not a Medicaid-billable diagnosis in DC. Thus, CSAs cannot bill for services provided to consumers who have a primary diagnosis of TBI. Because CSAs cannot bill for this diagnosis, they ultimately have not invested resources

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[6] DC TBI Work Group. (2018). *Traumatic Brain Injury in the District: The Ignored Injury. A Paper Examining the Prevalence of TBI in the District and the Need for Services.* http://www.uls-dc.org/media/1150/tbi-white-paper-final-7-25-18.pdf.

[7] *Findings from the District of Columbia Traumatic Brain Injury Needs and Resources Assessment of Homeless Adult Individuals, Homeless Shelter Providers, TBI Survivors and Family Focus Group, TBI Service Agency/Organizations*, DC Department of Health, revised August 2010, http://www.nchv.org/images/uploads/DC_TBI_Report.pdf.

into training staff to assess for, treat, and accommodate TBI. DRDC acknowledges that the current service gap is a multi-agency issue that will not be solved by DBH alone, and our working group has engaged in numerous productive discussions with DHCF to address the current gap in TBI services as well. However, because our survey demonstrated that a significant percentage of consumers who walk through the doors of CSAs have a history of TBI, DBH plays just as large a role in addressing this service gap. We continue to urge the District to make TBI a Medicaid-billable diagnosis and ultimately create ways for DBH's community based providers to begin to assess for and treat TBI in the District.

Thank you for the opportunity to submit testimony on these important issues.

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Investigating Abuse and Neglect:

The Need for Accountability at Saint Elizabeths Hospital

March 2024

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ABOUT DISABILITY RIGHTS DC

Since 1996, Disability Rights DC at University Legal Services, Inc. ("Disability Rights DC"), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. Additionally, Disability Rights DC provides legal advocacy to protect the civil rights of District residents with disabilities.

Disability Rights DC staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education, and group advocacy efforts. Disability Rights DC staff address client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint and medication.

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I. INTRODUCTION

Prior to a recent change in practice, the Department of Behavioral Health's Office of Accountability ("DBH's Office of Accountability") completed detailed, thorough investigations of allegations of serious abuse and neglect at St. Elizabeths Hospital. DBH's Office of Accountability investigation findings have been critical in not only substantiating allegations of abuse and neglect, but they also provide meaningful recommendations to improve care and treatment practices and to keep patients safe.[1]

However, in 2023, DBH's Office of Accountability informed Disability Rights DC that in order to be efficient with resources, they would no longer be conducting separate, independent investigations. Instead, St. Elizabeths Hospital itself would be conducting all investigations of alleged abuse and neglect.[2] As described below in Section III, this change in practice has been implemented in a confusing and contradictory manner, causing serious delays in investigations. More importantly, if continued, this new practice will certainly result in placing all patients at St. Elizabeths Hospital at risk, which contravenes the Department of Behavioral Health's ("DBH") responsibility to protect consumers from abuse and neglect.[3]

The importance of independent agency investigations into deaths, injuries and allegations of serious abuse and neglect cannot be overstated. Although St. Elizabeths' incident management personnel can and have completed adequate investigations for many incidents, because of its expertise and independence in conducting detailed investigations related to behavioral health abuse and neglect, and its ability to independently identify staff deficiencies, it is critical that DBH's Office of Accountability continues to investigate certain, more serious incidents.

In fact, DBH's Office of Accountability currently investigates certain serious incidents at psychiatric facilities in the District, including the Psychiatric Institute of

[1] For example, *see* DBH Accountability Administration Investigative Report dated 7/10/20; DBH Accountability Administration Investigative Report dated 6/28/22.
[2] Email from DBH to DRDC (October 30, 2023).
[3] See DC Code § 7–1131.04 (13); *see also* DC Code § 7–1231.04(c) ("Consumers shall be free from... abuse [or] neglect").

Washington. As is the case with St. Elizabeths Hospital, the Psychiatric Institute of Washington is a stand-alone psychiatric facility and internally governs its own departments, medical and nursing staff, and incident management personnel. Per DBH policy and practice, DBH's Office of Accountability conducts separate investigations of select, more serious incidents at the Psychiatric Institute of Washington, as well as other District Hospital psychiatric units.[4]

The Department of Behavioral Health should not exclude St. Elizabeths from this important oversight. Efficiency of resources cannot take priority over the safety and wellbeing of the hundreds of patients at St. Elizabeths Hospital. DBH's Office of Accountability, as the independent oversight agency, must continue to conduct investigations of allegations of serious abuse and neglect at St. Elizabeths as well.

II. DEPARTMENT OF BEHAVIORAL HEALTH POLICY

In order to protect mental health consumers in the District from abuse and neglect, DBH developed a policy that obligates DBH's Office of Accountability to conduct its own investigations of certain incidents, noting that DBH *shall,* among other incidents, *investigate* any consumer death and any incidents that raise immediate concerns regarding the health and safety of a consumer.[5]

However, DBH's Office of Accountability failed to follow this policy and failed to conduct separate investigations for the allegations of abuse and serious neglect at St. Elizabeths Hospital discussed in detail below. The incident involving Craig Thomas[6] was an unexpected death. The other incidents involved allegations of St. Elizabeths staff abuse and neglect, all which raised serious immediate concerns for the safety of the patients and should have been investigated by DBH's Office of Accountability.

[4] DC Department of Behavioral Health Policy 480.1A (5c) (May 3, 2019).
[5] DC Department of Behavioral Health Policy 480.1A (5c)(1), (5c)(7) (May 3, 2019).
[6] Pseudonym used to protect patient confidentiality.

III. ABUSE AND NEGLECT THAT DBH'S OFFICE OF ACCOUNTABILITY FAILED TO INVESTIGATE

1. Craig Thomas

Craig Thomas, a patient at St. Elizabeths Hospital, died suddenly and unexpectedly on October 22, 2022. On January 30, 2023, Disability Rights DC sent DBH's Office of Accountability a detailed analysis of the staff deficiencies uncovered during the Disability Rights DC investigation. After multiple follow-up inquiries, in July 2023, DBH's Office of Accountability indicated that it was "still working on the investigation" into Mr. Thomas' death.[7] It was not until over a year after his death, on October 30, 2023, that DBH's Office of Accountability informed Disability Rights DC that it was not investigating the death, but that St. Elizabeths Hospital was conducting the investigation. [8] However, this information contradicted an email from St. Elizabeths Hospital incident management sent a month earlier on September 28, 2023, which informed Disability Rights DC that St. Elizabeths Hospital did NOT conduct its own investigation because, per policy, DBH's Office of Accountability investigates unexpected deaths.[9]

It was not until over a year and one month after Mr. Thomas' death that DBH provided Disability Rights DC with a "St. Elizabeths Hospital Summary Review of Unusual Incident Report regarding Craig Thomas," which was dated November 9, 2023.[10] Unlike prior DBH's Office of Accountability investigation reports, this St. Elizabeths Summary Review was not an in-depth investigation and failed to: (1)

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[7] Email from DBH OA to DRDC (July 27, 2023).

[8] Email from DBH OA to DRDC (July 27, 2023).

[9] Email from St. Elizabeths to DRDC (September 28, 2023). The email states "Regarding Craig Thomas, since his death was considered unexpected SEH did not initiate an investigation per DBH policy 662.1 (Major Investigations 6.6a.1.b). Historically, my team does not conduct investigations for unexpected deaths because DBH Accountability did them. I know there was some confusion regarding who was doing the investigation. [The Director of the Office of Accountability] mentioned that DBH was deferring to SEH for it, but unfortunately no one communicated that to me...".

[10] St. Elizabeth Summary Review of Unusual Incident Report regarding Craig Thomas (11/9/23) ("St. Elizabeths Summary Review").

contain witness interviews; (2) provide a detailed, thorough analysis of the videotape and include screenshots; and (3) substantiate St. Elizabeths staff neglect.[11] The report also failed to note that, according to Mr. Thomas' records, on August 12, 2022 – two months before his death – a Code Blue was called because Mr. Thomas was noted to fall to the floor and became unresponsive,[12] and on September 23, 2022, less than a month before his death, a housekeeper found Mr. Thomas verbally unresponsive in the bathroom.[13] Moreover, the St. Elizabeths Summary Review failed to recommend or discuss steps the Hospital should take in response to the cause of Mr. Thomas's death, which was a drug overdose. Recommendations should have included steps such as supplying crash carts and units with Narcan. Unacceptably, the hospital's own internal analysis of the death was not completed until more than a year after the death, which delayed the implementation of important life-saving recommendations.

Finally, the St. Elizabeths Summary Report fails to address and/or substantiate Disability Rights DC's investigation findings of neglect that were sent to DBH's Office of Accountability and summarized below.

- Videotape footage of the unit the evening of his death showed that 27 minutes after Mr. Thomas entered the shower, staff persons appeared to be undergoing a security check of the hallway where the shower room was located.[14] One staff person knocked on the door and the other attempted to open the door, however, the staff persons were only able to push the door open a few inches. It appeared as though the door was jammed by something blocking the door.[15] The staff did NOT make further attempts to open the door. ***Inexplicably, the staff persons did not return to make other attempts to open the door.***

- The video shows that over 20 minutes later, at around 9:25 p.m., another patient attempted to open the door to the shower room but was also only able to open it a few inches as it appeared to still be blocked.[16] He then

[11] *Id.* The report refers on Page 3 to a DC Health review of the incident which concluded that St. Elizabeths staff failed to conduct security checks properly, but fails to conclude that staff were negligent.
[12] RN Progress note, dated 8/12/22, timed at 11:33 a.m.
[13] RN Progress note, dated 9/23/22, timed at 3:19 p.m.
[14] Videotape at 9:04 p.m.
[15] *Id.*
[16] *Id.* at 9:25 p.m.

sought the attention of a staff person sitting in a chair in the hallway, and both the staff person and the patient then tried to push open the door but were unable to.[17] Several other individuals finally got the door pushed open at approximately 9:27 p.m., and multiple staff then converged around the shower room.[18] It is not until approximately 9:32 p.m. that staff pulled Mr. Thomas' body into the hall and began resuscitation measures – almost 30 minutes AFTER staff were initially not able to open the door during the 9:03 p.m. security check.[19] Although the initial incident report states Mr. Thomas was seen in the living area with other patients at 8:30 p.m., review of the video provided to Disability Rights DC – which begins at 8:37 p.m. – demonstrates that Mr. Thomas went into in the shower room at the beginning of the video and did not appear until he was removed by staff at 9:32 p.m., almost *an hour after Mr. Thomas entered the shower room.*[20]

- Disability Rights DC's investigation also notes other discrepancies between staff documentation and the videotape footage. The initial incident report and medical records indicate that during the 9:03 p.m. security check, Mr. Thomas was in the shower and responded by name.[21] However, neither the initial incident report nor the medical records note that staff attempted to open the door, that they were only able to get the door open a few inches and it appeared as though something was blocking the door from being opened. It is also questionable whether Mr. Thomas did actually speak to staff.

Inexplicably, in a clear violation of its own policy, DBH's Office of Accountability failed to investigate this death.

2. *Robert Jones*

On November 10, 2022, Robert Jones suffered a dislocation of his right shoulder during an unsafe restraint performed by St. Elizabeths staff members. After reviewing a video of the incident, on February 17, 2023, Disability Rights DC sent a letter to DBH's Office of Accountability outlining Disability Rights DC's

[17] *Id.*
[18] *Id.* at 9:27 p.m. to 9:32 p.m.
[19] *Id.* Psychiatry Resident Progress Note dated 10/22/22, timed at 11:14 p.m.
[20] *Id.* at 8:37 p.m. to 9:32 p.m.
[21] DBH SEH MUI # I-DBH-051998 (October 22, 2022); RN progress note dated 10/23/22, timed at 8:46 a.m.

preliminary investigation findings and requesting that DBH's Office of Accountability investigate the incident.[22]

Disability Rights DC's review found that the videotape clearly showed (1) that staff failed to use proper technique when multiple staff converged on Mr. Jones resulting in his falling to the floor; and (2) that staff held Mr. Jones on the floor in a prone position on the floor for almost two minutes[23] – a technique that is very dangerous and strictly prohibited by Hospital policy.[24] However, it was not until almost a year later, on October 30, 2023, that DBH's Office of Accountability informed Disability Rights DC that it was not investigating the incident.[25]

On September 28, 2023, St. Elizabeths Hospital had supplied Disability Rights DC with a "Summary Review of Unusual Incident."[26] Although the Summary Review noted in its report that "for a portion of the time he was on the floor he was likely in a prone position," as noted above, Disability Rights DC's analysis of the videotape clearly shows multiple staff holding Mr. Jones in a prone position for almost two minutes. Critically, the Summary Review also failed to note that Hospital policy forbids staff to restrain patients in a prone position and that staff used a dangerous technique when multiple staff converged on Mr. Jones, *who was retreating from staff*, causing him and staff to fall to the floor. The Summary Review failed to substantiate any wrongdoing by staff and as such, did not make any recommendations to ensure that staff avoid techniques that are not only prohibited by policy, but that can cause serious injuries, as was the case with Mr. Jones.

Moreover, the St. Elizabeths investigation report failed to address additional Disability Rights DC findings including:

- The staff documentation did not reflect the activity on the videotape footage. Progress notes indicated that staff "held" Mr. Jones but did not describe that Mr. Jones and staff fell to the floor after staff converged on him.[27]

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[22] Letter from DRDC to DBH OA (February 17, 2023).
[23] Videotape: Security Footage of St. Elizabeths Unit 1G at 10:42 a.m. to 10:45 a.m. (November 10, 2022).
[24] St. Elizabeths Hospital Policy 103 § III.D.2.e.
[25] Email from DBH OA to DRDC (October 30, 2023).
[26] Summary Review of Unusual Incident regarding Robert Jones (July 7, 2022).
[27] RN progress note dated 11/10/22, timed at 2:53 p.m.

- Records indicate Mr. Jones was placed in four-point restraints for an hour and 45 minutes after the incident. Staff documentation stated the reason for continued restraint was that he was delusional or "pulling on restraints."[28] This does not constitute adequate justification for continued four-point restraint.

- The records contain no evidence that the RNs conducted an adequate physical assessment after the incident or in response to Mr. Jones' complaints of pain after the restraint.[29]

DBH's Office of Accountability should have investigated this incident, which resulted in a serious injury and threatened Mr. Jones' immediate health and safety.

3. Greg Miller

In the spring of 2023, Disability Rights DC sent notice to DBH's General Counsel's Office of serious allegations of abuse at St. Elizabeths Hospital that had occurred about three weeks before, including an allegation that a staff member punched patient Greg Miller in the face.[30] DBH responded that they "inquired with the [SEH] Incident Investigations Manager, who acknowledged that they were aware of the incident. They determined that it did not warrant an investigation because staff did not act as alleged. As a result of this decision, no investigation or related interventions (staff separation) occurred."[31]

In the summer of 2023, Disability Rights DC sent a letter to DBH's Office of Accountability outlining initial investigation findings from the records reviewed of a serious likelihood of staff physical abuse.[32] The letter asked DBH's Office of Accountability to specifically investigate whether a staff person struck Mr. Miller in the face during a restraint incident, noting that Mr. Miller's medical records confirmed and documented that Mr. Miller *sustained a facial injury during the restraint.* A doctor's progress note from the day after the incident stated: "Patient was involved in a Code 13 yesterday. *He was struck in the face and sustained slight swelling under his right eye.* There was no bleeding or drainage. He was treated with an ice pack ... ."[33] Mr. Miller reported to the doctor that staff had "punched"

[28] RN Assessment of Individual in Seclusion or Restraint (November 10, 2022).
[29] *See* RN progress notes dated 1/10/22, timed at 7:16 p.m. and dated 11/11/22, timed at 7:00 a.m.
[30] Letter from DRDC to DBH OA (Spring 2023).
[31] Email from DBH to DRDC (Spring 2023).
[32] Letter from DRDC to DBH OA (Summer 2023).
[33] GMO Progress Note dated Spring 2023, timed at 8:52 a.m.

him, the doctor noted the swelling under Mr. Miller's right eye. There is no follow up note regarding his facial injuries.[34]

Approximately one month later, DBH's Office of Accountability confirmed to Disability Rights DC that the investigation was complete.[35] To this date, DBH's Office of Accountability has not provided Disability Rights DC with its own investigation of the complaint of staff abuse. Moreover, in the fall of 2023, an email from the St. Elizabeths Incident Investigations Manager to Disability Rights DC confirmed that the Hospital itself did "not complete a formal report" after viewing the initial videotape which showed that Mr. Miller was the aggressor.[36]

This incident should have been investigated by DBH's Office of Accountability as required. A serious allegation that staff punched a patient in the face, along with documented facial injuries of the patient after the allegation, warrants an investigation by DBH's Office of Accountability. St. Elizabeths' response that they did not investigate the incident because "staff did not act as alleged" is woefully inadequate. There should have been a more thorough review of the records by DBH's Office of Accountability, the independent oversight authority.

4. Charles Smith

In March 2023, Disability Rights DC investigated an allegation of excessive use of restraint and seclusion at Saint Elizabeths Hospital, yet another allegation that threatened the safety and wellbeing of a St. Elizabeths patient. The investigation found that Mr. Smith was restrained nine times[37] and placed in seclusion once[38] over a one-month period at the end of 2022. Disability Rights DC requested that DBH's Office of Accountability investigate the alleged violations of D.C. Law, D.C. regulations, and SEH policy which occurred during the restraints and seclusions.[39] In response, DBH's Office of Accountability did not agree to investigate as requested, but sent only a "Summary Investigation of Unusual

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[34] *Id.*

[35] Email from DBH OA to DRDC (Summer 2023).

[36] Email from St. Elizabeths Investigator to DRDC (Fall 2023).

[37] SEH Unusual Incident Reports dated 11/30/22 (UI DB #I-DBH-052342), 12/1/22 (two separate incidents on this date: UI DB #I-DBH-052348 and UI DB #I-DBH-052352), 12/10/22 (UI DB #I-DBH-052464), 12/12/22 (two separate incidents on this date: UI DB #I-DBH-052482 and UI DB #I-DBH-052483), 12/14/22 (UI DB #I-DBH-052513), 12/19/22 (UI DB #I-DBH-052571), and 12/25/22 (UI DB #I-DBH-052610). The videotape footage was not available for DRDC's review.

[38] SEH Unusual Incident Report (UI DB #I-DBH-052610) dated 12/25/22. Seclusion was ordered during the morning incident on 12/12/22, but four-point restraint was used instead.

[39] DRDC Letter to DBH OA (May 25, 2023).

Incident Report" completed by St. Elizabeths Incident Management and dated June 27, 2023.[40]

As was the case in the other St. Elizabeths "Summary Investigations" described herein, the Hospital's summary did not identify important deficiencies discovered in Disability Rights DC's investigation, including that hospital staff failed to comply with D.C. law and regulations, as well as St. Elizabeths Hospital policy, when staff failed to document that they considered Mr. Smith's history of trauma as required.[41] This is especially important when patients with a history of trauma are subjected to multiple incidents of restraint and seclusion, as was Mr. Smith. Hospital policy safeguards are in place to prevent the trauma associated with repeated restraint and seclusion, which is especially important for patients with a history of trauma.[42]

Additionally, patient records lack required documentation which demonstrates that staff (1) failed to conduct post-event analyses and debriefing following each incident of restraint and seclusion[43]; and (2) failed to follow Hospital policy which requires that the St. Elizabeths Director of Medical Affairs review the patient's chart[44] and the Interdisciplinary Recovery Team review the patient's IRP and comfort plan[45] when a patient experiences two or more episodes of restraint and/or seclusion within 24 hours or three or more episodes within a 30-day period.[46] This review is necessary so that professionals can assess the causes of the behavior and make changes to the patient's care in order to avoid the use of

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[40] Saint Elizabeths Hospital, Summary Investigation of Unusual Incident Report Regarding Charles Smith, Individual in Care (Involved) [SEH Restraint and Seclusion Review].

[41] *See* D.C. Mun. Regs. Tit. 22A § 506.10(c); SEH Policy 103.00 III(A)(3).

[42] SEH's own policy recognizes the potential trauma that restraint and seclusion can inflict on a patient, noting the "trauma inducing aspects of seclusion and restraint" and the "potential for physical and psychological harm and loss of dignity." SEH Policy 103.00 III(A)(1).

[43] *See* D.C. Code § 7-1231.09(j)(3); D.C. Mun. Regs. Tit. 22A § 510.1-3; SEH Policy 103.00 III(K).

[44] St. Elizabeths Hospital Policy 103.00 III(O)(4).

[45] St. Elizabeths Hospital Policy 103.00 III(N)(4).

[46] In addition, Disability Rights DC found that, for two restraints, SEH staff failed to document in detail what less restrictive strategies were attempted and why they were not effective. *See* SEH Unusual Incident Report dated 12/14/22 (UI DB #I-DBH-052513); SEH Initiation of Seclusion or Restraint: RN Assessment form, dated 12/14/22 at 5:18 PM; SEH Unusual Incident Report dated 12/19/22 (UI DB #I-DBH-052571); SEH Initiation of Seclusion or Restraint: RN Assessment form, dated 12/19/22 at 7:15 PM. St. Elizabeth's Summary Investigation of Unusual Incident Report did not fully address this allegation. Disability Rights DC also found that, based on a description of events in the records, one incident of restraint was continued beyond the point when the patient no longer posed an imminent risk of serious injury to himself or others. *See* SEH Unusual Incident Report dated 12/19/22 (UI DB #I-DBH-052571); SEH Progress Note, dated 12/19/22, timed at 9:39 PM. Again, St. Elizabeth's Summary Investigation of Unusual Incident Report did not address this allegation.

seclusion and restraint. These concerns were not addressed in St. Elizabeths' investigation of its own conduct.

DBH's Office of Accountability should have investigated this incident, which threatened Mr. Smith's immediate health and safety and involved multiple violations of policy and District law.

VII. CONCLUSION/RECOMMENDATIONS

Disability Rights DC's review of St. Elizabeths Hospital's response to allegations of serious abuse or neglect demonstrates that the facility alone should not be the sole investigator of serious allegations of abuse and neglect against its own staff. It is clear that St. Elizabeths Hospital failed to uncover important staff deficiencies in its investigations of its own facility. It is also clear -- from prior DBH's Office of Accountability investigation reports of serious allegations of St. Elizabeths staff abuse and neglect -- that DBH's Office of Accountability not only has the requisite independence, but also has the knowledge and expertise to uncover staff deficiencies. *Such deficiencies must be uncovered so they can be addressed.* Failure to do so only increases the risk of serious injury and trauma to patients and can result in preventable deaths.

DBH's Office of Accountability must adhere to DBH's own policy and independently investigate unexpected deaths and serious allegations of St. Elizabeths staff abuse and neglect that threaten the health and safety of patients, such as the incidents described herein: serious injuries, abuse and neglect during repeated restraints and seclusions of an individual, and serious neglect perhaps leading to death.

Ayominde Miller-Aganyemi - YWP

Testimony to the Committee on Health

For the Budget Oversight Hearing for the Department of Behavioral Health

Ayominde Miller

Youth Advocate, Young Women's Project

April 10, 2024

Good morning Councilmembers. My name is Ayominde Miller and I am a sophomore at Phelps ACE High School. I am a Ward 8 resident. I am planning to pursue a career in engineering. I am also a Youth Advocate with the Young Women's Project (YWP). YWP builds the leadership and power of DC youth so that they can improve systems and services. I am here today to share my thoughts on why the budget for DBH needs to be increased to have more mental health groups, therapists, and nurses within DCPS schools.

I am part of The Youth Justice Campaign (YJC), which develops youth as advocates and organizers to advance a bold agenda and leverage their power through collective action. In response to the youth mental health crisis and the need for school based services, YJC youth started the Mental Health Campaign, now in its fourth year, which aims to strengthen school-based mental health programming, connect youth to services, reduce stigma, expand access to mental health education, and advocate for stronger school based programming and funding. Since 2019, YJC Youth Advocates conducted 3 Annual Youth Mental Health Surveys with more than 2,000 students, Youth Staff Advocates presented 72 Performance Oversight and Budget Testimonies on a range of health, employment and education issues to DC Council, helped create the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that codifies the essential role of peer educators into law, and created the Student On-line Support (SOS) Virtual Wellness Centers in 16 schools (and in Spanish), educated more than 18,625 students and adults and reached 800 youth with referrals to DCPS counselors and DBH clinicians. This year's MHC team includes 100 youth in 22 schools. Youth work 4-6 hours a week, receive 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and then work in our schools to collect data, educate and connect peers to resources, and work with adult leaders in DC Council, Agencies, and Public Schools to address the youth mental health crisis. Our 2023-24 Youth Mental Health Survey is linked here.

The main issue I came to discuss was the necessity of more funding to have more mental health groups, therapist within DCPS schools. As a youth advocate I have done a mental health wellness group or one to one if personally needed. One problem I faced is while in some schools there is a whole mental health wellness team, ready for any students who need them, in others there aren't. This problem becomes more apparent when looking at our *2023-24 Youth Mental Health Survey*. 20% of the 690 students didn't feel welcome at their schools, 57% of 690 students don't know their Mental health counselor, and finally for this subject 91% of the 690 students don't know their DBH clinician. This is a major problem, due to the fact that while most people think mental health outreach right now is fine, though the data and statistics says that there needs to be a better and more efficient way to get students in the already existing programs.

While outreach is one problem, another is the lack of resources many schools have to deal with many problems students have. Though some students don't know, the ones that do are in schools who have a lack of resources online or in the schools. In the school many students sometimes just need a small break for class or work but there isn't a place for them to go, due to the school not having staff that can do that or a place with things to help calm down or relax students. 64% of the 690 students Mental Health team never or rarely provide Mental Health online resources, 75% of the 690 students Mental Health team never checked in with their class, and finally 78% of students Mental Health Team never or rarely provide one on one support.

The problem of not having enough resources in dcps schools can be fixed through an increase of budget. Though, to maximize the effects, you can run a dcps school wide survey to see the schools who need mental health resources, and increase the budget according to the survey. By doing the survey you can also better see the needs of every student

individually from each school, to see the different things they need like a cool down room, one to one programs, a mental health month, and/or a mental health team.

Another way to ensure students having good mental health is by putting and ensuring that Mental health teams are doing their jobs the best way possible. By making it mandatory at least once every school year to have a meeting with every student to ensure they are mentally fine.

Part 4 – Solutions. This is an opportunity for you to make the case for what solutions you would like to see developed, implemented, funded. Based on your experience as a YWP Advocate, what do you think will work to solve the problem. Solutions can come from your ideas – or – ideas that were developed by YWP or your program team.

Some solutions for not having mental health groups,or therapists within DCPS schools, is to re-invest more into the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot*) for FY2025. This program hired students within certain schools and trained them to distribute surveys, do wellness groups with school, write and speak testimonies, and work in the field of mental health and/or clinic assessment. Within the YWP I learned all of those things, and performed class presentations in school during lunch. I received positive feedback, and many people came to me with problems they had, but could never share with anybody. I also help distribute surveys in which the data that was collected was used today. That data helps me see the thoughts of my peers at school better and find solutions to help them with their problems and needs. By increasing funding into the P2P pilot, many students can become peer educators and can help other peers they know need help.

We are grateful to you and your staff for developing and budgeting the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot*) *that codifies the essential role of peer educators into law and* DBH award 2 grants totaling $325,000 to non-governmental entities to train and supervise at least 100 high school student behavioral health peer educators. We are asking you to include this finding again in FY2025 either in the DBH budget or the DOH budget. The work that YWP's Youth Advocates are doing demonstrates the critical role they play in Here is what we achieved in the past year:

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Hired and trained more than 110 Peer Educators & Support Specialists in 16 schools: *Youth work 4-6 hours a week, are paid $10-17 and hour, and receive 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and* develop a portfolio of products, build cross-school friendships; 52% are from wards 5, 7, and 8.

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Surveyed 657 public and public charter students from 16 schools living in all DC wards (with heaviest representation from wards 4 and 7). Data from the 2023-24 Youth Mental Health Survey linked here. More details on the survey findings are included below.

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Distributed paper and electronic materials to 4,125 public and public charter students so far this year. Materials include infographics with QR codes on 10 mental wellness issues, links to self paced slide presentations, and hands on worksheets and skills building links—as well as counselor information, hot line numbers, and 2023 Student On Line Support: Virtual Wellness Center:

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Trained 4,125 peers through classroom presentations and training in 16 schools on a range of mental health & wellness issues including toxic stress, trauma, resilience building, anxiety, suicide, social health, and how to build resilience through relationship building, meditation, exercise, nutritional healing, self-care, self-agency, and other wellness practices.

Thank you for hearing my testimony, council members.

Louise Gray

1. DEAR MAYOR BOWSER: PLEASE FUND DBH FOR THEM TO START PROVIDING BEHAVIORALHEALTH SERVICES FOR PEOPLE WITH THE DIAGNOSIS OF HOARDING DISORDER. DBH COULD PROVIDE EARLY INTERVENTION AND HARM REDUCTION SERVICESWHICH WOULD BE A COST SAVING OVER THE CURRENT SITUATION WHERE ADULT PROTECTIVE SERVICESPROVIDES HEAVY DUTY CLEAN OUT AT A A GREAT COST INCL GUARDIANSHIP AND NURSING CARE LONG TERM AT A GREAT COST

JOINT BUDGET COMMITTEE ON HEALTH
TESTIMONY OF WARD 8 FARMERS MARKET, INC. (a 501(c)(3))
By John Gloster, Chairperson of the Board

April 10, 2024 (12 pm)

Good afternoon, Chairperson and members of the Joint Budget Committee on Health.

I am John Gloster. I am the founder and Board chair of the Ward 8 Farmers Market. The Ward 8 Farmers Market is the creation of Ward 8 residents who banded together after the last supermarket in the Ward closed in 1997. It was a bold, self-empowerment move at a time when the Ward's residents felt disempowered, cast off by business interests, and forgotten and neglected by our government. Today, we live in the eerie déjà vu of an Alabama Avenue Giant with empty shelves, poorly run by management that is so afraid of shoplifters that they seem intent on running the store into the ground.

Back in August of 1998, when the Ward 8 Farmers Market began operation, there were no farmers markets in Ward 8. There were no farm stands. There was not even a converted school bus pulling up with produce. Eventually, other markets would pop up. Established nonprofits from across the River came and raised a flag in Ward 8. Some continue to help bridge gaps in the Ward. Some may have come principally because it had become fashionable to do so and was useful in raising funds. But we have remained an authentic Ward 8 product: created by Ward 8 residents, for Ward 8 residents. We are more than a service; more than a place and time for transactions. We are a community.

Along the way, we have served hundreds of Ward 8 families, providing the substance of many tens of thousands of healthy meals. Many years ago, WE pioneered a program of putting healthy fruits and vegetables in corner stores. We have had innumerable healthy cooking demonstrations, free blood pressure readings, free dental exams, free yoga classes, meditation, massages, line dancing and more. Many of our vendors have traditionally been Ward 8 residents, providing some a means to tryout and grow their entrepreneurial aspirations. For others, it is more about a way to connect with the community.

Perhaps it should not be surprising that we have done this all on a shoestring all these years. We have never quite reached that critical mass where we could attract enough funding to hire a fulltime market manager all-year around, so that we could properly grow the organization. Instead, we have to reinvent ourselves each new season, reminding our customers where we are, and pulling up stakes every few years for lack of a permanent location.

Our problem is not confined to the Ward 8 Farmers Market. Other grassroot nonprofit efforts struggle in the same way to reach that critical mass that would inspire more confidence in grantors and qualify us for another tier of funding.

We would like to make a suggestion and a request. We ask this Committee and the Council to place a requirement on related grants requiring that grantees provide a minimum percentage of their awards in subgrants or subcontracts to local, small nonprofits in the communities they serve (especially in Wards 8 and 7). By small nonprofits, we mean those with annual budgets of less than $250,000. The concept is the nonprofit analog to the CBE requirements placed on construction contracts. In this way, the government, through the Council, can tap the larger nonprofits to help mentor and nurture smaller, grassroots nonprofits toward sustainability. In this way, more of those ideas and energies that come directly from the community can reach their highest expression. We hope that you share and value this

ideal. If you do, please take action in **this** budget cycle. Fund healthy lifestyle transformation, particularly East of the River, and pair it with a mandate to partner with small, local nonprofits. Thank you.

Adam Zaid

DBH needs to do something to address the unmet need and severe behavioral health service gap for District residents living with the diagnosis defined in 2013's DSM-5 as “hoarding disorder” (HD). Numerous other jurisdictions in the DMV have hoarding that task forces. Why doesn’t DC? DBH early intervention will reduce harm and save DC taxpayer dollars for FEMS and APS. Please allocate $50,000 for DBH to train care providers for one week with follow up about identifying and mitigating the effects of HD. $50,000 is nothing compared to the cost of responding to emergencies caused by skipping training Dept of Behavioral Health staff easy accessible techniques to ameliorate the hazards to person and property struggling with hoarding disorder.

Recovery Centers *of* America

Opening Remarks:

Good day to the DC City Council, Olive Tree and community providers, my name is Fredericka Ford and I am the CEO at Recovery Centers of America-Capital Region.

About Recovery Centers of America:

For almost a decade, Recovery Centers of America is dedicated to helping patients achieve a life of recovery through evidence-based treatment for substance use disorder and co-occurring mental health conditions. RCA has 11 inpatient facilities, including its Waldorf location near Washington, DC. [1] RCA's programs also offer a full spectrum of outpatient services. Patients can obtain care by calling a centralized call center (1-844-5-RCA-NOW) 24 hours a day, seven days a week. Complimentary transportation is provided in most cases. For the fourth year, Newsweek recognized RCA among America's Best Addiction Centers.

Our Response to the Crisis
The Washington Post indicated that fatal opioid overdoses in the District of Columbia have more than doubled over the last few years reaching over 474 avoidable overdose deaths in 2024. The surge is in keeping with a nationwide trend that emerged as the potent synthetic opioid fentanyl entered and overtook the drug supply. RCA is eager to partner with and support the District of Columbia to address this crisis. RCA can as dedicate existing infrastructure to this partnership as our RCA Capital Region facility in Waldorf, Maryland has 44 licensed detox beds and 96 residential beds. RCA Capital Region has been successful in reducing unnecessary ED and hospitalization through our care model which consists of 12-step recovery, dialectical behavioral therapy DBT, Community and Family Involvement, Measurement Driven Care, Alumni and Medication for Addiction Treatment (MAT) for a patient-centered approach. RCA Capital Region offers its experience and expertise to help the District of Columbia addressing the ongoing opioid crisis.

Our Approach
As a community of providers, we acknowledge the staggering impact of the opioid epidemic on the community, particularly our local Emergency Departments. RCA Capital Region is committed to gaining certification as an Overdose Response Program in partnership with respective Departments of Health. This will provide Narcan for patients, staff and family and readily available access on hand. Additionally, we are committed to providing a brief training to all individuals accepting Narcan and will plan to give every discharging individual a kit to take with them. As part of our model, we ensure individuals completing treatment at RCA Capital Region continue with ongoing outpatient care and committed to prescribing medications for Opioid Use Disorder including Buprenorphine as early in the treatment stay as possible, and to coordinate post-release care to continue these treatments. On site we offer outpatient medication assisted treatment ("MAT Simply put; our model is **reducing harms while reducing barriers!**

[1] RCA's other locations are in Earleville, Maryland, Massachusetts (Danvers and Westminster), Illinois (St. Charles), Indiana (Indianapolis), New Jersey (South Amboy and Mays Landing), and South Carolina (Greenville).

RCA's evidence-based care model is a unique, innovative and patient-centered approach to treating addiction and sustaining recovery.

a. Three specific pathways ensure personalized and effective care.
    1. Pathway 1, Foundations, for first-time recovery patients focuses on finding and addressing the sources that drive an individual's addiction.
    2. Pathway 2, Fresh Start, for returning/relapse patients focuses on addressing the gaps in previous recovery experience and identifying top triggers.
    3. Pathway 3, Balance for patients with cooccurring disorders assesses and addresses triggers for SUD as well as mental health and other contributing conditions.

b. Six core tenets provide patients with a variety of resources to achieve lasting recovery.
    1. The 12-step program and other successful recovery support programs are integrated on a daily basis.
    2. Medication for Addiction Treatment (MAT), a highly proven effective treatment – is strategically offered at a higher rate by RCA than the national average, leading to an impressive 20% reduction in readmissions.
    3. Dialectical Behavior Therapy (DBT), evidence-based skills training and coaching
    4. Measurement-driven care, evidence-based symptom measures that track and contribute to positive outcomes.
    5. Robust alumni program helps ease the transition back into daily life and provides long term sober supports.
    6. Family support and involvement also contribute to long-term success.

RCA's commitment to personalized care and proven results throughout a patient's recovery journey sets them apart from others in the industry.

c. A full continuum of care is provided at each step of the recovery process.
    1. Medically supervised detoxification in a safe and comfortable setting
    2. Residential treatment with medical and clinical care
    3. Partial Hospitalization Program (PHP) includes structured program to transition to outpatient services
    4. Intensive Outpatient Program (IOP) is continuation of weekly group and individual therapy sessions
d. RCA collaborates with primary care physicians (PCPs) and mental health providers to support all aspects of patient care.
e. Embracing the guiding principles of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), RCA weaves these evidence-based philosophies into the care model, ensuring that patients benefit from the latest research, innovation, and a comprehensive approach to addiction treatment.

New data shows that the outcomes of RCA's model are significantly surpassing national benchmarks and other recovery centers. Readmission data is based on RCA readmission data and is corroborated by major payors.

f. RCA is outperforming national readmission rates.
    1. At 30 days, RCA's readmission rate is 7.5%, below the national expected rate of 10%.
    2. At 90 days, RCA's readmission rate is 14.9%, below the national expected rate of 20%.
g. Utilizing Brief Addiction Monitor (BAM) as its primary psychometric screener, RCA's results are also successful in better preparing patients for recovery and preventing relapse-related behaviors.
    1. Protective scores are 7 points higher than the national average.
    2. Risk scores are 18 points lower than the national average.
h. For patients opting to use MAT, RCA's approach contributes to a 20% reduction in readmissions.
i. Positive, lasting outcomes are also seen across spirituality, self-help program attendance, confidence in sobriety, and reductions in sleep issues, cravings, etc.

RCA's commitment to exceptional, customized care is evidenced by addressing common obstacles that hinder recovery – including rapid admission, insurance coverage and other accommodations.

j. RCA's patient-first approach is reflected in a high patient satisfaction rating of 4.5 on a scale of 1–5.
k. Contracted with over 50 health insurance carriers, RCA's broad network ensures accessibility and reduces cost barriers for patients.
l. RCA has completed 2,400 staged interventions to date.
m. RCA places patients at the center of care right from the first call.
    1. 82% of patients are admitted within one day of calling the facility, with a call center response time averaging 7.1 seconds.
    2. The Mission Center, which is open 24/7 and 365 days a year, has answered over 800,000 calls to date.
    3. RCA has admitted over 70,000 patients into care and transported 35,000 patients to treatment.
    4. RCA will drive 3+ hours to pick up patients, including those out-of-state.
    5. RCA offers patients world-class facilities designed to provide an unparalleled comfortable environment designed for healing and recovery.

Closing Remarks:

RCA Cap Region would like to thank the District of Columbia City Council, Olive Tree and community providers for the opportunity to partner on practical solutions to address the complexities and challenges of the Opioid crisis that has plagued our communities.

Philip Carpenter

I started with no one to turn to. I couldn't locate anyone I knew or trusted. I really didn't want to meet the wrong type of person. I was homeless. That's when I connected with Catholic Charities. It took time but they gained my trust by showing me more and more the heard stories like mine. They showed organizations that would help me like Social Security and Social service. They found housing that I would be safe in and could afford.Slosly but surely things have progressed I'm now a Catholic Charities employe. I have maintained employment for the last 11 years.

Hello. My name is Robin Perry, and I am here to testify on behalf of my brother Jermaine Crank. The agency overseeing him is MBI on Taylor Street, N.W. MBI is not assisting Jermaine to the capacity they are getting funding for. First, there is no accountability as far as me, his family member trying to make sure he is getting the services he needs. Even though he is 50 years old on paper, mentally his is not 50. Every time I try to talk to the head person for him, he has not responded or returned my telephone call.

I am the type who likes to meet the individuals helping him, so I know who is who. I have been trying to find out about is HIV status. He has had a problem with his teeth and his feet for a while. We did get him inserts from the Good Feet Store but now he is stating he has knots on his feet and cannot walk far because his feet hurt. What is his social worker getting paid for and what is her job as far as helping to make sure his getting the things he needs. He complains that they are not doing what they are supposed to do. When I step in, my hands are tied because of his age. He does tell them they can talk to me because he knows I will always try to make sure they are helping him. When he has his episodes, he will go and ride the bus any time of the night and that is dangerous. He is afraid to go to the Whitman Walker office in SE because he has been jumped and his jacket was taken. He now goes to the Whitman Walker office on 14th Street. I have told MBI about him going out at night and early morning and how I am afraid for him.

He was one of the residents at the house at 1500 Park Road, NW that caught fire. We finally got him housing last November and he lives in a nice house on Arkansas Avenue, N.W. The issue with that is Catholic Charities ran the house and they did not reimburse any of the residents for their belongings that they loss. The lady who ran the house Ruth Mundell only gave the residents back their security deposits which was $500. Who is responsible for reimbursing the residents for their belongings they loss. Someone should be held accountable. Catholic Charities have been giving me the runaround because I have said to them and Ms. Mundell someone should be responsible. Its like they do not care and not trying to cough up any money.

The whole mental health system in DC is an absolute mess and it is a disgrace for the individuals who depend on these services are not getting what they need especially if they have family that care. So, can you imagine what is happening to those individuals who do not have family who are concerned about their well-being.

Some type of regulations and guidelines should be in place for these agencies to have to abide by and if they do not, they should not get the funding they are requesting. MBI is like a daycare center with the individuals walking around looking like zombies begging for cigarettes and what not. Can someone please take the lead to help because I am only one person, and I cannot do it all. I have a full-time job and constantly get calls from my brother complaining about things. I even tried to become is guardian when it was Green Door. I even had Jermaine an attorney and had court dates set up. When it came time to go to court, Jermaine was a no show and the Judge said that there was nothing I could do without him participating. Green Door got in his ear telling him I was trying to get his money which was not true. Bread for the City manages his money and when he needs something, I must get approval from Bread for the City to cut a check for whatever, example, The Good Feet Store and give Bread for the City the receipt so they will know we did what we were supposed to do. I would never try to get money from him. I do not need his money.

District of Columbia Behavioral Health Association
PO Box 33515
Washington, DC 20033-0515
202-929-3757

Testimony of the District of Columbia Behavioral Health Association
Department of Behavioral Health FY '25 Budget Oversight

To the District of Columbia Council Committee on Health
April 10, 2024

Chairperson Henderson and Members of the Council,

Thank you for the opportunity to testify today. My name is Mark LeVota. I am the Executive Director of the District of Columbia Behavioral Health Association and a Ward 2 homeowner. The District of Columbia Behavioral Health Association works to advance high-quality, whole-person care for District residents with mental illnesses, substance use disorders, or both, including the 33,000 District residents our 33 member organizations serve annually.

This hearing's focus on the Mayor's proposed FY '25 budget for the Department of Behavioral Health should raise stark concern for anyone interested in the emotional wellbeing of District residents. While the Covid public health emergency period has ended, District residents continue to experience escalated levels of emotional distress.[1] The opioid fatality rate has been twice the rate of homicides four years in a row. Suicides and suicide attempts are up, especially among our young people. 10% more residents regularly report symptoms of anxiety and depression than before Covid, an unsurprising response to continuing trauma, toxic stress, and community violence. Yet, this budget withdraws resources that have increased access to care and enhanced health equity.

We commend DBH leaders for the time and dedication they surely devoted to the excruciating task of drafting this budget, and we are grateful that we see no evidence of going back on hard won gains this year, such as payment rate increases for Community Residential Facilities for the first time in six years. This glimmer of silver lining does little to abate the raging thundercloud.

Cuts to grants, contracts, and billable services occur alongside significant reductions to DBH's staffing. Multiple cuts to the school behavioral health program collectively place the program on the brink of collapse. The budget eliminates a fifteen-year investment in providing behavioral health urgent care services at the courthouse, naming the vendor in the reduction narrative rather than describing the

[1] Citations for the following statistics are in DCBHA's DBH Performance Oversight testimony.

nature of the contract,[2] and the budget eliminates onsite behavioral health assessments at the courthouse provided by different professionals. The budget also includes an $11.6M reduction "in community support benefits and restriction of audio only service modality," which deserves close scrutiny. DBH's own staff members are not spared, as the budget proposes a remarkable net reduction of 27.6 FTE positions from DBH staff.

The proposed reductions to school-based services pose a real threat to the continuing viability of the program. ARPA funds ended, leaving school behavioral health services budgeted for a $9K per grant reduction, despite the fact those grants were already $9.5K per school underfunded. Millions of dollars in FY '25 reductions are bad enough, but the Mayor's FY '24 supplemental budget also makes it impossible to sustain the tactic of the past several years that relied on previous year vacancy savings to provide supplemental payments into the next school year. Clinicians have active caseloads in 168 schools, and through the other resources in the program, only a handful of schools are not receiving support from the program. Finding a way to set the program on a more sustainable path is imperative. CBOs have a cost of over $130K per school to operate the program[3] and, on average, can expect to recover approximately $35K per year in claims billing. We estimate that grant amounts need to be rebased to $98,500 per CBO clinician per school. This would allow CBOs to increase clinician salaries to approximately $74,000, the 10th percentile of pay for licensed clinical social workers in the District, instead of paying, on average, $10,000 less than the 10th percentile, the $64K that CBOs reported actually paying in DBH's most recent CBO clinician salary survey. The Council should find a way to fund the program at $25M and give CBOs a chance to close vacancies by offering reasonable and sustainable compensation. The Council should also find a way to maintain funding for the Community of Practice, so clinicians, school behavioral health coordinators, educators, school leaders, families, and other stakeholders do not lose access to these valuable supporting resources that have operated as a core component of the program since it was launched.

The Council should carefully scrutinize what it is being told about the proposed $11.6M reduction "in community support benefits and restriction of audio only service modality." The District's federal Medicaid match means an $11.6M reduction of District spending also forfeits $27.1M in federal

[2] The "Mayor's Proposed Budget" section of "Reduce" includes the clause "$922,833 for the Pathways to Housing contract." Pathways to Housing has been the successful awardee of this competitively bid contract three times, but the contract is not a "Pathways to Housing" contract. It is a contract for a behavioral health urgent care clinic at the DC Courthouse. Perhaps the wording is intended to avoid confusion with the separate "$659,180 contractual savings at the Assessment Center/Courthouse and Assessment and Referral Center," also listed in the "Reduce" section, but that only obscures that the entirety of the proposed budget eliminates two distinct sets of behavioral health services at the Courthouse. OCFO Budget Volume 4, E-35. Available online April 5, 2024 at https://app.box.com/s/s5zt9krml3wnhnexaldged0mu89ylc2v

[3] This includes the cost of increasing clinician salaries to $74K as well as the costs of benefits, overhead, and subsidized clinical supervisor salaries, benefits, and overhead to maintain the 1:6 clinical supervision ratio for CBO clinicans. Detailed financial calculation estimates available on request to Mark.LeVota@DCBehavioralHealth.org.

spending, for a total expected reduction of $38.7M in spending.[4] At current payment rates[5] for community support services ($29.66 per fifteen minutes = $118.64 per hour), this would eliminate 326,000 hours of care for DBH enrolled consumers and require DBH-certified mental health providers to reduce 223.85 FTEs.[6] DBH has reasons to seek different parameters for how the community support benefit is administered and how audio telehealth can be used more effectively, but community support services make up 82% of DBH's community behavioral health spending and are still paid at rates based on 2016 costs.[7] Instead of eliminating $11.6M, this funding should have been repurposed to start paying the provider network at current costs[8] for the single largest billing category in the system.

DCBHA supports reasonable reconsideration of the community support benefit, especially if there are reasonable replacement services available, and DCBHA supports removal of bad actors from the provider network and methods to ensure that a majority of community support services are delivered face to face.[9] If these reductions are the result of a restructuring of the community support benefit, no explanation has been offered to the provider network about what that requires or what DBH enrolled consumers should expect, and no meaningful replacement has been offered – or budgeted. If these reductions are, as the Mayor's budget director indicated to the Committee of the Whole on April 3, telephone telehealth "compliance work,"[10] no explanation has been offered to the provider network about what types of program integrity enforcement actions DBH has undertaken or plans to undertake or what method of restriction of audio telehealth DBH proposes.

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[4] Once again, the Mayor's supplemental FY '24 budget makes this issue worse, since $6M is proposed to be reduced from these same services, again forfeiting $14M in federal match, for a total $20M projected reduction in spending within the remainder of FY '24.

[5] Current payment rates are based on 2016 costs, plus one 6.2% adjustment. The CMS Medicare Economic Index, which DHCF uses as its inflation reference for medical spending, shows medical inflation from 2016Q2 to 2023Q2 was 23.5% (CMS uses Q2 of the previous year as a basis for current-year rate setting), meaning current payment rates are 17.3% below 2016 costs. Available online April 5, 2024 at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data. Calculations about DBH reduced spending solely reflect provider revenues and do not account for the impact of rate insufficiency.

[6] Presumes an average of 70% of a regular 2,080 hour work year (1,456 hours) results in a paid billable claim. Even if community support workers are on contracts that are not paid except for billable time (=100% productivity), this would require a workforce reduction of 156.69 FTEs.

[7] As DHCF told this Committee during budget oversight, behavioral health provider payment rates have been updated for over twenty different billing codes. DHCF omitted that the payment rate for the billing code (H0036) that comprises 82% of all claims billed by DBH's mental health rehabilitation providers has not been updated, and compared with CMS market basket data is now 17.3% below 2016 costs.

[8] Again, given CMS lookback parameters, this would be minimally updating to 2023Q2 costs.

[9] Specifically, we would support DBH approaching community support on a modified basis consistent with the way it did before the Covid pandemic, with an expectation that 60% of care must be delivered face to face in home or community settings, and the remaining balance could be additional face to face care or any mix of office-based or telehealth services (including video and audio telehealth).

[10] Notably, this implies that DBH believes some paid claims for telephone services were not actually connected to services delivered, and the Council should press DBH to explain how many thousand fewer consumers it believes were served than DBH reported in its most recent MHEASURES report.

We expect DBH to tell the Council that it is working to 'right size' the community support benefit and the audio telehealth modality. We understand that the 'right size' may be a reduction, but the 'right size' still needs to be enough to support clinical needs and to ensure that audio telehealth's important role in expanding access and making access more equitable are protected. Audio telehealth has increased the provider network's engagement with DBH enrolled consumers who are otherwise sometimes difficult to find, and the provider network deserves to be compensated for the time and cost of work conducted by phone. Even while we fully support efforts to ensure that audio telehealth is responsibility provided at appropriate clinical standards of care, audio telehealth for behavioral health should not face more substantial burdens than audio telehealth for physical healthcare as a matter of behavioral health parity. Additional administrative burdens that require more paperwork and delayed care approvals do not support timely access for consumers or take seriously the workforce challenges the provider network continues to face. The Council should immediately begin to consider what actions will be needed to restore at least part of this proposed $11.6M reduction.

We acknowledge and express our concern that DBH itself is not spared in the Mayor's proposed budget. The Council should critically evaluate how a government agency facing a workforce crisis, that spends less than 2% of the District's overall budget, can afford to lose one out of every twenty FTEs proposed for elimination across the whole District government in this budget, three times DBH's share of the District's overall budget. While the choices are stark at the surface, deeper investigation paints an even more bleak picture. DBH faces 27.6 FTEs of net staffing reductions, but the components that make that net number should be disaggregated. DBH faces reduction of 16.3 FTEs of staff from its children services teams, including 10.3 FTEs from school based services alone. The adult services team also faces reduction of 16 FTEs, including six at 35 K Street and four in the Integrated Care team. These positions overwhelmingly provide direct clinical care or evaluate authorization requests for direct clinical care. These reductions will cause District residents delays in accessing care, and some may never receive the care they need if it is delayed. The 4 FTE reduction from the Access Help Line similarly allows current delays to persist for people calling seeking behavioral health care waiting up to 45 minutes for non-crisis calls. We applaud the increase of 10.8 FTEs to help CPEP right-size its staff capacity to meet demand, but this one improvement is hard to celebrate in light of so many other ways people are losing access to care and may not be enough to compensate for further increased demand when those other losses of access to care increase the frequency of decompensation to crisis.

Thank you again for the opportunity to testify today. I look forward to answering any questions that you might have.

Budget Oversight Hearing for the DC Department of Behavioral Health (DBH)

My name is Nene Rhodes, a retired public health practitioner and a Policy advocate for the American Foundation for Suicide Prevention (AFSP) National Capital Area Chapter (NCAC). We appreciate the opportunity to testify in support of improving access to mental health care for the uninsured, underinsured individuals including youth in District of Columbia (DC). Unmet needs for counselling and behavioral therapy in individuals reporting mental health conditions (i.e. depression, anxiety, substance use...) are more likely to lead to death by suicide than in individuals without mental health conditions. Suicide is a leading cause of death in US. Suicide can be prevented by more investment in suicide prevention, education, research…

Research shows that 61%of communities did not have enough mental health providers to serve DC residents in 2023 according to federal guidelines. In 2021 Suicide was the 3rd leading cause of death for ages 10-24 and 25-34. Depression is the most common condition associated with suicide and is often untreated. 30.7 % In DC reported mental health conditions compared to national data of 32.3% in February 2023 survey. Unmet need for counselling and therapy in adults reporting symptoms of mental health conditions in an April - May 2022 survey was 49 .3 % in DC compared to 26.8% national average, higher in all states.

We urge therefore the Council to support the suicide prevention strategy of better advertising the 988-crisis helpline to youth by putting signs up in schools or having 988 on student IDs; advertising access to crisis services will help get youth connected to mental health care regardless of insurance status. In addition, we recommend putting up 988 crisis helpline signs in shelters, and substance abuse treatment centers, more investment in expanding mobile crisis care, and increasing availability of mental health services in the District to meet the mental health needs of vulnerable residents.

We also urge your support in gun safety provisions such as accessing free gun locks and safes through DBH.

Please do not hesitate to contact me at gouba1@aol.com or (703) 255 1569 if you have any questions, or would like to discuss further.

Thank you for considering our views.

Mark Ruppert

Hoarding is a serious issue in Washington DC. I have personally known two elderly people who lived in homes packed with their hoarding collection making their living condition unsafe and unhealthy.

DBH needs to do something to address the unmet need and severe behavioral health service gap for District residents living with the diagnosis defined in 2013's DSM-5 as “hoarding disorder” (HD).

Numerous other jurisdictions in the DMV have hoarding task forces. Why doesn’t DC?

DBH early intervention will reduce harm and save DC taxpayer dollars for FEMS and APS.

Please allocate $50,000 for DBH to train care providers for one week with follow up about identifying and mitigating the effects of HD.

Thank you!

Council of the District of Columbia
Health – Budget Oversight Hearing
Testimony: Luis Chavez - The Family Place
April 10, 2024

Good day esteemed members of the Council,

My name is Luis Chavez and I'm the Director of Operations and Outreach at The Family Place and a former Home Visitor for 5 years. The Family Place is an organization located in Ward 1 serving low-income immigrant families across the District of Columbia. I stand before you today to advocate for the importance of maintaining funding for home visiting programs. These programs are critical in supporting families during their most vulnerable and crucial years, ensuring that infants and children reach their developmental milestones on time and without delays.

Home visiting programs utilize evidence-based methods to promote parent-child bonding and provide essential material support to expectant parents and families with young children. The impact of these programs on the overall well-being of families cannot be understated. They create a safe and stable environment, help families reach their parenting goals, and ultimately contribute to the healthy development of children which gives them an advantage once they reach school age.

Budget cuts to home visiting programs not only destabilize these vital services but also disrupt family continuity and support systems. The loss of a home visitor creates instability and a gap in access to critical resources for families in need. It places additional stress on staff members who are already working tirelessly to support these families.

Furthermore, the populations served by home visiting programs are often neglected by mainstream systems of social services. These underserved families rely on the consistent and reliable support provided by home visitors to navigate the challenges they face. Maintaining stability in home visiting programs is essential to ensuring that these families receive the support they need.

I urge you to consider the long-term impact of reducing funding for home visiting programs. The benefits of these programs extend far beyond individual families and have a positive ripple effect on communities as a whole. Investing in home visiting is an investment in the future of our children and our society. I implore you to prioritize the well-being of families and children by protecting the funding for these invaluable programs.

Thank you for your time.

Luis Chavez
Director of Operations and Community Engagement

Carlos Garcia

DBH needs to do something to address the unmet need and severe behavioral health service gap for District residents living with the diagnosis defined in 2013's DSM-5 as “hoarding disorder” (HD). Several other jurisdictions in the DMV have hoarding task forces, and DC should as well. DBH early intervention will reduce harm and save DC taxpayer dollars for FEMS and APS. Please allocate $50,000 for DBH to train care providers for one week with follow up about identifying and mitigating the effects of HD.

JOHN HOGEBOOM, PRESIDENT AND CEO, COMMUNITY BRIDGES INC.
TESTIMONY, COMMITTEE ON HEALTH
THE COUNCIL OF THE DISTRICT OF COLUMBIA
APRIL 9, 2024

My name is John Hogeboom, and I have had the privilege of serving as the CEO/President of Community Bridges, Inc. (CBI) since 2019 and working for CBI since 1994. Across my three-decade journey as a CBI employee, I've witnessed firsthand the transformative power of integrated behavioral healthcare and leading-edge substance abuse treatment in communities across Arizona, Oklahoma, and here in Washington, D.C.

Founded in 1982, by individuals with lived experience, CBI is committed to a holistic approach to addiction treatment and behavioral health concerns. We understand that every individual is unique, and their journey to recovery should reflect that. With a dedicated team of over 1,600 professionals nationwide, we strive to uphold our mission of maintaining the dignity of human life through innovative and compassionate care.

Our collaboration with the D.C. Department of Behavioral Health and FEMS to open the D.C. Stabilization Center last October marks a significant milestone in our commitment to serving the needs of the District. Through this partnership, we have leveraged our decades of experience and expertise to create a safe haven for individuals experiencing substance use disorder crises.

The Stabilization Center, located at 35 K Street NE, is a beacon of hope for those in need. It operates 24/7, providing immediate, low-barrier access to crisis services for individuals aged 18 and older, irrespective of insurance or residency status. Our "no wrong door" philosophy ensures that nobody seeking help is turned away regardless of how many times they seek it, and we work tirelessly to connect individuals with the care they need, when they need it.

I am proud to say that our partnership with the DBH has been instrumental in making the Stabilization Center a reality. Together, we have created a model of care that prioritizes dignity, respect, and accessibility for all.

Furthermore, our commitment to the local community is reflected in our staffing practices. Currently, 56% of our staff are DC residents demonstrating our dedication to supporting the local workforce but also strengthens our connection to the community we serve. Our organizational culture rooted in the support of an upward mobility model has allowed us to hire primarily individuals with lived experience who have access to tuition reimbursement, student loan repayment, and workforce development programming that supports growth within the organization. This model has already taken root with multiple promotions at the Stabilization Center which is the same process that allowed a person like me to work my way from a tech to CEO.

Looking ahead, our focus is on continuing to build upon the existing continuum of care to increase throughput and meet the growing demand for services. By investing in partnerships with local

providers, infrastructure, technology, and staff development, we aim to further enhance our ability to serve the community and make a lasting impact on the lives of those affected by substance use disorders.

In closing, I want to express my gratitude to the Council of the District of Columbia for their continued support of initiatives like the D.C. Stabilization Center. By working together, we can make a real difference in the lives of individuals and families struggling with addiction. Thank you for your time and attention.

AMERICAN ATHEISTS

April 10, 2024

The Honorable Councilmember Christina Henderson
Chairperson, Committee on Health
The John Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

Re: Informing the Committee on Health regarding the issue of medical denial of care from health institutions and practitioners, encouraging the Committee to explore this issue further

Dear Chairperson Henderson and Members of the Committee on Health:

My name is Rob Hofmann. I am a Ward 5 resident and have lived in DC for almost five years, but I am here today in my role as the State Policy Manager for American Atheists. American Atheists is a national civil rights organization dedicated to equality for atheists and other nonreligious people. We protect the rights of atheists, advance social inclusion, and empower nonreligious people through advocacy, education, and community building.

I am here today to discuss the issue of nonmedical denial of care by health care institutions, which has a disproportionate impact on LGBTQ individuals and pregnant individuals in the District. Denial of care increases insurance costs and negatively impacts patient outcomes, and therefore the Department of Health, DBH, and the Committee on Health should take steps to mitigate these harms by requiring disclosure and transparency.

Federal and District law allows hospitals and health care facilities to deny various types of care based on nonmedical factors such as the religious beliefs of hospital executives. Because hospitals often fail to publicly disclose nonmedical restrictions on services, patients too often lack vital information necessary to make critical decisions about their health and where to receive care, including care for LGBTQ people, end-of-life care, and reproductive care.

For example, a hospital may deny emergency contraception to a survivor of rape, timely abortion care for a pregnant person whose life is at risk,[1] sterilization procedures for patients seeking them, or gender affirming care for trans patients. There is no requirement that health facilities warn patients that they will be denied care, and too often, patients may not even be informed of all their medical options. This lack of information can result in patients wasting time and money,

[1] A nationally representative survey found that 11% of participants had someone on their plan who was denied reproductive care. Hebert LE, Wingo EE, Hasselbacher L, Schueler KE, Freedman LR, Stulberg DB. (2020). Reproductive healthcare denials among a privately insured population. *Preventive Medicine Reports*. 2021;23:101450.

being prevented from receiving needed care, facing discrimination, and even suffering increased risk in emergency situations.

While some types of denial of care are required under federal law, the District can and should require hospitals and health care facilities to inform patients and the Department of Health about nonmedical restrictions on care. The informed consent process is a well-recognized and critically important factor in health care, but there cannot be informed consent if key information about treatment options is withheld from patients. If care related to pregnancy management or gender affirming care is withheld because of a facility's religious beliefs without a patient's knowledge, the informed consent process has been breached.

Several factors make nonmedical denial of care an increasingly significant problem in DC. Because nearby states have banned or have considered severely limited access to abortion services after the Dobbs decision,[2] the number of patients crossing state lines to access reproductive care in DC has and likely will continue to increase. Similarly, an increased number of people are seeking gender affirming care across state lines as more states consider banning health care services for trans people. Patients visiting DC for medical services need to know where they can access necessary care and where the care they seek may be denied. Requiring disclosure to patients about nonmedical denial of care would help address this.

This issue is especially important in the District, which has one of the largest populations of trans people in the country.[3] The U.S. Conference of Catholic Bishops, which issues guidelines that Catholic hospitals must follow, has recently issued new guidance to limit trans care overall, seemingly in conflict with discrimination laws both in the District and the federal level.[4] As of 2020, one out of five hospital beds in DC are in religious facilities that deny care for nonmedical reasons.[5]

Refusals of care have real consequences for those denied needed services, particularly if they already face barriers to care or discrimination.

- In an assessment of 34 states, one study found that delivering at a Catholic hospital was much more common among Black and Hispanic women than among white women. Black women are especially vulnerable to denial of reproductive health care because they are significantly more likely to die from pregnancy-related causes and more likely to seek

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[2] *Dobbs v. Jackson Women's Health Organization*, 597 US __ (2022).
[3] LGBT Demographic Data Interactive. (January 2019). Los Angeles, CA: The Williams Institute, UCLA School of Law. Retrieved from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=11#about-the-data.
[4] U.S. Conf. of Catholic Bishops, *Doctrinal Note on the Moral Limits to Technological Manipulation of the Human Body* (20 March 2023). Retrieved from https://www.usccb.org/resources/Doctrinal%20Note%202023-03-20.pdf.
[5] Solomon, Uttley, HasBrouck, and Jung. (2020). *Bigger and Bigger: The Growth of Catholic Health Systems. Community Catalyst*. Retrieved from https://communitycatalyst.org/wp-content/uploads/2022/11/2020-Cath-Hosp-Report-2020-31.pdf.

frequently restricted services such as abortion or tubal ligation.[6]

- Nearly one in five LGBTQ people, including 31% of trans people, report that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away.[7]

Notably, denial of care is not restricted to any one type of hospital or health facility. Research has also shown that reproductive and LGBTQ care are frequently denied by both religious and secular institutions.[8]

Pregnant patients should feel comfortable that the hospital they select will provide the lifesaving care they need in the event of a complication, and LGBTQ patients should know where they can receive the care they need without judgment or discrimination. No one should have to spend time and money seeking health care only to be unexpectedly turned away by hospitals that prioritize the beliefs of executives over the health and safety of their patients.

We urge you to consider how the Department of Health, DBH, and the DC Council can address this important issue**.** American Atheists, along with national partners, has worked to address the issue of denial of care in several states, and we would eagerly work with the Departments and Councilmembers to help ensure that denial of care is appropriately disclosed to patients before they receive services. Thank you for your time and consideration.

Sincerely,

Rob Hofmann
State Policy Manager
American Atheists

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[6] Shepherd, K., et al. (2018). *Bearing Faith: The Limits of Catholic Health Care for Women of Color.* Public Rights & Private Conscience Project and Public Health Solutions. Retrieved from https://lawrightsreligion.law.columbia.edu/bearingfaith.

[7] Mirza, S. A., & Rooney, C. (2019, July 19). *Discrimination prevents LGBTQ people from accessing health care*. Center for American Progress. Retrieved from https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care/.

[8] Platt, L., et al. (2021). *The Southern Hospitals Report: Faith, Culture, and Abortion Bans in the U.S. South.* Columbia Law School Law, Rights, and Religion Project. Retrieved from https://lawrightsreligion.law.columbia.edu/content/southern-hospitals-report.

DC CHARTER SCHOOL ALLIANCE

Testimony Before the Council of the District of Columbia
Committee on Health

at the Budget Oversight Hearing on
Department of Behavioral Health

By Nicole Travers
Senior Director of School Support & Program Data, DC Charter School Alliance
April 10, 2024

Good morning, Chairperson Henderson and members of the Committee. My name is Nicole Travers, and I am the Senior Director of School Support & Program Data at the DC Charter School Alliance, the local non-profit that advocates on behalf of public charter schools to ensure that every student can choose high-quality public schools that prepare them for lifelong success.

Students nationwide are experiencing a mental health crisis.

According to a recently released survey of adolescents aged 12-17, about one in five reported symptoms of anxiety or depression.[1] And results from a 2021 CDC survey revealed around one in three high school girls have seriously considered suicide, a staggering increase from the less than a fifth of teen girls who reported so a decade earlier.[2] Whether these troubling trends are a result of isolation and loss from the pandemic or other societal factors such as increased violence in their communities, there's no question that it's critical we ensure the physical and mental needs of the whole child are met.

DC public & charter school leaders alike understand the pandemic's lasting impact on how students show up to school, and they are doing all they can to prioritize mental health service resources. This includes focusing on social & emotional learning curricula & activities, providing restorative justice interventions for students, incorporating extracurricular programs before & afterschool, increasing field trip opportunities and utilizing outdoor space for learning and school community events all as a thread of enhancing their school wide culture. We at the DC Alliance are working hard to support them. In the fall, we launched a monthly collaborative learning community for charter LEA Student Support Leaders to come together and share best practices and strategies to address challenges with student behavior, chronic absenteeism, safety, and social-emotional health. To date, 41 LEAs have engaged in this network to collaborate on better serving our city's youth.

We appreciate all the Department of Behavioral Health (DBH) has done to ensure more schools have access to clinicians through its School-Based Mental Health (SBMH) program. So many of our schools rely on these clinicians to support their students. We're also grateful the agency has worked hard to identify solutions to fill clinician vacancies with a pilot program that provides funding directly to charter schools when the SBMH program faced challenges with meeting staffing needs. Based on the pilot criteria, charter schools were eligible to apply for this pilot if they 1) were not partnered with a community-based organization (CBO), 2) were partnered with a CBO but did not yet have vacancies filled, or 3) had a CBO disruption.

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[1] KFF. Recent Trends in Mental Health and Substance Use Concerns Among Adolescents. Feb. 6, 2024. https://www.kff.org/mental-health/issue-brief/recent-trends-in-mental-health-and-substance-use-concerns-among-adolescents/

[2] CBS News. Nearly a third of teen girls say they have seriously considered suicide, CDC survey shows. Feb. 13, 2023. https://www.cbsnews.com/news/teen-girls-suicide-depression-mental-health-cdc-survey/

When DBH initially put out a Request for Applications (RFA) to this pilot program, many charters were hesitant to apply because of some challenges with eligibility and requirements. The agency worked collaboratively with us to respond to these challenges and reissue the RFA. The DC Alliance provided technical assistance to charter LEAs with the application process, which included checklists, templates, and a workshop. As a result, twelve charter schools applied, and DBH awarded seven schools in the pilot program, with awards for services provided starting March 1, 2024. We then worked closely with DBH to ensure an opportunity was offered for the five schools that were denied to revise their applications and reapply. One of the five was subsequently matched with a CBO; the remaining four are resubmitting their applications. With services starting this spring, we are hopeful that through this innovative pilot, nearly 30,000 students will have access to a clinician when they previously did not without this program, which accounts for 67% of the charter school enrollment population.

Additionally, we know offering competitive compensation packages is critical to retaining and recruiting high-quality clinicians. That's why I want to thank the Office of State Superintendent (OSSE) for providing an ARROW grant to schools so that they could fund a one-time $1,000 bonus for mental health professionals. This is a positive incentive to encourage & recognize the mental health professionals who work tirelessly to provide clinical services to our city's youth.

As you consider the budget for the upcoming fiscal year, I'd like to share recommendations for how DBH can improve students' mental health supports, including (1) continuing the **SBMH pilot program, (2) growing the pool and pipeline of high-quality clinicians for DBH's SBMH, and (3) refining the pilot program** to ensure the funding provided to schools for clinicians is comparable to funding provided to CBOs.

Continue the DBH Pilot Program

First, we understand in this challenging budget cycle, deep cuts have been proposed to DBH's budget. As the Council makes tough decisions over the next couple of months to finalize the budget, we urge you to retain as much funding as possible for the School-Based Mental Health program, especially to extend the pilot program for another fiscal year. A successful pilot creates opportunities to fill these roles in an efficient way that directly meets schools and students needs. Hiring a clinician to only have services disrupted due to the ending of the pilot grant would have an adverse impact on students who have experienced deep trauma and loss.

Grow the Pool and Pipeline of High-Quality Clinicians

Second, while we appreciate that DBH has worked hard to address staffing vacancies with the pilot program, we urge the District to consider longer-term solutions to grow the pool of qualified clinicians. We're grateful to the Council for responding to our asks for innovative recruitment strategies, such as funding higher education and licensure programs for DC residents to pursue careers in mental health. Councilmember Robert White's bill that finances a Master of Social Work degree for DC residents shows great promise in training more mental health professionals and growing the pool of qualified clinicians.

As we've previously testified, we believe that one additional way to more immediately address the numerous vacancies across the SBMH program is by joining 17 other states in the Social Work Licensure Compact or pursuing reciprocity agreements with Maryland, Virginia, and other surrounding jurisdictions. Pursuing these innovative solutions could quickly grow the pool of providers, and we recommend DBH explore these options.

Refine the Pilot by Making the Funding Structure more Flexible

Finally, we urge DBH to refine the pilot program to make the funding structure more flexible, which would ensure that the funding provided to charter schools for clinicians is comparable to the funding provided to CBOs for clinicians doing the same role. Currently, CBOs receive a lump sum of $99,370.85 to hire clinicians. Charter schools in the pilot program receive $89,366.22 with a mandated breakdown to spend the money in specific ways, including $63,153 for the clinician, $16,666,67 for supervisory costs, $1,000 for workforce development, and an $8,546.55 one-time funding for retention. We urge DBH to ensure schools are receiving comparable funding to CBOs and are provided the flexibility to use that funding in the most efficient manner while ensuring appropriate staffing and supervision of clinicians.

Moving Forward

As always, the DC Alliance is committed to working together with our schools and the District to ensure our students' mental health needs are met. We're confident that extending the pilot program and making funding more flexible will help our schools provide consistent, reliable support for their students. We believe a pilot program with these changes can be an efficient way to deal with some of the challenges the SBMH program has faced with vacancies while pursuing other longer-term strategies to grow the pool of qualified clinicians.

Thank you for your time and attention, and I welcome your questions.

On March 14th, 2024, a Kindergartner at Shepherd Elementary School was hospitalized for a severe allergic reaction. According to news reports, the child had an established plan for her school allergies, but she did not receive the treatment she needed, and was placed on a ventilator at Children's Hospital. The news is unfairly portraying this epic failure as the fault of Shepherd Elementary School, thereby eroding confidence in DC Public Schools.

Let's be clear: this is a failure of the Department of Health's new model, authorized by DC Council, that seeks to cover most of the DC Public Schools with health techs rather than nurses. This model substitutes trained nurses for health techs, who may have only six months of training, and lack the deep knowledge and expertise of nurses. The tragedy at Shepherd Elementary School shows that health techs are not a substitute for school nurses.

At the January 4th DC Council oversight hearing, Dr Ayanna Bennet, District Department of Health (DOH) said that the era of all schools having a nurse is gone. Her remarks show that DOH and CNH intend to continue with a short supply of nurses, in direct contravention of DC B22-0027. As of January 5, 2024, Children's staffing report shows that they have "capped" the total number of RNs in the system at 56, and the total number of LPNs at 49. Even if these nurses float between schools, with 185 health suites to cover, this leaves 80 schools with either no nurse coverage or only sporadic nurse coverage. Why would we place a cap on RNs and LPNS? Years of low nursing pay has created the shortage in DC. We need to repair the damage and adequately fund this system.

There is no other alternative. If you continue this inadequate coverage and inadequate funding, you are placing all children in the District at risk. A child doesn't have to be medically fragile in this system. My kids have hurt their head in gym class. Without adequately trained staff to perform an assessment, who will determine the severity of their injury? Could my child develop a brain bleed and be sent back to class to die? You need to act now and stop playing Russian Roulette with our children's lives.

I have heard that the Council wants to give Children's another year to test this new model. The tragedy at Shepherd shows we don't have the time. Moreover, the staffing report shows that they are 86 staff members short, placing an already inadequate system in even greater peril. I urge the council to recognize that all children in DC public and DC Charter schools are at risk. I recommend:

1. Immediately increasing funding for the health suites program to assure above average salaries for nursing staff – our key public health defenders in this time of public health crisis.
2. Mandating that there be no cap on the number of RNs or LPNs hired.
3. Mandating a parent – DCPS team to provide input and on the ground information on what is happening in the schools

I realize we are facing a budget crisis of epic proportions. But if parents move their kids out of the District because they can't be kept safe at schools, the tax base will erode further. If DC faces costly lawsuits due to unsafe conditions in schools, the budget crisis will worsen. Please, invest in our kids and in DC's future. Thank you.

Testimony by
Dario Martinez , Director of Community Navigation
District Bridges
Before the
DC Council Committee on Business and Economic Development
for Department of Small and Local Business Development
April 10, 2024

Good morning/ afternoon chairperson and committee members,

My name is Dario Martinez and I am the director of community navigation for District Bridges, as a navigator, we are deeply connected to the community we serve.

The navigator program was established in 2021 through a 6-month pilot program called a Civic Plaza for All which consisted of activating the Columbia Heights Civic Plaza. Today, the Community Navigation program currently serves the Ward 1 community in coordination with District Bridges four Ward 1 Main Street programs, including Columbia Heights, Mount Pleasant, Lower Georgia Avenue, and U Street. The program has 5 full time navigators and we are in the process of hiring three more. The navigators specifically focus on street outreach and connective services weekly to build trusted relationships with residents who are struggling with substance use disorder, housing insecurity, mental and health issues, and a host of other vulnerabilities.

The navigators develop a robust support system for residents who need assistance navigating city resources, specifically those experiencing housing insecurity and/or substance abuse disorder. The community navigators also play an integral part in District Bridges “Placekeepers Program,” engaging residents and community partners in the sustainable implementation of community-based interventions to holistically serve the community. They work in collaboration with the Ward-based organizations to connect individuals with social services, support the implementation of community events, and recruit and manage volunteer Plackeepers.

Some of the connective services that we provide include, but are not limited to: accessing services, support, transportation, accompaniment to appointments, assisting with intakes, helping fill out applications for benefits, and referrals.

From September, 2021 through August, 2022 the Columbia Heights Civic Plaza Stakeholders Coalition met monthly to engage primarily the city agencies, some community based organizations, and a handful of residents, business owners and property owners who have stake in the success of revitalization efforts at the Plaza. The goal of these meetings was to bring those voices to the same table, to clarify roles, and to hold each other accountable for addressing the various areas of concern that are affecting the overall health of the neighborhood and of its residents.

At the start of 2023, a new more targeted working group formed for partners engaged in support for Ward 1 residents experiencing behavioral health issues, including SUD and co-occurring disorders. The Ward 1 SUD Working Group continues to meet monthly with a goal of increasing our collective capacity through regular communication and coordination. In fact, we will be meeting tomorrow.

Just in Q2 we were able to assist 60 individuals in 249 cases, providing 403 hours of direct connective services. These include, but are not limited to:
ID support via DMV or consulate
Intake to detox facilities
Social security benefits
Housing
Workforce development
Education
Hospital discharge planning
Hospital visits
Accompaniment to ER
Medication pick up
Free cell phone support
Applications for SNAP and medical insurance
Disability benefits
Connecting with housing case managers and social workers
Accompaniment to court appointments
Unemployment support
Accompaniment to unemployment office, social security office, and other social services office
Birth Certificates
Social security card application
Immigration and document support
Asylum cases, TANIF, FOIA requests
citizenship test support

DISTRICT BRIDGES

For FY25, I urge the DC Council to maintain the FY24 funding so that we can continue to provide the support that our most vulnerable neighborsneed and so we can continue to expand our services to support those neighbors. Without this additional support, the navigation program would dismantle and our neighbors would be in a more vulnerable state than they are now.

In the upcoming months, we plan on having meal distributions on Lower Georgia Ave and at the Columbia Heights Civic Plaza. We are coordinating with DBH to get certain trainings such as HMIS, homeless management information system. We will also be a naloxone distributor. We are also looking forward to expanding our outreach and connective service efforts to the U Street area, where we also look forward to collaborating with other organizations such as HIPS! and the DC Center, once our new team members join. Many of our clients have been approved for vouchers and so, they are awaiting housing. With your support, we hope to preserve this work and support our neighbors so that they can thrive in our community.

Thank you for the opportunity to testify today and I am available to answer any questions.

I can be reached at dario@districtbridges.org or 202-929-9117

Children's National

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Council of the District of Columbia

Committee on Health

FY 2025 Budget Oversight Hearing: The Department of Behavioral Health and DC Health

Testimony of Nathaniel Beers, MD, MPA, FAAP
Executive Vice President, Community and Population Health
Children's National Hospital
Wednesday, April 10, 2024

Good afternoon, Chairperson Henderson and members of the Committee on Health (Committee). My name is Nathaniel Beers, and I am the Executive Vice President of Community and Population Health at Children's National Hospital. Thank you for the opportunity to present testimony at the FY 25 Department of Behavioral Health (DBH) and DC Health Budget Oversight Hearing. Today, I will focus my testimony primarily on the FY 25 Proposed Budget for DC Health but have submitted combined written testimony outlining areas for further investment within DBH.

Children's National has been an integral part of the healthcare safety net, serving children and families in Washington D.C. for over 150 years. We partner with the Departments on several community health initiatives such as behavioral health services for youth struggling with or at-risk for substance use disorder, pediatric asthma, and comprehensive school-based health services through Children's School Services and School Based Health Centers. As we look towards FY 25 investments, we see the need for continued investment in school-based health resources and services for the full behavioral health continuum of care.

Investing in place-base care programs for children is crucial for ensuring better health outcomes and fostering health equity. We are pleased to see in the FY25 DC Health Budget the maintenance and investment in the Healthy Steps Program, an evidence based national model that integrates a child development specialist into primary care, which is currently being implemented at many locations across the city, including Children's Health Center Anacostia and Children's Health Center THEARC. In addition to place-based care programs in primary care,

school-based health programs are another important area for DC Health. We are in support of continued investment in the School Health Services Program budget as it is critical that DC Health continue to invest resources to address the health needs of students and schools.

As we have testified before, we continue to work with DC Health to provide coverage of school health suites despite consistent funding challenges year-to-year. Since we last came before the Committee to discuss the budget and staffing needs in January 2024, we have substantially improved our staffing in the cluster model. We are pleased to report that as of Monday, April 15, 100% coverage for 40 hours for every school in the program and anticipate being fully staffed by the end of the school year. The additional staff will ensure that we are able to move through the clusters as needed and cover any absences. However, with the proposed funding in the FY 25 budget remaining flat at $25.6 million, we are deeply concerned that we will not have the necessary resources to implement the full scope of this program including telehealth and care coordination. Full staffing for the health suites and their training will require $26.5 million. The telehealth portion of the grant is supporting the attendance efforts by ensuring that over 75% of all students seen by telehealth are able to return to class instead of being forced to leave school to go see a doctor. We hope to expand it to help support chronic disease management next year as well. Care management has been critical for supporting chronic disease management in schools for children with asthma, diabetes, and seizures as well as other newly diagnosed conditions. We believe Children's National is best positioned to implement and staff this program and address health inequities in DC when all components of the grant are fully funded.

We are also concerned about the significant reduction of local funds to school based health centers. Our school-based health centers at Dunbar and Ballou Senior High Schools continue to be a resource for adolescents to receive comprehensive medical care. While we recognize there have been some challenges in utilization for reproductive and mental health services, we are working to address these challenges through collaboration with Children's National Primary Care and Children's School Services. We welcome the opportunity to collaborate with DC Health on strategies to improve utilization and access of the program.

It is also important that DBH continue investment in having a fully comprehensive behavioral health system, and addressing gaps that exist in DC's continuum of care for children and adolescents. Over the past several years, our primary care, behavioral health, and emergency department (ED) have reported severe challenges in accessing quality community behavioral health services. At Children's National, we recognize the importance and impact of community-based providers in strengthening our behavioral health continuum for children and adolescents. We believe that children and adolescents benefit from holistic and tailored services that meet their diverse needs across the continuum of care, from universal prevention to intensive treatment options. We strongly urge that the District develop a comprehensive children's mental health strategic plan in partnership with public and private stakeholders and invest adequate resources.

Increased access to behavioral health services in schools is also vital to improving the safety and well-being of students. We support continued investment in school-based behavioral health and treatment services as they are essential to improving student success. With the growing mental health crisis, we value the school based behavioral health program as way to reduce health care access challenges, hospitalizations, and emergency room visits among youth. We urge the Committee to ensure adequate investments to support community-based providers.

Finally, we want to thank DBH for their investment in the expansion of youth treatment services for substance use disorders through the Opioid Abatement Fund. Children's National is the only pediatric program that offers treatment for substance use and co-occurring mental health problems in the District on an outpatient basis. With this funding, we will be able to support the District in mitigating the effects of opioids on youth through the expansion of our Addictions Clinic at Takoma Theatre and engagement with youth peer services at DC Youth Prevention Centers.

Children's National continues to be a safety net for so many families and communities in need. We thank DC Health and DBH for their emphasis on improving the health and wellbeing for children and adolescents in the District. As the Council considers additional funding in the FY 25 budget, we urge the Committee to consider continued investment in comprehensive school-based health services and services across the behavioral health continuum. Thank you for the opportunity to testify and I am happy to answer any questions you may have.

Testimony to the Committee on Health
For the Budget Oversight Hearing for the Department of Behavioral Health
Nyla Anderson
Youth Advocate, Young Women's Project
April 10, 2024

Good morning Chair Henderson and members of the Committee on Health. I would like to thank you for Your time today. My name is Nyla Anderson. I am a junior at Benjamin Banneker and a Ward 8 resident.Currently I'm the vice president of the debate team. I've been a YWP peer educator for two years now since my sophomore year of high school.Ywp is a multicultural organization that builds the leadership and power of DC youth so that they can transform policies and institutions to expand youth rights and opportunities. I have been working with YWP's mental health Team where we educate peers across the city as well as collecting information on how to manage ourselves and help other people manage themselves when it comes to their Mental Health and balancing school and personal life. The way we know what information to hand out to people is by collecting information from my peers and from this information I feel the need to talk about the lack of support for teens and their mental health.

I am part of the YJC ***Mental Health Campaign,*** ***w****hich hires and trains 100 youth staff advocates to educate peers, connect youth to counselors and clinicians, collect data, and develop Virtual Wellness tools. Since 2019, YJC Youth Advocates conducted 3* ***Annual*** *Youth Mental Health Surveys with more than 2,000 students).,_ _ presented 72 Performance Oversight and Budget Testimonies* , advocated for *the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot), and created the* ***Student On-line Support (SOS) Virtual Wellness Centers*** *in 16 schools (and in Spanish). We also educated more than 18,625 students and adults and reached 800 youth with referrals to DCPS counselors and DBH clinicians. This year's MHC team includes 100 youth in 22 schools. We work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

- ***Hired and trained more than 110*** **Peer Educators & Support Specialists in 16 schools:**
- **Surveyed 657 public and public charter students from 16 schools** living in all DC wards (with heaviest representation from wards 4 and 7). *(Our 2023-24 Youth Mental Health Survey Results are linked here*
- **Distributed paper and electronic materials** to 5,325 public and public charter students including infographics and slide presentations, hands on worksheets, hot line numbers, and 2023 Student On Line Support: Virtual Wellness Center:
- **Trained 5,325 peers through classroom presentations and training** in 16 schools on toxic stress, trauma, resilience building, anxiety, suicide, social health, sleep, nutrition, meditation, mindfulness, and self care.

YWP youth staff surveyed 105 students at Banneker, which is about 20% of the population. In reviewing the Banneker 2023-24 Survey Results (Slides), I noticed problems of overwhelming Academic depression and self-isolation within

my school—Banneker Academic High School. Among students surveyed, 45% had high or overwhelming stress (35% had high but manageable stress); 72% of students did not sleep through the night either because they were stressed or up doing homework. The stress gets especially bad around testing seasons like SATs, PSATs and the test formerly known as PARCC, Midterms and finals. There have been students who have broken down due to the grades, having panic attacks in class. The school continues to neglect the competitive nature or the school environment. Many students come to school even when they're ill or not in the best mental state just to make sure that their grades don't dwindle from missing the day. I've even had to choose between staying home while being visibly sick and coming to school just to complete my midterms because I know my grade depends on it. Students and staff need to work together to develop solutions to this academic stress.

Another issue was suicide and depression; 22% of Banneker students were so sad or depressed they stopped regular activities; 13% considered suicide. As for who they would tell if they were thinking about suicide – 38% said no one and 39% said a friend; only 3% would tell a school counselor. This continues to be a problem due to the fact that 71% of the students don't even know who the mental health counselor.

Peer education is an important solution for all of this. Our survey shows that students trust students and want to receive information and support from them. The lack of mental health education (88% of Banneker students had 1 horu of less) means that youth are not learning how to combat stress and build resilience. This is what YWP peer educators teach in our classroom presentations and training.

To provide a safe and supportive environment , create a nonjudgmental space where students can express their feelings, building trust is key, so let's continue to encourage open communication and actively listen to them. Helping my classmates develop coping skills to manage academic stress by teaching relaxation techniques like deep breathing and mindfulness. And, helping identify negative thought patterns and replacing them with more positive perspectives.

In closing, we are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.* Right now, peer educators are filling an important gap by educating youth and helping them connect to counselors.

Thank you for hearing my testimony, council members.

Johnny Bailey - HIPS

Good morning. My name is Johnny. I manage the “Hot Spot Pilot program.” which provides targeted health and referral services to individuals in and around the 7th &T area. I'm a recovered addict and a social worker, so this is all very close to my heart.

Ten years ago, I was unemployed, separated from my partner, living in a squat, with a tenth-grade education. Today, I have been sober for ten years; my marriage is solid, I have a degree, and I own a home and have a career where I get the privilege to testify here on behalf and with the trust of an organization as respected as HIPS. The biggest thing that made these achievements possible was that I did not die or go to prison, and some people believed I was worth caring about. It is my mission to extend the privilege and faith afforded to me to others, which has been made possible by HIPS. I’m here to testify on the “Hot Spot” program, funded through the council's actions and in collaboration with the Department of Behavioral Health, currently underway at 7th T St, NW. I serve as the manager of that program.

For 30 years, HIPS has worked to address the social, economic, and health disparities faced by

people in DC’s street economies. HIPS has grown from an outreach and referral service operating out of a passenger van to a holistic and comprehensive harm reduction-based program with a brick-and-mortar location and a satellite site. HIPS advances the health, rights, and dignity of people and communities impacted by sex work or drug use by providing non-judgmental harm reduction services, advocacy, and community engagement led by those with lived experience. We envision a world where all people engaged in sex work and drug use are empowered and can live healthy, self-determined, and self-sufficient lives free from stigma, violence, criminalization, or oppression. Today, we serve over four thousand people a year, seven days a week and two overnights; HIPS offers services through a 24-hour hotline and at our drop-in center at 9th & H NE, which provides a variety of social and clinical services, including medication-assisted therapy substance use treatment, HIV/HEP and STI testing and care, a variety of wrap-around services and the targeted outreach program has allowed us to provide these services in a very intense and holistic way to uplift the community.

One of the most exciting things about the 7th & T pilot is that we have been able to get buy-in from the community, including homeowners and folks on the street, the local business community, and the ANC. Everyone feels involved and excited to be a part of this program. We host regular town halls and have a monthly neighborhood focus/review group. It has been expressed to me that it matters to the community that they have been involved and had a spot at the table for all decisions that have been made and that they have been listened to on how to do things in their community.

The program operates on a relatively small budget, employing only myself, my coordinator, and four peer navigators working 12 hours a week each. Still, we can address challenges for that investment and truly move toward meaningful change for the entire neighborhood. While getting a harm reduction center set up is ultimately the goal of the project and something that would really take the plan to the next level, even without one, we have very effectively worked to improve people's access to food, mental health services, and housing while increasing their safety and the safety of the community at large. I can not stress enough how important the ability to do this holistically is. Many targeted area initiatives simply push people out of one area and into another; we are there to try to make material changes at the roots of the issues. Based on our experience, it will take roughly six months for us to be stable in the one area and capable of deploying to other locations.

In just one month, the program we initiated in the 7 & T area is already showing clear signs of success. So far, we have helped eight people begin the process of getting housing and found one person whom the housing organization had been unable to locate to get them their vouchers.

Moreover, we started a new recovery meeting at the Shaw library, reversed two overdoses, organized weekly and targeted cleanups, distributed 100s of harm reduction supplies, and referred multiple people to clinical services ranging from HIV/HEPC testing to suboxone.

We are currently working with RightProper to create a food program that will allow community members to add an entree to their check for someone in their community who could otherwise not afford it. We are also meeting with other NGOs and institutions to see how we can best collaborate.

The program has proven beneficial in multiple ways to meet people where they are at–quite literally. We can now reach clients we were previously unable to find, and most importantly, we have developed trust and understanding within the community like never before; this trust has allowed us to get several people who did not feel they could talk to others about their problems to consider recovery. Studies have shown that drug users who engage with a needle exchange program are five times more likely to enter recovery, primarily because of the relationships and trust built. The folks we are working with within the 7th and T area are members of our community -- they are long-term residents of the District who are facing the impact of gentrification. Programs like the Hot Spot project are critical - where new and old neighbors can work together, supported by organizations trained in this work to care for all our residents.

The program has also streamlined operations across multiple organizations and departments to treat clients holistically. For example, our partnership with Miriam's Kitchen has enabled us to connect clients to receive critical housing services. We are also establishing testing days and medically focused support groups with our clinical department and working daily to develop more connections that will benefit the community.

I believe this type of targeted, highly localized, and holistic service that assists a community so that a rising tide will lift all the ships is an important part of the future of harm reduction. I hope we can continue at 7 & T and expand into other areas that desperately need this kind of intervention.

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Testimony of Kristin D. Ewing, Policy Counsel
DC Appleseed Center for Law and Justice

Budget Oversight Hearing:
Department of Behavioral Health
April 10, 2024

Thank you for the opportunity to provide testimony regarding budget oversight for the Department of Behavioral Health ("DBH"). My name is Kristin Ewing, and I am Policy Counsel at the DC Appleseed Center for Law and Justice ("DC Appleseed"). DC Appleseed is a non-profit, non-partisan organization that aims to make the District a better place to live and work through litigation, teamwork, and advocacy. Throughout our history, we have taken on some of the District's most challenging problems, developed proposed solutions to those problems, and then worked to implement our proposed solutions.

My work at DC Appleseed focuses on health equity and working toward a more equitable, just, and thriving city for all District residents. My testimony today will emphasize the importance of a well-funded and fully staffed School-Based Behavioral Health Program ("SBBH") and the need for robust crisis response programs in the District.

School-Based Behavioral Health Services

DC Appleseed is acutely aware of the District's disparities in access to behavioral health care services. Behavioral health services and therapy can be challenging to access in our healthcare system, and many students who could benefit from them never connect to these services. Co-locating behavioral health services in our schools facilitates students' access to care.

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We know that behavioral health support is vital to District youth, especially as we see increases in suicide, substance use, depression, trauma, anxiety, and absenteeism in juveniles, made worse by the impacts of the pandemic, ongoing public safety issues, and the impacts of financial strain on many District families given the current economic landscape.

As a member of the Strengthening Families through Behavioral Health Coalition, we stand with our fellow coalition members in calling for the District to maintain and expand critical investments to School-Based Behavioral Health in FY25 by increasing compensation for community-based clinicians. Currently, compensation for Community Based Organization ("CBO") Clinicians in SBBH averages roughly $63,000 per year, well below the 10th percentile (approximately $74,000) of salaries for clinical social workers in the DC market. We must make clinician jobs more attractive and sustainable, especially during a workforce shortage. Behavioral health services provided at District schools are crucial for prevention, intervention, and treatment and for providing the safe and supportive environment students need to thrive and excel academically, socially, and emotionally**. We must create a robust pipeline and workforce of clinicians so students in every school can flourish, and a key component is increasing base salaries to improve recruitment and retention.**

We ask for the following funding for FY25 to ensure a sustainable and strong SBBH Program:

- **The Council must find $6,155,587 to increase CBO grants for every school to the required $98,465, allowing salaries to rise to $74,033.**
    - CBOs require at least $98,465 per CBO clinician to increase the base salary to the 10th percentile, $74,033, and cover fringe benefits, overhead, and supervision costs.
    - In the proposed budget, CBO grants will only be $80,819.67 - a full $17,645.33 less than required, and funding for a base salary of $63,153.
    - It appears the Mayor reduced the total grant allocation to $18,854,523. Divided by the above grant amount, there is only enough to fund 233 clinicians versus 254 eligible schools.
    - The total cost to fully fund grants for each of the 254 schools in the program is $25,010,110.

- **DBH must maintain investments in the Community of Practice ($593,780).**
    - The Community of Practice brings providers, staff, and school leaders together in a collaborative learning environment to share best practices, support, and participate in learning activities. Continued investment in the CoP is essential to building provider capacity, maintaining consistent quality of services across the SBBH program, and ensuring providers have a supportive community of peers.
    - The proposed budget cuts this feature of SBBH entirely. In addition to making the CBO grants whole, we hope the Committee can restore the funding to the FY24 level ($593,780) for this contract.

While DBH has not yet released the evaluation reports on the program for the last two school years, the evaluation data shared with the DBH Coordinating Council shows:

- Most students and families reported comfort in seeking help from a therapist or counselor at school.
- School staff reported feeling knowledgeable about warning signs of behavioral health challenges and believe SBBH staff do a good job supporting student behavioral health.
- Many school staff who reported referring students for behavioral health services believed the students benefited from treatment services, such as decreased behavior incidents, improved symptoms and use of coping skills, and increased connection to school.

SBBH is working, and we must continue to support and adequately fund CBOs and clinicians so this program can realize its full potential. **If we care about helping kids attend and thrive in school and the community, we must invest in School-Based Behavioral Health and the workforce of providers who help our children flourish in supportive, safe school environments.**

<u>Crisis Response</u>

As adults and youth continue to face behavioral health challenges and substance use disorder ("SUD"), it is imperative the District have a robust crisis response infrastructure to ensure those dealing with a mental health or SUD crisis receive timely care from a trained expert. The District has crisis response teams trained to respond to these crisis situations: the Community Response Team ("CRT") through DBH and the Child and Adolescent Mobile Psychiatric Service ("ChAMPS"), currently implemented via a grant at Catholic Charities DC. These teams ideally respond to direct calls for immediate intervention or diverted calls to 911 or 988 that necessitate a prompt, in-

person response.

However, given staffing and funding issues, these calls are too often handled by police who may not have the proper training to understand the situation or to respond with best practices for the specific crisis. Trained responders are vital to ensuring more positive outcomes for residents in crisis.

Although the budget narrative reports an enhancement in funding to CRT, this is misleading. While the Mayor's budget provides a modest infusion of new local funds, this does not offset the more significant cut in federal funding. In reality, DC's CRT program faces a reduction of 1 FTE in FY25 despite being underfunded and understaffed in FY24. In its responses to performance oversight questions, DBH reported that they aim to have a CRT responder onsite within 30 minutes of a 911 call, but their average response time in 2023 was 91 minutes. As a result of these substantial delays, DC currently faces a lawsuit by Bread for the City and the ACLU-DC for failing to respond to calls for assistance in a timely manner during 2024. Additionally, DBH reported that only 60% of CRT positions were staffed at the time their responses were submitted. The District must adequately fund these crisis teams so they can offer adequate salaries, benefits, and support to employees, which will allow them to recruit and retain the staff needed to respond to crises promptly and 24/7.

While the budget for the grant for ChAMPS appears to be maintained at $1.36M, we recommend increases to this funding. Due to inflation, a higher grant amount will be needed to maintain services and staff. Additionally, ChAMPS services do not currently adequately meet the needs of DC residents. Per DBH's responses to the Council's oversight questions, the ChAMPS team operates only Monday through Friday from 8 am to 8 pm, leaving District youth without specialized crisis care after hours. When ChAMPS cannot respond to a crisis due to limited capacity, CRT responds instead, heightening the need for better funding for both ChAMPS and CRT.

We know residents have better outcomes for behavioral health or SUD crises when they receive prompt, evidence-based care from trained professionals. DC residents deserve to have access to

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appropriate and timely care 24/7. Please ensure our crisis teams have adequate funding to provide this much-needed care and response.

Please don't hesitate to reach out with any questions regarding my testimony.

Respectfully submitted,

Kristin D. Ewing
Policy Counsel, DC Appleseed Center for Law and Justice
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Testimony before the Committee on Health

Oversight Hearing on the Department of Health

Janet A. Phoenix, MD, MPH, MS

Assistant Research Professor

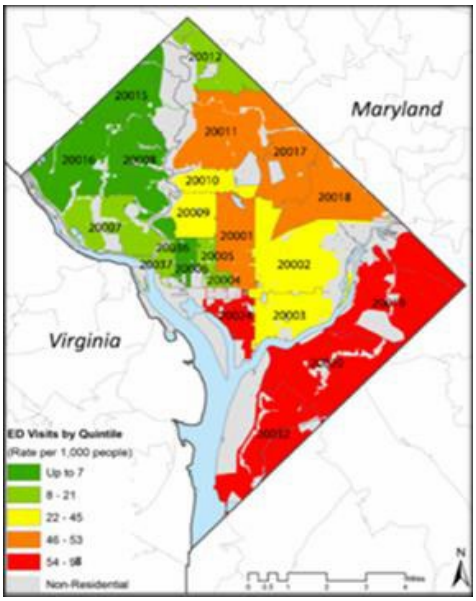
George Washington University Milken Institute of Public Health

Testifying on behalf of the Campaign to Reduce Lead Exposure and Asthma

Presented Wednesday, April 10, 2024

Good morning, Chairperson Henderson and members of the Committee of Health. My name is Dr. Janet Phoenix. I am an Assistant Research Professor at the Milken Institute School of Public Health at George Washington University and a physician by training. I chair the DC Asthma Coalition. I am representing the Campaign to Reduce Lead Exposure and Asthma which was launched two years ago. Members of the campaign have met with and will continue to meet with many of you to advocate for improved conditions to reduce the numbers of DC residents exposed to lead and suffering from asthma.

Asthma is a chronic disease. This year's proposed budget has cuts to the Community Health Administration which is responsible for asthma. Wards 5, 7 and 8 have some of the highest rates of asthma emergency room visits and hospitalizations. I have included below a map of rates of hospital and emergency room visits for children in DC. Neighborhoods with higher rates are highlighted in red and neighborhoods with lower rates in green.



Source: Asthma Surveillance in DC Emergency Departments and Hospitals. Children's National. December 14, 2017.

This data was provided to me by Children's National. Similar data probably exists for adults in DC, but I have been unable to obtain them. The last data on asthma for DC residents that the Department of Health prepared was released in 2016 and was based on 2013 data.

Children living in SE Washington are 23 times more likely to be hospitalized or in the ER for their asthma than children living in Ward 3. Traffic corridors that run through Wards 5, 7 and 8 are a contributing factor to the pattern of ER visits and hospitalizations as are housing conditions. Many children live in housing that is poorly maintained exposing them to mold and pest infestations. Are there similar patterns for adults? Is proximity to traffic associated with adult asthma as well as childhood asthma? These are questions I would like DC Health to explore.

The proposed budget contains decreases for the State Center Health Statistics in the Center for Policy, Planning and Evaluation. For chronic diseases like asthma, there is a need to provide evidence linking sources of exposure to asthma allergens and irritants to outbreaks of disease.

The Center for Policy Planning and Evaluation may need additional resources are needed to ensure the DC Health has access to recent data on asthma from sources like the American Hospital Association and Children's National so that this data can be analyzed and regularly made available to the public. \

Our lead and asthma campaign and others advocating for improved health for vulnerable children in the District of Columbia have had to rely upon outdated information as we advocate for policies to address lead exposure and asthma. This has undermined our effectiveness.

7 years is too long to wait to have accurate data on the extent of a prevalent condition like asthma which affects so many DC residents. We should not have to rely solely on private entities like the Hospital Association and Children's National. for collection of health outcomes data for DC residents. It is not unreasonable to ask city agencies to take the lead in collecting, analyzing and publishing current data on asthma for DC residents.

The Office of Health Equity is another source of data within DC Health. The Office of Health Equity is one of the few sources of data on neighborhood level health indicators. I am pleased to see level funding for this office in a budget that is rife with cuts.

Thank you for the opportunity to testify.

Karla Reid-Witt
Testimony
DC Council Budget Oversight Hearing for the Department of Behavioral Health
April 10, 2024

Hello Chairperson Henderson, Committee members, and Council staff. My name is Karla Reid-Witt. I am a PAVE Advisory Board Member. I am here to advocate for the development of a full continuum of DC Children's mental health services, including a strong school-based mental health program.

I started my work as an educational advocate doing broad systems level work but narrowed my focus to special ed after one of my own kids was identified as having a disability. Special education advocacy has become my life's work. I have supported hundreds of parents of kids with learning disabilities and have learned that many children with learning and other school challenges struggle with anxiety and depression, often occurring due to the lack of appropriate school support, making it difficult for them to access the general curriculum, devastating their self-esteem and making school an unpleasant experience. Over the years, I thought about including mental health advocacy within my work because emotional health is integral to the success of children with learning challenges. However, because there was so much to be done to improve special education, I consciously decided to limit my advocacy.

But you know what they say: if you want to make God laugh, tell her your plans. I was thrust into the world of mental health advocacy when one of my children had a mental health crisis. That experience taught me that mental health challenges make no sense. They are not linear.

Mental health challenges are irrational, confusing, and frequently don't follow a pattern. You can't set the end date on a calendar. It's not like a broken leg. Set it and you'll be up and walking in 6 weeks. That's why people have to spend years and tens of thousands of dollars going to school to learn to be mental health clinicians. For me, it was like my child was on a rollercoaster going up and down with steep turns and loops, and I was on the ground running alongside, trying to keep up with my child who was experiencing something they could not control, let alone make sense of. Can you imagine that?

Now imagine being a parent of that child struggling emotionally and forced by law to send your precious baby to school, one of the most inflexible and linear environments there is. I felt like I was torturing my child. More to the point, imagine being that child forced to spend 6 hours a day for 180 days of the year there. It's cruel.

Mental health challenges and disorders manifest in a million different combinations and come to be for a million different reasons. Teachers are no more equipped for kids' mental health challenges than parents. I have heard several teachers say that kids now are different. I asked one teacher what that meant. How have kids changed? She said, "The kids don't have the bandwidth and difficulty with concentration and focus. They are overwhelmed, have little tolerance, and the demands are too high." She said she thought that this long after COVID, things would have gone back to the way they were, but they have not.

An undergraduate student teacher I spoke with thought kids' mental health was impacted not by social media per se but by the changes in social media technology. She shared that adults were more likely to hand kids technology because it is an easy solution, but she said the real problem is that technology has changed. She said eight years ago, a secondary school student's social media exposure was much smaller. She explained that back then, you only saw posts from people you followed on your page, but when "explore" pages were added, you had no control over what was included on those pages, and later, personal pages were flooded with unrequested posts based on an algorithm. All these changes encourage perpetual scrolling and randomly expose kids to information kids were not exposed to just eight short years ago. So, yes, kids have changed.

There are rational reasons for kids being this way. COVID changed all of us. It changed adults. Why did we think it did not change kids? "[S]omething fundamental has shifted in American childhood and the culture of school, in ways that may be long lasting. What was once a deeply ingrained habit — wake up, catch the bus, report to class — is now something far more tenuous."[1] After the COVID shutdown, why did we feel we could shove kids back into a school system not designed for them, and they would all just take it? Adults have resisted being shoved back into their old work environments. More than forty percent of DC public school students are chronically absent.[2] I think the absentee rate is our kid's version of not-so-quiet "quiet

[1] Why School Absences Have "Exploded" Almost Everywhere https://www.nytimes.com/interactive/2024/03/29/us/chronic-absences.html?unlocked_article_code=1.gU0.PRvZ.XUqqmB2jOKHx&smid=nytcore-ios-share&referringSource=articleShare&ugrp=m&sgrp=c-cb

[2] DC School Attendance Report 2022-23 https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2022-23%20Attendance%20Report_FINAL_0.pdf

quitting," of controlling the part they can. A parent succinctly put it this way, "Kids no longer have time for our bullsh**." **We can not overcome chronic absenteeism if we do not attend to children's mental health needs,** including designing the school day for today's student.

A Jackson-Reed student shared her thoughts in the school newspaper article explaining the need for school-based mental health services. She wrote:

"Even in cases where mental health issues don't result in severe physical problems, numerous studies have shown that they decrease a student's ability to learn and receive good grades. A 2005 study showed that diagnosed depression was associated with a 0.49 drop in a student's GPA, or half a letter grade, and a 2009 study showed that depression is a significant predictor of lower GPA and higher probability of dropping out. These studies, and other similar ones, prove the significance of mental health issues in education. Lack of student support systems is damaging, not only to our health, but to the one thing that many in DCPS care about more than anything else: our grades.

During my time in the DCPS system, I have struggled with anxiety, depression, suicidal ideation, and an eating disorder. Never, across five years, three severe mental illnesses, and one attempt at taking my life, have I felt supported by the school system. I'm very lucky in that I have understanding parents and the financial means to pay for the therapy that I need, but not everyone at [Jackson-Reed} has the same resources that I do. When [Jackson-Reed] refuses to increase funds for mental health, they put the lives of 2,000 children at risk. The statistics are horrifying, but they're not just statistics. They are your friends, your siblings, your classmates. Without [Jackson-Reed] stepping up and providing what we need, people will continue to suffer.

The lack of student support in [Jackson-Reed], and all public schools, is immoral, dangerous, and cruel. When a school refuses to hire more psychologists, therapists, and social workers, it shows

what the school values, and what it doesn't. A school's budget shows its morals more clearly than anything else a school says. When a school can't find room in its budget to provide mental health care, that proves that the school doesn't care for its students. A school that doesn't care for its students has failed in its most fundamental duty. If [Jackson-Reed] wants to do its job, it has no other choice but to hire more psychologists, more therapists, and more social workers, without delay."[3]

Over the years, I have worked with organizations such as Parents Amplifying Voices in Education, Decoding Dyslexia DC, the National Alliance of Mental Illness DC ("NAMI DC"), Strengthening Families Through Behavioral Health Coalition, the Fair Budget Coalition, Special Education Advocacy Coalition, as well as individual parents to address school-based mental health needs. With the Council's help, we have made strides. I thank you for that.

Students need school-based mental health services for a multitude of reasons and some require complex assistance, while simultaneously being required by law to attend school. If we are going to continue to require kids to attend school, we have to continue providing, maintaining, expanding, and innovating school-based mental health services where the kids are. Where we want them to be, in school. This is a difficult time, and I understand that you have a lot of hard budget decisions to make, but this is not one of them. School-based mental health is a vital component of the comprehensive DC children's mental system that DC is sorely lacking, and we must begin to build. One clinician per school is not enough. We must grow the pipeline and

[3] Wilson desperately needs more student support systems, https://thejackson-reedbeacon.com/17282/opinions/wilson-desperately-needs-more-student-support-systems/

provide multiple clinicians in schools that need them. We must innovate Tier 1 services, because the need is broad based and we need to provide prevention to students to help them manage challenges so they do not rise to a critical level. Right now, we can not go backwards. We must sustain and move forward with what we already have in place. It is our foundation for recovery. The kids know this , the parents know the kids know this, the teachers know this, we need you to know this and take action.

As recommended by the Strengthening Families Through Behavioral Health Coalition, I ask you to continue making critical investments in children's behavioral health – and increase the reach and efficacy of the SBBH program" and that you:

- **Sustain compensation for SBBH's community-based clinicians,** with inflationary adjustments, so that they are available to respond to behavioral health needs in DC public schools.
- **Provide compensation and develop guidance for the SBBH Coordinator role**, equipping every school's Coordinator to effectively connect staff, students, and families with school behavioral health resources.
- **Pilot non-clinical staff positions to SBBH teams**, increasing the reach and capacity of the SBBH program's social-emotional learning and skill-building components.
- **Invest in the development of a District-wide strategic plan for children's behavioral health** to provide a cohesive, whole-system, multi-sectoral, and evidence-based approach to the current crisis and **to provide the full continuum of pediatric mental**

health services for both privately and Medicaid-insured children. (See Priority 6 of the DC DME School Safety Strengthening Report) [4]

- **Fully Fund the Community of Practice** providing a community for clinicians to improve their practice, ask questions, brainstorm, and receive advice and information. The CoP brings together experienced and novice clinicians crowdsourcing their intellect and deepening knowledge through specialized practice groups.
- **Provide funding for robust Home and Hospital programs for every school location.**
- Follow the "actionable, comprehensive" recommendations from the 2023 School Funding Study Final Report, prepared by the Office of the Deputy Mayor for Education ("DME")[5] to:
    - "Adjust the UPSFF to better meet student needs [by **increasing] the foundation level to support schools' delivery of Tier I and Tier II mental health supports."**
    - "Pay for specific, proven interventions directly, outside the UPSFF [by providing] **funding to DBH to deliver Tier III mental health interventions, in addition to increasing foundation level to accommodate school-based Tier I and II interventions."**
- Adopt the "Invest in Youth Mental Health" Recommendations of the Fair Budget Coalition[6]

[4] Strengthening School Safety in Washington DC, Reports and Recommendations. https://dme.dc.gov/safetyreport
[5] 2023 School Funding, Study https://dme.dc.gov/fundingstudy
[6] Safety is Investing in the Community, Fair Budget Coalition Recommendations 2024, https://fairbudget.org/wp-content/uploads/2024/03/Desktop-View.pdf

- In solidarity with the recommendation of the Strengthening Families Through Behavioral Health Coalition, **Fund the School-Based Behavioral Health Program (SBBH)** "making critical investments in children's behavioral health – and increase the reach and efficacy of the SBBH program by sustaining compensation for SBBH's community-based clinicians, with inflationary adjustments."
- **Fund an Expansion of the Community Schools Model to "**bring in health care services, wrap around supports, after-school activities and much more to our schools."
- **Create and fund a DBH Mobile Mental Health Unit to Meet Needs of Unhoused Youth "**bringing behavioral health clinical services to the places young people physically congregate…[and]staffed by culturally competent clinicians trained in trauma-responsive care would rotate among youth homelessness services programs to provide assessments, counseling, therapy, and medication management on a weekly basis.[7]

Thank you for your time.

[7] Safety is Investing in the Community, Fair Budget Coalition Recommendations 2024 https://fairbudget.org/wp-content/uploads/2024/03/Desktop-View.pdf

Testimony of MBI Health Services, LLC

Department of Behavioral Health FY25 Budget Oversight Hearing

To the District of Columbia Council Committee on Health

By Marie Morilus-Black, CEO – MBI Health Services, LLC

202 820 3009

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April 10th, 2024

Chairperson Henderson, Members of the Council

Thank you for the opportunity to testify at the Department of Behavioral Health Budget Oversight Hearing. My name is Marie Morilus-Black, I am the CEO of MBI Health Services, LLC. We are one of the largest behavioral health agencies in the District serving over 6000 adults and children and families in the District. MBI connects with every Human Service Agency in the District providing services to over 15,000 District residents in all its programs and employing over 1000 staff. We are committed to providing good customer service, quality care and achieving positive outcomes to better the lives of the District Residents enrolled in our care. MBI operates within an interdisciplinary team which includes License Clinicians, Psychiatrist/Nurse Practitioners and Community Support Workers to address the mental health needs of our District Residence. At MBI, every consumer receives an appointment for a well-being evaluation by one of the providers in our Psychiatric Practice within 7 days of their Diagnostic Assessment.

We want to start by thanking Director Bazron for her leadership of DBH and for her continued collaboration with the provider network. Dr. Bazron is willing to listen and make midcourse corrections when she believes it's warranted. Dr. Bazron has met with us regarding the challenges we face as ACT providers, and we are asking that DBH in partnership with DHCF adopt permanently the recommendations made by the group of ACT Providers which has no adverse impact on the budget since all the recommendations are cost neutral.

We want to thank Dr. Bazron for approving the payment increase for Community Residential Facility. It was a huge relief since it had been 6 years since the last increase. I am asking that DBH established an annual Cost of Living adjustment to its rates to support the fiscal viability of its provider network. We are also concerned about the reduce FTEs for DBH and its impact on timely local dollars and specialty services authorizations which could become a barrier to immediate access to mental health services or continued access to on-going care.

We want to command Dr. Bazron and the Bowser administration on school-based expansion of mental health services. It is imperative to provide mental health support to children and youth in their own natural settings making easy to access care. In addition, the school model allows for prevention work in the school that proactively addresses mental wellbeing and prevents onset of serious mental health issues. There is a serious workforce shortage, and the current grant does not support the market rate for clinicians in the system. We need $10,000 more per school to help us with staff recruitment for some of our most needy schools. I am asking that the council and the administration please restore the funding taken due to social work vacancies and add the $10,000 per school to support the real cost of hiring a license clinician in the District.

In the DBH budget there is a $11.6M reduction of community support benefits and to restrict audio only. This could represent approximately 43 million dollars in services including the federal match. Since the pandemic, many residents have access services using this modality. I am concerned that these significant cuts may reduce access to care for many residents who may need mental health services. We are asking that DBH closely monitor these restrictions to ensure that it does not become a barrier to needed and necessary care.

As the chair of the DCBHA Board, I see the work we are doing as a network. I want to thank Dr. Bazron for being responsive to our feedback and for continuing to address providers concern and the many issues we bring to your attention to improve our system of care and services for the Districts residents. We acknowledge that they are bad actors in the system, however, I want this council and the public to know that the vast majority of the provider network care about the people we serve, are supporting recovery resulting in better quality of life and positive outcome for the people in the District struggling with Mental Illness.

Finally, thank you Dr. Bazron for your commitment to this work. MBI is committed to providing excellent services to the District Residents and we stand ready to continue our partnership with you and the MCOs once the transition happens to deliver timely and quality care to the Districts resident.

Thank you very much for the opportunity to share MBIs testimony and I am open to any questions that you may have for me.

Testimony to the Committee on Health
For the Budget Oversight Hearing for the Department of Behavioral Health
Aliyah Ibikunle
Youth Advocate, Young Women's Project
April 10, 2024

Good morning Chair Henderson and esteemed members of the Committee on Health. Thank you for the opportunity to testify today. My name is Aliyah Ibikunle, and I am 15 years old. I currently reside in Ward 7 and am a sophomore at Mckinley Technology High School. As a fervent advocate for youth empowerment, I actively engage in community service as a Youth Peer Educator with YWP. My future aspirations include pursuing a career in neurosurgery after completing college. This ambition extends beyond personal fulfillment to a commitment to contribute meaningfully to our community through my chosen profession. Serving as a youth advocate allows me to amplify the voices of my peers, particularly in addressing critical issues that impact our lives. We are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educators like me and my peers.*

I am part of the YJC ***Mental Health Campaign,*** ***w****hich hires and trains 100 youth staff advocates to educate peers, connect youth to counselors and clinicians, collect data, and develop Virtual Wellness tools. Since 2019, YJC Youth Advocates conducted 3* ***Annual*** *Youth Mental Health Surveys with more than 2,000 students).,* *presented 72 Performance Oversight and Budget Testimonies* , advocated for *the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot), and created the* ***Student On-line Support (SOS) Virtual Wellness Centers*** *in 16 schools (and in Spanish). We also educated more than 18,625 students and adults and reached 800 youth with referrals to DCPS counselors and DBH clinicians. This year's MHC team includes 100 youth in 22 schools. We work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

- ***Hired and trained more than 110*** **Peer Educators & Support Specialists in 16 schools:**
- **Surveyed 657 public and public charter students from 16 schools** living in all DC wards (with heaviest representation from wards 4 and 7). *(Our 2023-24 Youth Mental Health Survey Results are linked here*

- **Distributed paper and electronic materials** to 5,325 public and public charter students including infographics and slide presentations, hands on worksheets, hot line numbers, and 2023 Student On Line Support: Virtual Wellness Center:
- **Trained 5,325 peers through classroom presentations and training** in 16 schools on toxic stress, trauma, resilience building, anxiety, suicide, social health, sleep, nutrition, meditation, mindfulness, and self care.

I am here to testify about the alarming levels of stress endured by high school students. Since October 7th, 2022, I've been actively engaged in the Young Women's Project (YWP) Program, dedicated to amplifying the voices of youth and addressing pressing community issues.

Through the Mental Health Campaign, I've had the privilege of working on initiatives aimed at supporting the mental well-being of our youth. Survey data collected from McKinley High School paints a concerning picture. Nearly half of our students, 43.16%, report receiving no mental health instruction this year. Furthermore, a staggering 45.26% of students don't even know the name of their mental health counselor, highlighting a significant accessibility gap in critical resources.As a peer educator, I've had the opportunity to conduct classroom presentations on mental health topics such as stress, mindfulness, meditation etc. These engagements have shown clear knowledge gaps and resource deficiencies among our student body. Shockingly, over a third of students, 35.79%, have not received any online resources from counselors or the mental health team in the past three months.The inadequacy of our current curriculum in providing comprehensive mental health education only exacerbates the issue. According to survey results, 42.11% of students consider mental health education in class to be important, emphasizing the urgent need for curriculum reform.

To address these challenges head-on, I propose several critical recommendations. First and foremost, our schools must prioritize the hiring of effective guidance counselors and ensure they receive continuous training to adequately support students' mental health needs. Additionally, we must overhaul our health education curriculum to include comprehensive coverage of mental health topics alongside physical health subjects. Finally, integrating modules on managing mental health crises in students into teacher training programs is essential to equip educators with the necessary skills and knowledge.In closing, the well-being of our high school students is not a matter to be taken lightly. It is incumbent upon us to take decisive action to alleviate their burdens and create a healthier learning environment for all. I implore the Committee to give earnest consideration to these

recommendations.

In closing, we are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.* Right now, peer educators are filling an important gap by educating youth and helping them connect to counselors.

Thank you for your time and attention.

Testimony
Public Oversight Hearing
Committee on Health
April 12, 2024

Good afternoon, Chairperson Henderson, Councilmembers and Council staff. Thank you for this opportunity to provide testimony of the positive outcomes of mental health support offered through the School Based Mental Health (SBMH) program and the ongoing and pressing need to maintain the funding of this robust and necessary work in light of the proposed budget cuts in 2025.

My name is Anna Heath and I am a Clinical Supervisor with SBMH, a program within Catholic Charities of the Archdiocese of Washington in the Behavioral Health Services, also known as Anchor Mental Health Association. In addition, I am a Licensed Independent Clinical Social Worker (LICSW) and a DC Resident.

Since the Fall of 2019, SBMH has partnered with public and charter schools in DC to support students' mental health needs and provide educators and parents access to resources. SBMH serves 16 elementary school communities, 6 middle school communities, 2 high school communities and 1 adult learning community. SBMH is funded through grants awarded by the Department of Behavioral Health (DBH) Expansion Program. This funding has enabled SBMH to offer high quality mental wellness services using a multi-tiered level of support. For example, SBMH provides services to each school community through Tier 1 efforts, which focus on promotion and primary prevention interventions, such as staff professional development, school-wide mental health awareness initiatives, and classroom-based social emotional learning opportunities. It also allows for Tier 2 interventions, which covers early intervention work done in our school communities, such as student groups, staff wellness, caregiver and parent groups, and educator consults for skills training. Lastly, but certainly not least, the program providers Tier 3 interventions, which focus on the more intensive level of support for students who have been identified as in need of individualized therapy or family therapy to improve their functioning at school, home, and in the community. The provision of these supports utilizes effective evidence-based treatment modalities, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Cognitive Behavioral Therapy (CBT) to name a couple.

Many of our schools are in historically underserved and under resourced areas, leading to poorer health outcomes and additional barriers to success. We treat a range of mental health challenges, such as trauma, grief, depression, anxiety, and ADHD. In March 2023, we served 949 clients. In March 2024, we increased our impact to 1487 clients served. The demand and need for mental health services is only increasing and therefore, more funding is needed rather than less. So far, this fiscal year, we have 100% reported satisfaction from both our clients and families, as well as our school partners. In our last quarter alone, our program provided a total of 159 tier 1 wellness prevention services, 429 tier 2 early intervention services in our school communities, and 1792 individual therapy and family therapy sessions, as well as 101 topic-

specific group therapy sessions, such as support and skills groups empowering social skills development, restorative conflict resolution, emotion regulation, grief and loss, and self-esteem.

SBMH utilizes the CAFAS assessment tool, a multidimensional rating scale that measures the degree of behavioral and emotional impairment across various domains in children and adolescents. According to our CAFAS assessment results for every quarter of this fiscal year, the percentage of clients experiencing overall improved scores increased significantly by 10% and progressed even greater in quarter three, landing at 55% of our clients experiencing overall improved functioning. Qualitatively, it is also important to highlight the unique and significant positive impact SBMH has had on its clients and communities in reducing elopement at schools, truancy, and unsafe behaviors. For example, one middle school client comes to mind who started services with SBMH back in November 2023 due to social-emotional concerns voiced by the student's family and school staff with frequent physical and verbal conflicts with peers. Initially this student received five behavior referrals in each quarter and after less than four months of therapy, the student's number of behavior referrals reduced to only one for this last quarter with particular growth seen through utilization of Nature Informed Therapy (NIT).

Prior to my role as a Clinical Supervisor, I was a school-based therapist and therefore, I possess intimate knowledge of the demands, barriers, and inequities already in existence presenting challenges to students and staff from receiving quality mental health services. The proposed budget cuts will vastly impact not only the overall mental health of students in receiving even less access to these supportive services but also reduce the number of supportive staff skilled and trained to provide those interventions, thus, putting our beloved students, families, and staff in the district at risk for negative mental health outcomes, likely leading to regressed or underdeveloped social-emotional functioning among students and significant burnout among staff. It is no surprise that the mental health of children, adolescents and adults is in a crisis era and I do not need to educate you on the long-lasting and profound emotional, and physical burden from COVID-19; however, it is clear these burdens have resulted in startling increases of anxiety, PTSD, and depressive symptoms, as well as specific heightened suicidality and suicide attempts among children, for example (Mayne et al., 2021; Kauhanen et al., 2022). This is not the time to reduce the necessary supports that exist but to amplify them.

In closing, I am encouraging the City Council and the Committee of Health's senior leaders and stakeholders to reconsider the proposed funding and budget cuts. By doing so, we can continue to respond to the growing mental health crisis through deployment of highly qualified clinicians to partner with public and charter schools across the district, mitigating exacerbated mental health challenges through limited funding and resources, and instead increase mental wellness outcomes across school staff and students.

Sincerely,
Anna Heath, LICSW

References

Kauhanen, L., Wan Mohd Yunus, W. M., Lempinen, L., Peltonen, K., Gyllenberg, D., Mishina, K., Gilbert, S., Bastola, K., Brown, J. S., & Sourander, A. (2022a). A systematic review of the mental health changes of children and young people before and during the COVID-19 pandemic. *European Child Adolescent Psychiatry*, *32*(6), 995–1013. https://doi.org/10.1007/s00787-022-02060-0

Mayne, S. L., Hannan, C., Davis, M., Young, J. F., Kelly, M. K., Powell, M., Dalembert, G., McPeak, K. E., Jenssen, B. P., & Fiks, A. G. (2021a). Covid-19 and adolescent depression and suicide risk screening outcomes. *Pediatrics*, *148*(3). https://doi.org/10.1542/peds.2021-051507

Testimony to the Committee on Health

For the Budget Oversight Hearing for the Department of Behavioral Health

Ayominde Miller

Youth Advocate, Young Women's Project

April 10, 2024

Good morning Councilmembers. My name is Ayominde Miller and I am a sophomore at Phelps ACE High School. I am a Ward 8 resident. I am planning to pursue a career in engineering. I am also a Youth Advocate with the Young Women's Project (YWP), which I joined in 2022. YWP builds the leadership and power of DC youth so that they can improve systems and services. I am here today to share my thoughts on why the budget for Department of Behavioral Health which needs to be increased to have more mental health groups, therapists, and nurses within DCPS schools. We are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.*

I am part of the YJC ***Mental Health Campaign.*** ***w****hich hires and trains 100 youth staff advocates to educate peers, connect youth to counselors and clinicians, collect data, and develop Virtual Wellness tools. Since 2019, YJC Youth Advocates conducted 3* ***Annual*** *Youth Mental Health Surveys with more than 2,000 students).,_ _ presented 72 Performance Oversight and Budget Testimonies* , advocated for *the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot), and created the* ***Student On-line Support (SOS) Virtual Wellness Centers*** *in 16 schools (and in Spanish). We also educated more than 18,625 students and adults and reached 800 youth with referrals to DCPS counselors and DBH clinicians. This year's MHC team includes 100 youth in 22 schools. We work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

- ***Hired and trained more than 110*** **Peer Educators & Support Specialists in 16 schools:**
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- **Distributed paper and electronic materials** to 5,325 public and public charter students including infographics and slide presentations, hands on worksheets, hot line numbers, and 2023 Student On Line Support: Virtual Wellness Center:
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The main issue I came to discuss was the necessity of more funding to have more mental health groups, therapist within DCPS schools. As a youth advocate I have help connect my peers to mental health counselors in the schools if needed and give them resources. One problem I faced is while in some schools there is a whole mental health wellness team, ready for any students who need them, in others there aren't. This problem becomes more apparent when looking at our *2023-24 Youth Mental Health Survey*. 20% of the 690 students didn't feel welcome at their schools, 57% of 690 students don't know their Mental health counselor, and finally for this subject 91% of the 690 students don't know their DBH clinician. This is a major problem, due to the fact that while most people think mental health outreach right now is fine, though the data and statistics says that there needs to be a better and more efficient way to get students in the already existing programs.

While outreach is one problem, another is the lack of resources many schools have to deal with many problems students have. Though some students don't know, the ones that do are in schools who have a lack of resources online or in the schools. In the school many students sometimes just need a small break for class or work but there isn't a place for them to go, due to the school not having staff that can do that or a place with things to help calm down or relax students. 64% of the 690 students Mental Health team never or rarely provide Mental Health online resources, 75% of the 690 students Mental Health team never checked in with their class, and finally 78% of students Mental Health Team never or rarely provide one on one support.

The problem of not having enough resources in DCPS schools can be fixed through an increase of budget. We need more staff with the job or providing one on one and group counseling to all youth. Though, to maximize the effects, you can run a DCPS school wide survey to see the schools who need mental health resources, and increase the budget according to the survey. By doing the survey you can also better see the needs of every student individually from each school, to see the different things they need like a cool down room, one to one programs, a mental health month, and/or a mental health team.

Another way to ensure students having good mental health is by putting and ensuring that Mental health teams are doing their jobs the best way possible. This starts with youth assessment and making it mandatory that at least once every school year mental health staff meet with every student to ensure they are mentally fine. *This is not happening right now. I never received an assessment.* Some solutions for not having mental health groups, or therapists within DCPS schools, is to continue to invest n peer educators. My peers on the Mental Health Campaign team worked in certain schools and trained them to distribute surveys, do wellness groups with school, write and speak testimonies, and work in the field of mental health and/or clinic assessment. Within the YWP I learned all of those things, and performed class presentations in school during lunch. I received positive feedback, and many people came to me with problems they had, but could never share with anybody. I also help distribute surveys in which the data that was collected was used today. That data helps me see the thoughts of my peers at school better and find solutions to help them with their problems and needs. By increasing funding into the P2P pilot, many students can become peer educators and can help other peers they know need help.

In closing, we are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.* Right now, peer educators are filling an important gap by educating youth and helping them connect to counselors.

Thank you for hearing my testimony, council members.

Testimony to the Committee on Health
For the Budget Oversight Hearing on the Department of Behavioral Health
Seojin Kim
Youth Advocate, Young Women's Project
April 10, 2024

Good afternoon members of the committee. My name is Seojin Kim. I'm a Ward 3 resident and a junior at School Without Walls Senior High. I'm testifying to you today on behalf of the Young Women's project, a nonprofit that works for the empowerment and increased leadership of D.C youth. In my work with the Young Women's Project, the main issue my peers and I have focused on, and the topic of my testimony today, is the lack of proper mental health support present in DCPS schools.

(Don't read this section) I am part of the YJC ***Mental Health Campaign,*** ***w****hich hires and trains 100 youth staff advocates to educate peers, connect youth to counselors and clinicians, collect data, and develop Virtual Wellness tools. Since 2019, YJC Youth Advocates conducted 3* ***Annual*** *Youth Mental Health Surveys with more than 2,000 students).,* *presented 72 Performance Oversight and Budget Testimonies* , advocated for *the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot), and created the* ***Student On-line Support (SOS) Virtual Wellness Centers*** *in 16 schools (and in Spanish). We also educated more than 18,625 students and adults and reached 800 youth with referrals to DCPS counselors and DBH clinicians. This year's MHC team includes 100 youth in 22 schools. We work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

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Part of my work as a peer educator has involved giving classroom presentations on relevant mental health topics. This work has allowed me to have a positive impact on my school community and inform my classmates about important issues that affect many of them. While these presentations are often brief, the significant impact they

have should not be discounted. This work has been incredibly meaningful to me and I would greatly appreciate the opportunity to continue it. Peer educators serve a vital role in ensuring that students in schools that lack sufficient mental health education still receive the resources they need.

At Walls, the mental health education offered is inconsistent and often fails to fully address student needs. Although our health class curriculum does include a unit on mental health, and we receive occasional presentations on the topic during our advisory period, both fail to provide any comprehensive information on what services are available to students and how they can be accessed. Rather, they repeat the same tired adage that most stress can simply be solved with a better sleep schedule and an organized to-do list. This approach only alienates students struggling with more serious issues and overall erodes trust in school-based mental health supports. In the YWP Mental Health Survey, 76% of Walls students said they received 1 or less hours of mental health education.

While Walls is fortunate enough to have a school psychologist and social worker on staff, there is a large disconnect between them and the student body as a whole. According to the 2023-24 YWP Youth Mental Health Survey for School Without Walls over 30% of students at my school did not know the name of their mental health counselor, and under 20% reported being "very comfortable" with going to either the psychologist or social worker for support. These disparities are especially alarming when considering the prevalence of students at my school that struggle with their mental health. Only about 23% of survey respondents at Walls ranked their motivation level as being consistently or relatively high. Additionally, 21% reported having considered attempting suicide in the past three months, 29% had considered self harming, and 31% reported feeling so sad or hopeless in the past two weeks that they were unable to continue with their usual activities. No matter what resources are made available, they cannot be effective unless students are able to trust their mental health faculty enough to seek these services out.

We are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) program that supports the work done by peer educators like me.* Right now, peer educators are filling an important gap by educating youth and helping them connect to counselors. Additionally, when asked what changes would make it easier for them to access mental health support, there were a number that garnered a large degree of student interest. In particular, providing links to online appointment scheduling, lists of all services offered, and the contact information of mental health staff were all especially popular initiatives. These adjustments would be relatively easy to enact, especially considering the positive impact they could have. Going forward, I urge you all to prioritize student voice when combating the mental health crisis in DCPS. Thank you for your time.

Testimony to the Committee on Health
For the Budget Oversight Hearing for the Department of Behavioral Health
Carmen Brito
Youth Advocate, Young Women's Project
April 10, 2024

Good morning Chair Henderson and members of the Committee on Health. Thank you for the opportunity to testify today. My name is Carmen Brito. I am a Ward 3 DC resident and a Senior at Jackson Reed High School. Currently, I am a part of the Digital Media academy, learning and growing in the art of digital media as well as teaching others who are interested in joining our academy. I also run the social media for our academy.

This fall I will be a freshman in college majoring in Graphic Design as I hope to work for myself, becoming a freelance Graphic Designer. I have been a youth advocate for the Young Women's Project (YWP) since July 2021, working on mental health issues. YWP is a multicultural organization that builds the leadership and power of DC youth so that they can transform policies and institutions to expand youth rights and opportunities. I've been working with YWP since September on the Health Team where we review, learn about government, collect information from our peers, and educate our peers on important health issues.*I am here to talk about the lack of funding for mental health peer educators. We are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.*

I am part of the YJC ***Mental Health Campaign.*** ***w****hich hires and trains 100 youth staff advocates to educate peers, connect youth to counselors and clinicians, collect data, and develop Virtual Wellness tools. Since 2019, YJC Youth Advocates conducted 3* ***Annual*** *Youth Mental Health Surveys with more than 2,000 students).,* *presented 72 Performance Oversight and Budget Testimonies* , advocated for *the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot), and created the* ***Student On-line Support (SOS) Virtual Wellness Centers*** *in 16 schools (and in Spanish). We also educated more than 18,625 students and adults and reached 800 youth with referrals to DCPS counselors and DBH clinicians. This year's MHC team includes 100 youth in 22 schools. We work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

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The lack of mental health education is a big problem in schools. When students do not have time to develop resilience building skills, they are less able to deal with stress on their own. But students are not getting mental health education. Within DCPS Schools as a whole, 72% of students have noted that they have not received Mental Health support and 287 students have reported this school year to have not received any mental health instructions, according to our Data from the 2023-24 Youth Mental Health Survey . The results of the Jackson-Reed survey were similar.

While working with YWP I have been able to take my knowledge on Mental Health and apply to peer education within my school (Jackson Reed). Youth Advocates have ensured that proper mental health resources and education are distributed to youth within schools through means of connecting with counselors and administration on furthering mental health education, but we have 2 big projects that we have taken the time to create and administer into our schools. Our first one is our 2023 Student On Line Support: Virtual Wellness Center: which we created back in 2021 (and are updated each year) that allowed for school students and youth to have easy access to mental health support systems, counselor numbers and emails and resources. The S.O.S Center includes different pages for each school along with specific mental health topics for each school created by youth advocates from those schools.

Our most recent projects have been our presentations to class rooms on topics such as mind over matter and stress. This year advocates from different schools have been working on 4; 5, 10 and 15 minute long presentations on topics such as stress, mind over matter and 2 of you own choice (I chose stress and depression). These presentations serve to educate and aid students with knowledge on certain mental health topics so that they can use that knowledge to help aid themselves or those around them. Stress and Depression stand out as important issues among JRHS students: 39% said their stress was too much or unbearable, 22% report being sad or depressed and 67% can't sleep most nights.

Through presentations I've done at my school students were able to pick up on certain aspects of stress and mind over matter as well as depression and anxiety to better their minds, they learned about what these topics were, the different types of each topic (anxiety, depression, stress, etc) as well as exercises and methods that are available to help them and others around them (art exercise, therapy, physical exercise etc). Overall, our work as youth advocates and educators to our classmates and friends has allowed us to learn more about the different parts of mental health and mental advocacy that we hadn't learned of before or on our owns and then giving that same information that we didn't have before back to our peers to then spread to other people around them and hopefully start a chain reaction on mental health education and advocacy.

I have a couple of recommendations I would like to put forth to the committee. First, push funding towards mental health classes. Thus, we are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.* Right now, peer educators are filling an important gap by educating youth and helping them connect to counselors. Learning about Mental Health is crucial for youth especially if they don't know much about mental health or its various aspects, mental health classes led by youth or other mental health providers/ professionals can be a productive way for students to gain more knowledge on mental health. (280 students in our survey have voted that they would like mental health education in schools.) My second recommendation is to increase funding for clubs and after school activities where students can come and learn from their peers about mental health or come if they need help with their own mental health struggles. (According to our mental health

survey 23-24, 245 students think Support groups at school are important; 264 think after school wellness activities are important; and 262 think Individual counseling is important). Many students are already immersed in after school/ lunch clubs and activities like theater or sports, so having mental health based clubs would allow for both knowledge and support from educators and those around them within the clubs. With mental health issues on the rise right now, especially in youth, we need all the help we can get right now and giving funds to resources that help school students is a big step in being a part of that help.

Thank you for listening to my testimony and I hope you take my recommendations into consideration.

Testimony by Brianne Dornbush
Executive Director, District Bridges
Before the
DC Council Committee on Health
April 10, 2024

Good afternoon Chairwoman Henderson and Committee Members,

My name is Brianne Dornbush and I am the Executive Director of District Bridges. We are a community ecosystem development nonprofit organization. We have the vision to thrive together in, equitable, resilient, connected communities here in DC and beyond. We manage six of DC's twenty-eight Main Street programs namely, U Street, Lower Georgia Avenue, Columbia Heights | Mt. Pleasant, Cleveland Park, Logan Circle, and Chevy Chase Main Streets, which have served as on-the-ground learning labs where we can develop innovative strategies for place-keeping, economic development, community engagement, and connective services.

As you know the District's community ecosystem is rich with many incredible nonprofit organizations and agencies doing important work. However, the connections between these organizations are weak for a variety of reasons including funding, staff time and capacity, and dedicated coordination to enable collaborations to last. The impact of this material weakness is that our ecosystem operates in a fragmented and inefficient manner. This inefficiency has an economic impact but it also has a social impact. It should not be the responsibility of the residents in crisis to navigate a fragmented system but unfortunately that is more often than not the experience of our most vulnerable residents here in the District.

In 2021, District Bridges was awarded a grant from the National Association City of Transportation Officials (NACTO) to launch a pilot program in the Columbia Heights Civic Plaza designed to take an ecosystem approach to place management and connective services. During the pandemic, the Columbia Heights Civic Plaza became a central meeting point for over 170 individuals who were experiencing substance use disorder, housing insecurity, and mental health challenges. For many of these individuals, the pandemic created or exacerbated the challenges they were already facing. But in addition to the new challenges, many of the organizations that had previously provided support to these individuals no longer had the capacity they did prior to the pandemic. Through the funding provided by NACTO, District Bridges was able to begin understanding the situation and devising potential interventions to address the needs we identified. Councilmember Nadeau threw her full support behind this effort, funding the pilot in both FY22 and FY23. Last fall we released the report on the successes of the pilot in the first 24 months, which I have provided a link to in my written testimony.

The success and learning from the first two years of the pilot focused in the Columbia Heights Civic Plaza positioned us to be able to expand the pilot program beyond to plaza. In FY24, our serve area has expanded to serve all of our Columbia Heights, Mount Pleasant, Lower Georgia

Avenue and U Street corridors. Moving the funds to DBH was an important move that positions this program to continue its long success and development. Our holistic approach incorporates the on-the-ground knowledge and relationships in our communities to collaboratively develop relationship-based interventions to meet the needs of our neighbors struggling with substance use disorder, housing insecurity, and other challenges.

You will hear testimony later today from our Director of Community Navigation about the direct impact this program is having. I know in a difficult budget cycle the city is looking for where cuts can be made, I urge the Council to continue to fight for the programs that are supporting our most vulnerable residents.

Columbia Heights Civic Plaza for All Report
https://www.districtbridges.org/case-study/columbia-heights-civic-plaza-for-all/

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Testimony to the Committee of the Whole
For the Budget Oversight Hearing for DC Health
Jahlonnie Easton
Youth Advocate, Young Women's Project
April 10, 2024

Good Afternoon Chairperson Henderson and council members. My name is Jahlonnie Easton and I am a ward 6 resident. I am a senior at Jackson Reed High School and plan to attend college in the fall, with the hopes of becoming a respiratory nurse. I am also a member of the school's creative writing club. I started working as a Youth Justice Advocate for YWP in 2022. YWP is a multicultural organization that builds the leadership and power of DC youth so that they can transform policies and institutions to expand youth rights and opportunities. I've been working with YWP on the Mental Health Team where we review and learn about government, collect information from our peers, and educate our peers on important health issues. *I am here to talk about the need for more school based education and support groups for youth who need mental health support. We are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.*

I am part of the YJC Mental Health Campaign, which hires and trains 100 youth staff advocates to educate peers, connect youth to counselors and clinicians, collect data, and develop Virtual Wellness tools. Since 2019, YJC Youth Advocates conducted 3 Annual Youth Mental Health Surveys with more than 2,000 students)., presented 72 Performance Oversight and Budget Testimonies, advocated for *the School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot), and created the Student On-line Support (SOS) Virtual Wellness Centers in 16 schools (and in Spanish). We also educated more than 18,625 students and adults and reached 800 youth with referrals to DCPS counselors and DBH clinicians. This year's MHC team includes 100 youth in 22 schools. We work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

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Jackson-Reed currently has upwards of 2500 students and with each school year that number only grows. With that large student body comes many students in need of support. At the moment we do have a dedicated and hard working

mental health staff, but there aren't enough of them to support all of the students in need. I believe that this budgetary cut would only serve to exacerbate this issue and cause more problems leaving more students to feel helpless. Many of my peers and friends have had good experiences with school counselors and mental health staff and found them to be understanding with their needs, but there are many students who haven't had the opportunity to receive the same support due to understaffing. This issue would only grow if their budget were to be cut further.

As part of our work at YWP, we surveyed youth on their mental health needs. The Jackson Reed Youth Survey, completed by 122 youth at JRHS, shows that youth are more inclined to learn from and talk to their peers if they are having mental health problems: 43% said they would talk to a fiend if they were considering suicide, only 5% said they would talk to a counselor. Further, only 18% of youth know the names of their counselors and 4% know the name of the DBH staff. Individual counseling and support groups are important to the youth surveyed (75% and 97% said so). But right now, we don't have support groups at JRHS.

I have three recommendations. *First, DCPS and Charter schools should be required to provide a link on their website home pages that takes youth directly to the mental health team and services. Right now most websites do not have a link – which requires youth to search through the staff directory to figure out who they can contact for support. And in certain cases they don't provide the office hours or room numbers of these staff. Next, all youth should have access to wellness programming – like time management, group therapy, meditation—at their schools after school and during the school day. Most students need these services!* Most students in the survey we did last year said they would participate in peer support, therapy, meditation, and art therapy. Right now, the Council is focused on funding DBH clinicians. Clinicians are important but they only work with a small percentage of students. We need support that everyone can access. To support more mental health education, we are asking the Committee on Health to Include $325,000 again this year in the DBH budget for the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot) that supports the work done by peer educator like me and my peers.* Right now, peer educators are filling an important gap by educating youth and helping them connect to counselors.

Thank you for hearing my testimony, council members.

Chelsea Van Thof

To the DC Committee on Health and members of the community:

It has been shown that, on average, 135 lives are impacted for every death by suicide, and that those affected have an increased risk of dying by suicide, as well. We know death by suicide triggers a ripple effect throughout the community that can last for generations. With this in mind, I urge the city to maintain insertion of construction of the Taft Bridge suicide prevention barrier as a line item in the FY 2025 budget.

Suicide is the 4th leading cause of death among youth and young adults ages 10-24, the 7th leading cause of death for those ages 25-34 in DC. The Taft Bridge is responsible for over half of the suicides facilitated by bridges in the District. Yet, we've known for over half a century that suicide deaths can be prevented.

On the night of April 13, 2022, my partner, Dr. Peter Tripp, died by suicide at the William Howard Taft Bridge at age 29. His senseless and untimely death came as a shock to all who knew and loved him. More still have contemplated jumping from the Taft and been lost to the Taft since.

In my search for Peter, I first spotted the police through the bars of the suicide barrier on the Ellington Bridge. Diplomat Ben Read successfully implemented the barrier on the Ellington Bridge in 1986 in the wake of losing his daughter to suicide. Fewer people have died by suicide on the Ellington Bridge in the 35 years since the barrier was implemented than in the one week that its construction was delayed. A barrier for the Taft was slated in the same time period as the Ellington, to the point where newspaper articles mention plans for its construction in 1987. However, any reference to a barrier on the Taft disappears from public record after that time, and the nearby Taft Bridge remains a threat to community members in crisis.

I recently met yet another survivor, whose daughter jumped from the Taft Bridge. She informed me that the city actually did begin barrier construction on the Taft, back then, and was actively prevented by the city. We - survivors who have lost loved ones to the Taft, those who have fallen victim to the Taft, and the community affected by the public health dangers the Taft still presents - were so close. So close to very likely avoiding the life-altering and life-ending tragedy of suicide loss.

Decades of research has demonstrated that barriers are the most effective means of preventing suicide on bridges. According to a meta-analysis of studies that reviewed structural interventions at sites that are notorious for jumping – including DC – researchers found an 86% reduction in jumping-related suicides per year at these specific sites, with a net 28% reduction in all jumping-related suicides per year in the cities/regions where such barriers were enacted.

A study conducted five years after the Ellington barrier went up showed that while suicides at the Ellington were eliminated completely, the rate at the Taft barely changed, inching up from 1.7 to 2 deaths per year. What's more, over the same five-year span, the total number of jumping suicides in Washington had decreased by 50 percent, or the precise percentage the Ellington once accounted for.

Bridge barriers not only prevent people from dying by suicide in a moment of crisis, but they also have long-term life-saving benefits. A study of 515 persons who were restrained from leaping off the Golden Gate Bridge over a period of 40 years found that nearly 94% were still alive at the time of the investigation or had died from natural causes. In general, research has shown that persons thwarted in utilizing a preferred method of suicide do not typically seek other approaches to kill him/herself, and 90 percent of those stopped from jumping do not later die by suicide or other violent means.

One of the most effective methods of preventing suicide is to give suicidal individuals and those who care for them something they desperately need: time. This includes time for the suicidal risk to diminish, time for the intense suicidal impulse to pass, or time for someone to intervene with mental health support and resources. Suicidal feelings are often temporary – to the point where about 50% are shown to be impulsive – and keeping people safe during those moments of crisis can get them through this critical period. Bridge barriers are not only the most effective means of preventing suicides, but they also act as a delay and deterrent to an individual at risk, providing more time to get through the intense, often brief, moment of

suicide crisis and for someone to intervene.

A retrospective analysis showed that, amortized, the $229,000 cost of this prevention effort on the Ellington Bridge equates to less than $2,000 per life saved, a cost that is declining daily. This compares with the average cost to society of a suicide at $1.33 million. Additionally, a suicide prevention barrier is proven to be a cost-saving intervention with a return of US $2.40 for every US $1 invested over 10 years. So to those who say that thwarting access to a lethal jump site is a waste of money, D.C.'s experiment resoundingly lays this argument to rest.

To summarize these points - suicide is often impulsive, restricting access to means is one of the most effective ways to save people who would otherwise die by suicide, barriers have been proven to work at preventing suicide over and over again, and this preventative measure is actually cheaper for the city than facilitating more jumper suicides.

Limiting access to lethal means prevents suicide. We can, and must, see to fruition the work this community has put in to prevent suicide in DC by installing bridge barriers on the Taft Bridge, thus far. Specifically, we request that you prioritize the District Department of Transportation's funding request to cover the cost of constructing this protective measure on the Taft Bridge, as soon as possible, by including it as a line item in the FY 2025 budget request.

Thank you for your attention to this urgent matter and helping me save lives in honor of Peter. He deserved so much more than his end.

Sincerely, Chelsea Van Thof

Young Women's Project (YWP) 1609 Connecticut Ave NW, WDC 20009 202.629.1370 **youngwomensproject.org**

Testimony to the Committee on Health
For the Budget Oversight of the Department of Behavioral Health

Nadia Gold-Moritz
Executive Director, Young Women's Project
April 10, 2024

Good afternoon Chair Henderson members of the Committee. Thank you for this opportunity to testify. My name is Nadia Gold-Moritz. I am the Executive Director of the Young Women's Project (YWP). I'm also a Ward 4 resident and have two kids in DCPS high schools. YWP builds the leadership and power of DC youth so that they can transform institutions to expand rights and opportunities. Our youth leaders work on three fronts – as organizers (educating, engaging, mobilizing their peers, working as teams to make decisions), as advocates (presenting testimony to city Council, convening accountability meetings of Agency leaders, developing and passing policies) and as system rebuilders (developing programs, creating new peer-led systems, integrating youth into decision making). *YWP programs engage a diverse group of student leaders,* mostly BIPOC youth and young women from all wards, especially 4, 7 and 8. We have 120 youth leaders on the ground right now in 22 DC public and charter schools – educating students, collecting data, connecting youth to services, and advocating for their peers. Founded in 1994 as organization by and for young women, YWP has a staff of 5, delivers in person programming daily in our Dupont office and several libraries**.** Young people work side-by-side adults on our Board of Directors, Staff, and volunteers. We are value-driven, anti-racist, and feminist, grounded in youth development and partnership, and work every day to dismantle oppression and rebuild institutions.

YWP engages youth through two programs. *The* ***Youth Justice Campaign (YJC)*** *team includes 110 youth advocates in 16 schools working together as part of YWP's Mental Health Campaign, launched in 2019 to strengthen school-based mental health programming, connect youth to services, reduce stigma, and expand access to mental health education. In three years, MHC has trained and employed 300 peer educators who educated 12,000 youth, conducted 3* Annual Youth Mental Health Surveys with more than 2,000 students, *presented 72 Performance Oversight Testimonies* to DC Council, *and revised and expanded our* **Student On-line Support (SOS) Virtual Wellness Centers** to 16 schools and will distribute the link to 6,000 students. Our work focuses on expanding peer to peer mental health and wellness interventions in DC high schools. **The *Youth Health Educator Program (YHEP)*** develops youth as sexual health advocates who work to reduce DC's unintended teenage pregnancy and STI rates through peer education, resource provision, and clinic referral initiation.

I am testifying today with two recommendations for the Department of Behavioral Health (DBH) FY2025 budget. *First, we* are asking the Committee to include $325,000 in the FY2025 budget to support **the *School-Based Behavioral Health Student Peer Educator Pilot (P2P Pilot)*** *that supports* 100 youth staff who will educate peers, collect data, connecting youth to services, and advocate for their peers. Peer educators are a vital resource for reaching youth with critical Tier 1 and 2 interventions – and – for making the counselor-clinician network more responsive to youth needs. They have been on the front lines reaching thousands of their peers in the last year. Next, we are asking the Committee *to reconsider how we are allocating school-based mental resources and redirect our limited resources to reach more children and youth. A signicant percentage of the school-based mental health funds are allocated to support 254 clinicians which have never been fully hired in 12 years. It would be more strategic, given the mental health provider shortage, to fund the 66% of clinicians who are currently employed and use the remaining resources to bring non-clinicians into the system.*

In the three years since YWP has been doing advocacy and front line youth work on mental health, the crisis has grown and the school based response has not kept pace. We do not have the plans, infrastructure, multi-tiered strategies, or decision making structure needed to build and implement an effective school-based mental health system. The youth support systems we have in place right now are by design, reaching a fraction of the youth who need support. The DBH *Expansion, funded at* $38 million last year and down to $28 million this year, aims to hire and place 253 mental health professionals, one in each school. But in 12 years, we the program has never reached capacity and even now hovers at 66% capacity (168 clinicians). Further, the DBH and CBO clinicians focus on*"Tier 3" interventions that provide intensive, individualized treatment focused on school functioning – and so –they are only able to work with an average of 25 students per year. Tier 1 and 2 interventions (education, prevention, skills building, support groups) go* Peer educators are a vital resource for reaching youth with critical Tier 1 and 2 education and resources – and – for making the counselor-clinician network more responsive to youth needs. They are on the front lines in the schools talking with their peers, tracking down counselors and clinicians, and navigating school culture and supports. Here are some details on the work our MHC Youth Advocates have accomplished since September:

- ***Hired and trained more than 110* Peer Educators & Support Specialists in 16 schools:** *Youth work 4-6 hours a week, are paid $10-17 and hour, and receive 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues) and* develop a portfolio of products, build cross-school friendships; 52% are from wards 5, 7, and 8. Youth Advocates work in their schools every *to collect data, educate peers through individual and group-based training, provide electronic and paper*

resources, and connect youth to hotlines, counselors, and other support. *educate and connect peers to resources, and work with adult leaders to address the youth mental health crisis*. *(YJC Staff bios here)* Youth educators received 40 hours of training so far this year and reached more than 2,000 peers. Each youth educator specializes in a range of wellness skills and strategies that will be shared through Virtual Wellness Centers and as part of school-based health education. Youth Advocates are paid as part of the DOES School-Year Internship Program (SYIP) .

- **Surveyed 657 public and public charter students from 16 schools** living in all DC wards (with heaviest representation from wards 4 and 7). The majority of survey takers were African American (43%), followed by Hispanic (23%), White (19%), Asian (5%) and Mixed Race (9%); 25% identified as LGBTQ. The survey is solution focused, peer distributed, and included information in five areas: 1) Stress, motivation, sadness; 2) Access to school based mental health staff; 3) Mental health education; 4) School environment; and 4) Recommendations for mental health supports and services needed. YWP will continue to collect data and publish final results in late February. In the coming months, youth leaders will be meeting with school, agency, and DC Council leaders. Data from the 2023-24 Youth Mental Health Survey linked here. More details on the survey findings are included below.

- **Distributed paper and electronic materials to 5,325 public and public charter students** so far this year Materials include infographics with QR codes on 10 mental wellness issues, links to slide presentations, and hands on worksheets and skills building links—as well as counselor information, hot line numbers, and DCPS self referral links. A key resource is the 2023 Student On Line Support: Virtual Wellness Center: in 13 schools and have added schools each year. Developed by youth for youth using the Google slides and Bitmoji application, VWCs provide interactive tools that support students to examine the impact of stress, toxic stress, and trauma and build resilience through relationship building, meditation, exercise, nutritional healing, self-care, self-agency, and other wellness practices. YWP youth leaders share their VWC link via their Linktrees, social media posts, email, text message, and in classroom presentations. *YWP's SOS centers are the only consistent source of on line education and resources available to DCPS and DCPCS students.*

- **Conducted Classroom Presentations and Training for 5,325 youth in 16 schools through classroom presentations and individual education.** And we are just getting started. In February will be launching an 8-week classroom-based education blitz where youth leaders will provide information and interactive tools that support students to examine the impact of stress, toxic stress, and trauma and build resilience through

relationship building, meditation, exercise, nutritional healing, self-care, self-agency, and other wellness practices. We expect to educate 6,000 youth and connect them to counselors, help lines, and crisis centers. The absence of mental health-wellness education for children and youth continues to be a serious blind spot; 78% of youth surveyed by YWP this year report receiving zero or less than 1 hour of mental health education (holding steady for the past 3 years). Even though mental health education is required by law (Healthy Schools Act[1], Student Safety and Consent Education Act[2] and Suicide Prevention Act of 2017 and School Climate Survey Amendment Act of 2015.[3]) -- the vast majority of DC public school students receive no mental health education—which creates a significant knowledge-skill gap in their capacity to understand and respond to stress and trauma – and – to build resilience.

Additional projects in progress include the following:

- Formalize YWP **Mental Wellness Curricula** and resources to share with health teachers and others working with school-based youth
- **Create and share a School-by-School Behavioral Health Data Base** that includes specifics on school-based mental health services in high schools including specific individuals, services provided, website links and other resources
- **Develop and pilot a Youth Wellness Network**: that offers free trainings, events, memberships, healthy food, and other resources to youth who sign up to be part of the YWN. Youth sign up, set wellness goals and identify resources they need, and then are matched with free services. Based on initial inquiries, donations are likely to include health club memberships, yoga classes, meditation groups, martial arts, dance and exercise classes, and gift certificates for produce, smoothies, and other health food.

Challenges: YWP has the capacity and is making significant inroads on the high school mental health education front. The much greater challenge is connecting youth to school-based non-academic counseling resources – which are hidden and in short supply. Youth are unclear on what counselors and clinicians can actually provide and how

[1] The Healthy Schools Act requires that all DCPS and PCS provide an average of 75 minutes per week of health education for grades K-8. They must also provide 150 minutes of physical education for K-5 and 225 minutes per week for grades 6-8. The data for 2018 show progress but are still not meeting the legal requirement.

[2] **The Student Safety and Consent Education Act of 2018 requires** all DC schools to adopt and implement a policy to prevent and address sexual harassment, sexual assault, and dating violence among students and to amend the HAS to require age-appropriate instruction on consent, training for parents and staff. Based on anecdotal evidence, it seems that the teachers have been trained – but not the students.

[3] **Suicide Prevention Act of 2017 and School Climate Survey Amendment Act of 2015 (DC Law 21-120)** requires all teachers and principals in public schools and public charter schools to complete the youth behavioral health program once every 2 years and requires OSSE to develop and publish online written guidance to assist local education agencies in developing and adopting policies and procedures for handling aspects of mental and behavioral health, an on line catalogue of resources, and to pilot a school climate survey.

to access that. The absence of clear information, service description, and appointment links make it very difficult for youth to seek help. In one positive step this year, DCPS finally developed an online Are You Good? Contact form through which youth can request mental health support. And I am pleased to say that it is working! We tested the online tool in January and youth testers received a prompt and positive response. The problem is – no one knows the online form is there unless you happen to get on the DCPS website which is not linked on DCPS school websites.

2024 Youth Mental Health Survey Findings: Since 2020, YWP has conducted an annual Youth Mental Health & Wellness Survey. Preliminary results from our 2023-24 Survey are included below and in the attached slides. I am also attaching links to YWP's 2022-23 Youth Mental Health Survey, the 2021 YRBS data, and the 2023 Child Trends School Based Mental Health Survey Data. All three surveys document the high rates of youth stress, depression, and hardship and low rates of service access. YWP's 2023-24 Survey was taken by 657 youth from 16 public high schools, living in all DC wards (with heaviest representation from wards 4 and 7). The majority of survey takers were African American (43%), followed by Hispanic (23%), White (19%), Asian (5%) and Mixed Race (95); 25% identified as LGBTQ. The survey is solution focused, peer distributed, and included information in five areas: 1) Stress, motivation, sadness; 2) Access to school based mental health staff; 3) Mental health education; 4) School environment; and 4) Recommendations for mental health supports and services needed. YWP will continue to collect data and publish final results in February. In the coming months, youth leaders will be meeting with school, agency, and DC Council leaders to present school specific data and discuss of mental health solutions. We would welcome the opportunity to meet with all of you. This year, we analyzed data at five high schools that reached 15% or more of the student body. Slides are linked here : Banneker Team Slides, School Without Walls Team Slides , the Jackson-Reed Team Slides , CHEC Team Team Slides, McKinley Team Slides. Highlights from 2022-23 Preliminary Results are as below.

- ✓ **On Stress & Sleep:** Stress levels continue to be high**;** 36% youth survey takers reported extreme stress that is "too much" or "unbearable (down from 42% last year and 57% in 2021);" 40% describe their stress as high but manageable. Motivation is a challenge for most youth; only 24% struggle with low motivation with 40% fluctuating. Sleep continues to be a significant problem among teens: The vast majority of survey takers have trouble sleeping and are not getting the recommended 8-10 hours; 20% of youth said they have trouble sleeping and get fewer than 6 hours a night; 45% have difficulty sleeping, and 23% have trouble falling asleep at night. Many of our youth staff believe that sleep deprivations contributes to school fights and other violence behavior.

- ✓ **Depression & Suicide:** Alarm bells still ringing; On depression, 32% of youth felt so sad or hopeless almost every day for two weeks in the past 3 months – that they stopped doing activities; Further, 14% of youth considered suicide in the past 3 months. When asked who they would talk to when experiencing suicidal thoughts in the future, 32% said friend, 20% parent, and 8% said they would talk to a school or outside counselor. Significantly, 30% said they would not tell anyone.

- ✓ **School Based Mental Health Education continues to be – extremely rare**: 78% of youth received zero or less than 1 hour of mental health education (holding steady for the past 3 years).

- ✓ **On Counselor-DBH Staff Access:** Most youth do not know the school-based mental health staff have not accessed mental health information or services (73%) and do not know the name of their school counselor (57%), or their DBH clinician (91%) . Some youth received on line resources (16%) and one on one support from school counselors (15%). Nearly half of students (42%) are not comfortable talking to school counselors or clinicians (69%).

- ✓ **On Mental Health Supports Youth Want:** Most youth want and would engage in one on one counseling afterschool (73%), virtually (73%), and during lunch (60%). Further, 60% would like after school wellness activities, 68% classroom education, 59% mindfulness and meditation, and 70% art therapy. More than half of youth would like to participant in support groups (56%) and 64% say discussing issues with peers is important.

Budget Recommendations: *We are and have been in a youth mental health crisis – with a significant percentage of our young people overstressed (*76%*) depressed (*32%*), and considering suicide (*14%*). Our current system has succeeded at crisis intervention services for 5% of the youth population but has not succeeded at delivering mental health services, including individual counseling and group therapy, education and other support to the 45% of our students who are sad, depressed, overstressed, dealing with trauma. The vast majority of youth in all schools do now know their counselors* (57%), or *clinicians* (91%). *Current y*outh support systems are by design, reaching a fraction of the youth who need support. Most of the DBH expansion budget funds one strategy – the clinician pipeline – which has stayed at 66% capacity for 12 years. Those of us working in the field are desperate for data, infrastructure, communication systems, clear decision making, and a coordinated system of engaging youth and a broader group of adult practitioners and volunteers – who can take on Tier 1 and 2 interventions. We've been trying the same strategy for 12 years. It has not worked. Now we are now in a budget crisis and a mental health crisis. It's time to go back to the drawing board. Here are our suggestions for doing that.

Recommendation 1: Continue to Support a Peer to Peer Pilot (P2P) to increase mental health education and support in schools: Regardless of what happens with DBH (and whether they ever release an RFP) – it's really important to issue the RFP next year. We suggest doing it through DOH-CHA and in partnership with their school based clinics. DOH-*YWP is working close with DOD-CHA on a number of health education fronts and we believe CHA shares the Committee's values (and ability to implement) around peer education, community partnership, planning, goal setting, and reporting. We believe DOH would be a better match with the Peer to Peer Behavioral Health RFP. The Peer to Peer (P2P) Pilot would formally acknowledge the contributions of peer educators and support 100 youth educators to provide Tier 1 (education & outreach) and Tier 2 (group support) interventions.* The P2P Pilot organizations would work with recruit and train students at 3 or more schools who would engage and lead one or more school-based interventions including: 1) Classroom and one on one mental health & wellness education; 2) Connecting peers to DBH and CBO providers through expanded outreach; 3) Working with DC Health School-Based Clinics to create student wellness centers; 4) Developing school-based Virtual Wellness Centers and other on-line resources; 5) Organizing and co-facilitate peer support groups on anxiety, grief, stress, academic overload, and other student priorities; 6) Organizing events and trainings including after school trainings & support sessions by high schools for middle schools; 7) Collect data and promote universal screening; and other projects.

Justification for Peer to Peer (P2P) Pilot: *Currently there are DBH clinicians or CBOs in 8/17 DCPS high schools and 11/21 Charter high schools – collectively reaching about 500 or the 18,000 public high school students with Tier 3 interventions. Based on recent YRBS data, close to 9,000 students are in need of immediate interventions and support to deal with depression, suicidal thoughts, and regular trauma exposure.* The P2P Pilot would help to close that gap by providing student to student education and support, recognizing the importance of social influence and peer attachments for young people who are more likely to rely on informal sources of support, including friends, for emotional and psychological needs. YWP youth staff have demonstrated the enormous capacity of students to educate peers, collect data, provide virtual education tools, and engage adult providers to improve their services. Our Mind Matters, another youth-led organization, is facilitating all of the Mental Health Ambassador groups for DCPS. *The California Department of Health Care Services (DHCS)* led by Surgeon General Nadine Burke Harris, is a model in documenting the youth mental health crisis and creating broad based, multi strategy legislation to create programming and opportunities including peer interventions. In FY2023, the state legislature allocated *$10 million to support eight high schools as pilot sites in California for a student peer–to–peer program. This P2P approach is* captured by the *California Children's Trust*, in this Brief on Peer to Peer Mental Health Programming. Recognizing the essential role of peers and the shortage of mental health professionals, California passed **SB 803. Peer**

Specialist Certification Program to establish statewide requirements for the certification of peer support specialists for mental health and substance abuse.

Recommendation 2: Reorganize the Community of Practice (COP) into 4 Grade-Band Hubs (2 at the Elementary School Level, 1 Middle School, 1 High School) funded at $300,000 each that would work with public schools. Led by existing CBO organizations who could opt to be hub coordinators in addition to placing school-based mental health providers, the grade-band Hubs would have the capacity and directive to take on the following work:

1. Identify priority SB MH goals, objectives, outcomes for their grade band and for each school;
2. Assess student needs, school needs, school infrastructure; share information with DBH and Hub providers, and the public; Design and coordinate a universal assessment program for all grade band;
3. Develop a plan to respond to school needs through direct student support and education including 1) Resilience Building Education; 2) Individual counseling; 3) Support groups; 4) Emergency interventions.
4. Develop a plan to respond to collective and individual school needs through staff development and support including 1) Staff training; 2) Administrative support (504-IEP); 3) Parent education. Staff training and parent education should be able to be clustered across school.
5. Create a hub website and dash board that shares resources, data, events, curricula, counseling protocol and tools and other relevant information and training with hub schools and supporters.
6. Serve as a gateway for peer educators, volunteers, graduate programs, and others to engage meaningfully with schools and students on mental health & wellness issues.
7. DBH could place 2-3 supervisory clinicians at each hub who could serve as the DBH point person and provide supervision to graduate students working in hub schools.

Justification of Grade-Band Hubs: The DBH school-based mental health delivery system and the funding allocation approach (see DBH school provider RFA) supports individual organizations who employ individual providers, managed by individual supervisors who are assigned to individual schools– most of which have no discernible mental health service delivery systems, a necessity for this strategy to succeed. The Community of Practice is charged with providing all training and support infrastructure to all providers, parents, and potential community partners in all grade bands but without the authority or school-based system to be able to assess and connect people at the ground level– also not a realistic strategy for providers who need grade-specific tools. Real time, school-specific d*ata collection and sharing is core to understanding mental health need, the quantity and depth of interventions, and whether we are making progress. Unfortunately, the Child Trends data is so broad and so delayed that it offers only general advice and information on how parents and youth feel. The Grade-Band Hubs*

seek to address these problems. This approach is gaining traction internationally. Ontario Canada has a viable model.

Recommendation 3: Allocate $300,000 to Fund a Pilot Program recruit, train, and place graduate students (in social work, psychology, and counseling) in DCPS and Charter schools: We need a new labor pool to provide counseling, support groups (97% of students in the YWP survey said that support groups are important!), and classroom-based education. Given the current labor shortage, we need to tap grad students and volunteer counselors. Our current COP provider is well positioned to succeed at this role as an academic institution with several graduate programs, a network of university peers, and a significant capacity for training, support, and placement. The program would be tested with 25 grad students in 25 schools in year one and if successful, could be expanded each year. This function could be expanded to develop and administer a certification program for volunteers who want to support mental wellness education, universal assessment, and other school-based mental health work through after school or in-school programs or to recruit credentialed volunteers (already certified as counselors, social workers) to provide virtual and in-person counseling and support groups for high school youth.

Recommendation 4: Allocate $1 million to Fund a Pilot to establish Wellness Centers at 7 DCPS high schools with existing School-Based Health Centers. School-based mental health delivery would benefit enormously from having a consistent physical space where youth could find providers, attend support groups and wellness activities. School based clinics are underutilized and now in this budget, on the receiving end of significant cuts of 1.5 million. As one model, San Francisco Wellness Centers—which was a partnership between SF Dept of Health and SF Public Schools. The School Based Wellness Centers would provide a physical space for all of our recommendations in addition to a Wellness Room, which many youth are requesting. The Peer Educators and DBH providers would be key partners. Providing physical space for wellness services is an essential step in bringing the work above ground.

Thank you for your leadership and commitment to youth and for this opportunity to testify. I am happy to answer any questions and serve as a resource for the Committee.

Testimony of Survivors and Advocates for Empowerment (DC SAFE)

FY25 Budget Hearings - Department of Behavioral Health

Committee on Health - DC Council

April 10, 2024

Thank you Chairperson Heanderson and members of the committee. My name is Kylie Hogan and I am the Crisis Intervention Team Director at DC SAFE. DC SAFE provides 24/7 crisis intervention for domestic violence survivors in the District. As I have testified to before and many of our staff and partner agencies have expressed, Domestic Violence is a dynamic issue that impacts the whole person or family. For individuals struggling with mental and behavioral health, the type of care provided by the Department of Behavioral Health is often an essential element both for immediate stabilization and long term healing for survivors as well as being a critical component of safety for victims and accountability for perpetrators.

DC SAFE services are geared to offer immediate stabilization at a time of a domestic violence incident, but an essential part of our services is to assist survivors in connecting to long term resources for ongoing support as they heal. We are proud to partner with DBH in this capacity. We strive to be a crucial link through our Crisis Response Line for case workers and clients within DBH when domestic violence-specific services are needed, but we are fortunate to be able to rely on DBH to provide ongoing mental and behavioral health care for clients in need whether this is immediate crisis dispatch for clients in acute crisis or ongoing assistance with things like replacing critical medications, reconnecting with providers or collaborative work with individual clients to find creative solutions to meeting their needs.

In particular, I have appreciated DBH's proactive and dynamic participation in the High Risk Domestic Violence Initiative's (HRDVI) Domestic Violence System Review (DVSR). This initiative ensures providers across disciplines are engaged to share information and consider how to best serve survivors, something that was crucial throughout the pandemic and as we have emerged into a new landscape of service provision. But, further, it allows providers to review and find solutions for our community's most critical and complex DV cases. Having a strong partner in DBH is essential when we know that safety often hinges on strong partners who are invested in teaming and creative solutions.

In that theme, I want to praise the Mayor's budget in allocating funds for substance abuse and behavioral-targeted outreach pilots in Wards 1, 5, and 7. The current MPD-DBH Co-Response Program

has been a much needed resource to help address both the immediate mental health needs of some of our most vulnerable citizens but also to maintain safety. As I have previously testified, we have long seen that the police department is asked to do too much. Further, approaching situations of mental health or substance abuse in a punitive way does not begin to address the root cause of issues that warrant immediate intervention. Any additional funding that can help pivot the city's response toward connecting individuals to critical services through DBH is money well spent to find solutions and support for vulnerable citizens.

However, I am hoping as DBH and other city agencies consider innovative approaches to crisis response that the need for sustained outreach efforts are not forgotten. Individuals with mental or behavioral health issues or who may be caught up in a cycle of addiction are often at a high risk for falling victim to domestic violence as abusive partners or families leverage a victims' vulnerability to feed into a cycle of power and control. Immediate intervention through these sorts of co-responses or through DBH's crisis response team can be helpful, but individuals will continue to need help once they are past an immediate crisis. How that assistance is delivered is critical.

Frequently I see that those most vulnerable are assisted and provided information on follow up services, appointments, case managers, etc., but momentum is lost as individuals struggle to manage these on their own. DC SAFE offers services in a proactive way, not waiting for individuals to call or find us on their own, but rather partnering with those we know will encounter survivors in the community. New programming seems to be on the right footing in engaging in this proactive offering of service, but the next step is then problem solving and bringing continued support to individuals to keep progress going. Finding innovative ways to continue to bring services to clients outside the crisis window is something we see as essential. I mentioned before that domestic violence impacts the whole person and we often see that our clients are overwhelmed as the violence in their lives disrupts their stability across the whole mosaic of their life. Rather than expecting those struggling with the greatest needs to come to services, initiatives to provide warm hand offs, continued support catered to individuals' needs **and** to meet individuals where they are in the community are promising leads to long term success. In addition, the ability to track and recognize trends for the most vulnerable are essential to making an impact. We recognize mental health as a health issue so we should take our cues from innovative approaches to health care where the most vulnerable are not just provided a list of resources or a pre scheduled appointment but where intervention plans are dynamic and service delivery is pre-crafted to bring long-term services directly to those in need.

As our work overlaps with many partners seeking to meet the needs of whole individuals, we have had significant success when we can partner dynamically with individual providers on behalf of our clients. This coordinated approach is best practice. I am pleased to see that the budget for DBH is expanding across not just pilots and collaborations, but in multiple aspects of their programing. Like many of our social service partners, we often find overwhelm and limited resourcing stifles the ability of case workers and mental health supports to excel and we hope this budget will help strengthen DBH as a whole. We hope that additional funding and staffing can add capacity in an area of work that sorely needs attention if we want to successfully support health and public safety for all DC residents.

Oversight Hearing

Department of Behavioral Health

Before the Committee on Health

Council of the District of Columbia

April 10, 2024

Good morning, members of the Committee on Health, and thank you for the opportunity to testify. My name is Laura Mainzinger, and I am a School-Based Mental Health Therapist at Kramer Middle School in Southeast DC through the Latin American Youth Center (LAYC).

Violent crime continues to soar in DC while high rates of suicidal ideation amongst youth continue to be captured through the Youth Risk Behavior Survey. With these rates higher in Southeast DC, the biggest needs to be fulfilled at Kramer Middle School are violence and suicide prevention initiatives, while teaching students the tools to be able to manage their emotions and resolve conflict in non-violent manners.

Therefore, on top of managing my caseload of students for individual therapy, I, together with the mental health team, implement multiple Tier 1 and Tier 2 interventions addressing these needs. Evidence-Based group curriculums such as Too Good for Violence, Love is Not Abuse, and Signs of Suicide are being administered to our students to help mitigate these needs.

In order to decrease the number of physical altercations inside and outside of Kramer, the mental health team also facilitates restorative circles and mediations between students, with the goal of teaching our students the skills to be able to resolve conflicts in non-violent ways.

I would like to introduce you to Student X. At the beginning of this school year, Student X was involved in several fights. Throughout this year, she has been in many small and large group mediations, and we talk about healthy conflict resolution skills and self-management techniques in individual sessions. Through these various interventions, Student X has not been in any physical fights inside of the school setting in months. She also took the skills that she learned in mediations and facilitated a mediation between five other girls in her grade, in which the conflict was resolved without adult intervention or any physical altercations. Student X shares that she can now talk through problems when there is an issue instead of fighting over the small things and getting into trouble. Student X's Panorama data (a database that collects student data) shows an increase in areas ranging from self-management to sense of belonging, to self-efficacy compared to her scores at the beginning of this school year.

Overall as a school, Kramer students have reported a 7% increase in self-management (how well students manage their emotions, thoughts, and behaviors in different situations) and a 4% increase in social awareness (how well students consider the perspectives of others and empathize with them) since the beginning of this school year. Many of the mental health team's initiatives were aimed at increasing scores in these areas.

In order to address the pressing concerns of the safety of our middle schoolers at Kramer, our programming does not always translate to billable services (individual therapy) which leaves a gap in salary. It is imperative that funding continues to be pushed into the School-Based Behavioral Health Expansion to be able to adequately address the needs of young people in DC and ensure that CBOs can pay salaries that allow clinicians to remain in these vitally important positions.

Pathways to Housing DC

Christy Respress, President & CEO
Pathways to Housing DC
Testimony on
FY 2025 Budget Oversight
of the Department of Behavioral Health
Committee on Health

April 10, 2024

Thank you, Chair Henderson, Councilmembers and Council staff.

My name is Christy Respress and I am President & CEO of Pathways to Housing DC. Pathways has been a certified DBH provider since 2005. We have also maintained a contract with DBH to run the Court Urgent Care Clinic at the DC Superior Court since 2012.

I am here urgently requesting the District to reinstate funding for the Court Urgent Care Clinic into the FY25 DBH budget. Let me start with responding to DBH's response to Question 22 on the justification for eliminating funding. DBH states it is justified due "to the requirement that all substance use disorder services providers conduct intake and referrals and low utilization". Let me clarify. Pathways recently identified the reduction in need for substance use intake services and proposed a budget modification which DBH accepted to decrease one addiction specialist and add another clinician due to INCREASED clinical demand for mental health services. To the second response on utilization, Pathways is on target to exceed our contractual obligation of persons served in this current fiscal year.

Since 2012, Pathways has been providing same day, no-barrier access to urgent behavioral health treatment at the DC Superior Court. We have served over 7,100 unique adults and youth with tens of thousands of follow up visits. In a tight budget year where Director Bazron had impossible decision to make, I am imploring the Council and Mayor to stay laser focused on the mental wellbeing of District residents. Nobody in the community is well served by people not obtaining the mental health and substance use services they need. This is a personal and public safety issue.

The Urgent Care Clinic was one of the first of its kind in the country. The goal is simple: by embedding a skilled group of clinicians in the courthouse, we divert people from costly and unnecessary interventions like cyclical incarceration by getting people the mental health and substance use treatment they need and are entitled to. There are many reasons why people fall out of care. Interaction with the legal system is one of them. The Urgent Care Clinic breaks that cycle by intervening with people in their moment of crisis and providing mental health treatment for up to 90 days or until they connect with an ongoing provider. For example it can take 6 weeks to get an appointment with a psychiatrist in the community. Instead of forcing a person to suffer with untreated mental illness for weeks (with increasingly poor outcomes), our psychiatrist prescribes medication and provides ongoing treatment until the person is reconnected with their core service agency. Removing same-day access to care at the court will result in increased and avoidable calls to police to respond to situations in the courthouse that our team currently resolves with clinicians responding literally in the courtroom or when an attorney walks someone to our office. Cutting this funding would lead to inappropriate FD-12s which is an extreme, costly, and traumatic response to a psychiatric crisis that is often avoided when our staff intervenes to meet the needs of court-involved adults and youth. I know my time is limited here. Our team is eager to answer any questions you may have about our services and the impact if they were cut. We've heard from judges, attorneys, and other court stakeholders that this is a short sighted and deeply concerning decision that will lead to poor and unsafe outcomes. We urge you to find the funds to keep this life saving service intact.

I want to thank Dr. Bazron for working closely with ACT providers to transform the payment for ACT services from a fee-for-service unit-based model to a monthly payment. She has been meeting regularly with CEOs for feedback on the rate structure and billing requirements. No provider is billing the 85% needed to sustain the service yet, but I am confident that Dr. Bazron and her team are hearing our concerns and will continue to refine the requirements to build a robust and solid ACT service that will meet the needs of DC residents.

Lastly, I am raising a flag of concern at the reduction of so many DBH positions. The move to carving in behavioral health services into managed care has been indefinitely delayed. I have serious concerns about the ability of DBH staff who are already overworked to carry out the administrative duties now back in their office that would have moved to MCOs under a carve-in.

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Christina Henderson, Chair, DC Council Committee on Health
Members of the Committee on Health
From: Patricia Quinn, VP of Policy and Partnerships, DC Primary Care Association
Re: Budget Hearing for DC Department of Behavioral Health
Date: April 10, 2024

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming DC care delivery, and advancing racial and health equity. Our collaborators in this work include community health centers, serving almost 1 in 4 District residents in every ward of the city. Thank you for the opportunity to provide testimony regarding the budget of the District of Columbia Department of Behavioral Health (DBH.)

Behavioral Health Treatment

Last year, we reported an almost 35% decline in the number of mental health patients seen at community health centers between 2019 and 2021 related to workforce challenges. Our 2022 data shows progress, though we are still 13% below 2019 numbers.[1] Even more significant is the decline in patients receiving substance use disorder treatment. More than 9,500 health center patients had a diagnosis of substance use disorder, yet fewer than 2,000 received treatment for the condition at a health center. Surprisingly, this ratio of diagnosis to treatment is considerably better than national averages. SAMSHA reports that in 2021, 94% of people with SUD received no treatment .[2]

The District's health system must engage and partner in new ways to reach those struggling with behavioral health challenges who could benefit from life-saving harm reduction services and life-changing clinical supports. According to an interim evaluation of the District's 1115 waiver to transform behavioral health, measures for initiation of SUD treatment improved, but adherence to and retention in treatment did not. The report recommends expanding access to peer support beyond providers certified by DBH, easing provider burden on service delivery requirements, and continuing to build the policy, payment, and delivery system infrastructure for telemedicine.[3] Given these recommendations, DCPCA is concerned about the proposed restriction of audio telehealth services. Audio services provide critical support for residents without access to video-enabled devices, internet, or the privacy necessary to engage in video telehealth.

The proposed FY25 budget for DBH anticipates necessary increases for the District's share of Medicaid behavioral health costs and for behavioral health services for residents who do not qualify for Medicaid. DCPCA supports these increases and the investment in staffing for the Access Helpline. Our members have struggled with the apparent reduction in Access Helpline service in FY24 in terms of linking patients to the more intensive services offered by DBH grantees.

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[1] District of Columbia Health Center Program Uniform Data System (UDS) Data (hrsa.gov)
[2] SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021 | HHS.gov.
[3] DRAFT 1115 Interim Eval Report_For public comment (dc.gov)

Of particular concern to DCPCA is the reduction of $4.8 million in School-based Behavioral Health. The Mayor has indicated the savings (and an additional $6.4 million elsewhere in the budget) come from staff vacancies. Rather than eliminating the positions and resources, DCPCA recommends redirecting the savings to continue investment in school-based behavioral wellness through emerging models that broaden the base of behavioral health supports available in school communities. Approaches to care need to build on social capital, individual and community agency, and support connections for a meaningful life.

Opioid Abatement

Opioid-related fatalities in the District have increased every year since 2018, despite focused attention within the health system and DBH's Live.Long.DC campaign. As a member of the Opioid Abatement Advisory Commission (OAAC), DCPCA is invested in pursuing evidence-based innovation and securing resources for infrastructure using the $14.6 million in opioid settlement funds. Three recommendations emerging from the OAAC deserve specific attention, particularly given that our collective past efforts have yet to stem the tide of opioid overdose deaths[4]:

1. "Bupe in the Field" as described by Dr. Robert Holman, Medical Director at Fire and EMS
    - 24/7 buprenorphine induction from EMS medics
    - Five consecutive days of EMS visits w/ buprenorphine dosing
    - High rate of 30-day adherence to buprenorphine treatment
2. PEP-V type housing for unsheltered residents with SUD
    - Private rooms with amenities, three meals plus snacks, and 24/7 security.
    - Daily primary care and 24- hour mental health support. Access to medical and community transportation, linkage to care, and support for accessing community services and long-term support.
    - Housing-focused case management with permanent housing exit planning. Staffed by people with lived experience, clinicians and peers for clinical, psychosocial support, and skill-building.
3. Contingency management pilot
    - Use human-centered design to stand up a contingency management (CM) system founded on and rapid cycle iteration to harness the power of tangible incentives for achieving drug-free tests, session attendance, and milestones.
    - Guide a transition to intrinsic self-motivation.
    - Embed across outpatient, inpatient, and residential facilities, incorporate peer recovery support, and target populations at higher risk.
    - Robust research shows CM's efficacy in increasing adherence, retention and reducing reuse.

Requirements for National Accreditation

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4 https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/OAAC%20Meeting%20Presentation_2.14.24.pdf

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

DCPCA supports DBH's efforts to improve quality among District providers by advocating for national accreditations from the Joint Commission, the Council on Accreditation, or the Commission on Accreditation of Rehabilitation Facilities. However, national accreditation should replace existing DBH certification requirements.

Replacing Certification Requirements

FQHCs are asked to maximize efficiency and health outcomes from limited federal funding. Establishing consistent standards across DBH and the accreditation bodies will minimize the administrative burden on FQHC compliance staff, allowing them to focus resources on patient outcomes. DBH should amend language in each Chapter affected by this proposed rulemaking by replacing its current certification requirements with those standards set forth by the national accreditation agencies in order to align both sets of evaluative standards and minimize undue burden on providers**.**

We are grateful to DBH Director Dr. Barbara Bazron and her dedicated team for their deep commitment to the well-being of District residents. We look forward to further partnership to build and strengthen pathways to recovery for everyone in our city.

Gregory Anthony
Civic Leader
Education Reform Now Advocacy D.C.

DC Council's Committee on Health Budget Oversight Hearing on:
Department of Behavioral Health

Good afternoon Chairperson Christina Henderson, members, and staff of the Committee of Health,

My name is Gregory Anthony, and I live in Ward 1. I'm here both as a Godparent, community member, advocate, and civic leader for the D.C. Chapter of Education Reform Now Advocacy, an organization fighting for a just and equitable public education system for all D.C. students. Today, I'm here to discuss the Department of Behavioral Health's budget for fiscal year 2025.

We appreciate the Mayor's proposed investments in school-based behavioral health, but the sustainability of this program requires much more. From my experience as an educator in the District, I've seen how in-school support, particularly behavioral health support, can benefit and bolster academic experiences across the communities deemed "at-risk". Today is such a time, so unstable, when it is of supreme fiscal importance to prioritize the vulnerable precious minds of our students and make the moral decision to empower them toward their future.

Over 19% of middle school students and 25% of high schoolers reported poor mental health, signaling ongoing unmet needs. In May 2022, among adults in the District of Columbia who reported experiencing symptoms of anxiety and/or depressive disorder, 49.3% reported needing counseling or therapy but not receiving it in the past four weeks, compared to the U.S. average of 28.2% - according to KFF, the independent source for health policy research, polling, and journalism.

Looking ahead to next year, we're urging the DC Council to continue expanding funding for school-based behavioral health (SBBH) clinicians by ensuring competitive salaries with inflation adjustments to attract and retain professionals. We join the Strengthening Families Through Behavioral Health Coalition in asking the DC Council to find an additional $6,155,587 to increase CBO grants for every school to the required $98,465. If all 254 eligible schools receive $98,465 then the school-based behavioral health clinician salaries will be fully funded. Currently, in the proposed budget, CBO grants will only be $80,819.67 - a full $17,645.33 less than what is needed at each school.

Additionally, the proposed budget eliminates the Community of Practice entirely. In addition to making the CBO grants whole, we ask the Committee to restore the funding to the fiscal year 2024 level ($593,780) for this contract. There are also additional investments needed.

Pilot non-clinical staff positions: Invest $2.4 million to increase the reach and capacity of the SBBH program, particularly for Tier 1 and 2 supports that address broader student needs. Making this a priority creates a support system and safety net in schools. As an in-class tutor and mentor with City Year DC, I learned that not all parents have the foundational capacity to meet their children's needs so the onus of equity fell on the shoulders of compassionate people in the school. Supporting work like this creates an environment conducive to effectively connecting with precious students who have special needs.

Provide strategic planning for future needs: Develop a District-wide strategic plan for children's behavioral health: Commit $300,000 to create a cohesive, evidence-based approach to addressing the crisis, with input from all stakeholders. This plan will, once it comes to fruition, strengthen cradle-to-career pipelines across the district. By equipping students with foundational skills, and healthy behaviors, that are conducive to fostering healthy relationships, we lead young folks to high-demand, high-wage careers.

Maintain funding for the Pathways to Behavioral Health Degrees Act ($1.7 million): supporting this funding is not only key for future generations of students, but the growth of our precious city, and the people in it.

We must act now because our children will grow into adults represented in the aforementioned statistic. That's why I'm urging the DC Council to play the long game and invest in the sustainability of the present that will bear fruit for the future. Thank you for considering this important issue. I am prepared to provide more details or help if needed.

Testimony of Ann Chauvin, Chief Executive Officer, Woodley House, Inc. To the Committee on Health Department of Behavioral Health Budget Oversight Hearing April 10, 2024

Good morning, Chairperson Henderson and members of the Committee. My name is Ann Chauvin, Chief Executive Officer for Woodley House. Thank you for the opportunity to submit this testimony to the Committee on Health for the **Department of Behavioral Health FY25 Budget**.

Founded 66 years ago, Woodley House is a nonprofit organization providing housing and support services to DC residents who face behavioral health disorders. As part of our continuum of care, we operate Mental Health Community Residential Facilities (MHCRFs) that serve vulnerable adults who need a high level of care to remain in the community and enjoy positive health outcomes.

We thank the leadership team at the Department of Behavioral Health, for their hard work in identifying and deploying the resources to increase the daily service rates for MHCRFs, such as those operated by Woodley House. These facilities provide an absolutely vital level of care and housing for the District's most vulnerable residents. But before 2024, MHCRFs had not received a payment rate increase in six years, and we desperately needed this. For fiscal 2025, we respectfully ask that the MHCRF rate increase remain in the budget.

We ask the Committee to please consider that the DBH portion of payment for MHCRFs is only $77.90 per day, compared to $1,236 to $1,545 per day for St. Elizabeth's, which is the source of most of our client referrals. This underscores the cost-effectiveness of Woodley House programs as an alternative to hospitalization, with highly positive outcomes for our MHCRF residents.

We are proud that, of the DBH-supported residents in Woodley House facilities in 2023, 96% sustained their housing or moved to a more appropriate level of care, and ZERO experienced a psychiatric hospital stay. Our anonymous client surveys consistently capture positive responses, including this quote from a Woodley House resident: ***"The house is beautiful! Also the staff is very kind and generous. I feel like I made family here. We are a big happy family."***

However, looking more generally at the 2025 proposed budget, we are dismayed with the cuts that DBH is being asked to make. The department's Access HelpLine team and Community Response Team have proven vital partners to Woodley House, particularly for our psychiatric crisis bed program, with excellent leaders and staff. They provide critical functions for DC residents in seeking and accessing timely care and services. With the delayed transition of mental health rehabilitation services to Medicaid managed care organizations, we believe the Access HelpLine in particular needs additional human resources, NOT a reduction, in order to maintain a high level of functioning.

Finally, in proposing to eliminate behavioral health urgent care services at the courthouse, the Mayor's budget narrative names the nonprofit vendor rather than the service. That vendor, Pathways to Housing, is one of our city's best providers. Naming them seems unnecessary, inappropriate and potentially misleading. My understanding is that this behavioral health service has proven highly successful in recent years. This stands as

yet another example of how the Mayor's budget takes an extremely short-sighted approach to DC's mental and behavioral health challenges, proposing extreme cuts to programs that we know are effective.

From all of us at Woodley House, we appreciate the Committee's time and consideration. I'm happy to take any questions.

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Felix Hernandez

DC Commite on Health
Budget Hearing

Good morning, Chairperson Henderson and members of the Committe of Health. My name is Felix Hernandez and I am advocating for the Home Visiting Programs in DC at Mary's Center.

It is great to know that home visiting programs have been able to survive another year allows us to keep their commitments to Families in the district navigating the joy and challenges of parenthood of young children. Despite cuts to last years investments to Home Visiting programs, Families are still able to access material resources and supports that they would otherwise struggle to access without the support of their Home Visitors.

I want to share with you about how current funding levels has impacted staffing and as a result our ability to serve families. Last year and previous years, we have experienced a high turnover of staff with the main reason for staff departing being low salaries. As a program, we have spent months rebuilding our team. We were finally able to hire four home visitors after the HV team increased the starting pay and included a starting bonus since September to today with another offer letter being sent within the week. The starting bonuses has been funded by salary savings from this grant and private dollars. At this time, three fifths of the PAT Team just finished training, and the sole senior home visitor is on extended medical leave. The salary increase was possible after restructuring the program and eliminating the PAT Supervisor position for PAT and two home visitor positions with HFA. PAT is under similar funding structures as HFA and due to which have struggled to hire candidates willing to accept the role for the previous salary offered. Challenges that they've been facing, have been voiced to DC Health that the team has had to shift efforts towards recruiting and onboarding staff to be fully staffed. We previously had a program supervisor for the PAT program and will not be filling that role due to the same budgetary constraints I've already mentioned. Due to this, the current PAT Program Manager, who would normally have structural manpower with a Program Supervisor is therefore proceeding without them. Because of the budgetary constraints, the PAT program is a clear example of what happens when Home Visiting Programs are not invested in and supported. They're finally building their Home Visitors caseloads after completing the training and onboarding process of the new cohort. At one point during this gap the PAT Program Manager and the senior Home Visitor were the only ones able to serve families and expected to fill the remaining 90 participant slots of the program while delivering home visiting services to the existing caseload. The PAT model allows to serve up to 20 families per home visitor and recommends that caseloads are adjusted to 15 when servicing families with complex needs. With this in mind, PAT's caseloads were adjusted to 15 families in collaboration with DC Health a few years ago. The math is easy, vacant positions translate into less families being served. DC Health also has its own database based on the MIECHV reporting needs and that does not include the model reporting requirements. This creates triple the documentation work that requires from our team. A stronger investment would allow us to hire a data entry role that would allow for our home visitors to focus more of their time on the relationship with participants over data entry. A common theme for Home Visiting Programs is cutting from one expense to cover another, or stretching a Home Visitors Capacity that usually covers 15 participants to covering 25 when transitions occur. We're setting up roles where burnout is not the exception but rather the norm. Still somehow, the support that families receive from their home visitors manages to transform, for the better, their health and life outcomes.

The case-study I shared with you is just one example of the issues that current funding levels have created for programs. I urge DC to prioritize prevention over punishment as the primary strategy we employ to support families. Home Visiting programs should be supported with a diverse set of funding streams. For example, fully funding the updated FIS adjusted Medicaid Reimbursement Bill is a more immediate opportunity that can support home visiting programs in DC.

10 April 2024

Chairperson Christina Henderson
Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue
Washington, D.C. 20004

The Committee on Health 2025 Oversight Hearing on D.C.'s Department of Behavioral Health

Testimony of LJ Sislen
Campaign Organizer, DecrimPovertyDC

Councilmember Henderson and members of the Committee on Health:

Thank you for the opportunity to address the D.C. Council today. My name is LJ Sislen, I am a Campaign Organizer with the DecrimPovertyDC Coalition, harm reduction volunteer, and medical anthropologist. I'm mainly here because I have struggled with life altering drug use, lost too many friends to overdose, and am sick of seeing the death toll rise every year. I am testifying about the dire need for the city to authorize and fund two 24-hour harm reduction centers to address the overdose crisis in the District. The current strategies are not enough and I hope that the Committee on Health and the Opioid Advisory Committee will commit to moving forward with safe consumption services within harm reduction centers.

I know that you know that DC continues to face an overdose crisis. Over 600 Washingtonians died from accidental overdose deaths in 2022 alone. Eighty-six percent of these deaths continue to be of Black Washingtonians with Ward 5, 7, and 8 leading in fatal overdose deaths. The overdose mortality rate among Black Washingtonians is still the highest in the country. At 107 deaths per 100,000 people, the Black overdose death rate is nearly 10 times higher than the white overdose mortality rate in D.C.

The adulterated drug supply, stigma, misinformation, criminalization, and lack of diverse and accessible treatment options keeps claiming more of our neighbors lives and we have the power to do something about that. Since safe supply and legalization are not viable at this moment and decriminalization is farther down the line, then the most accessible action we can take now are safe(r) consumption services within 24/7 harm reduction centers. Make no mistake about this, safe(r) consumption services are very well researched and the centers we're talking about will

provide even more services, community groups, resources, and referrals. If there are any doubts or questions about this, please contact me and I can send you and connect you to a local researcher.

While I'm not here to address the drug-free zones in depth, I will name that the creation of multiple 24/7 harm reduction centers would decrease public presence of drug use and drug-related litter, which has been noted as a reason for heightening the criminalization of people who use drugs and giving police more power to profile and discriminate. (If that was even about drug use and health at all.)

Besides the drug-free zones and flooding the streets with naloxone, one other answer was to invite outside contractors to create stabilization centers.[1] We understand that "Sobering" was omitted from the title due to community, direct service provider, and advocate suspicions that the center would be a "glorified drunk tank". While I do not stand behind that sentiment, direct service providers are reporting that people who use drugs are still hesitant to go to the site and according to data from February, "Nearly 60 percent of patients used alcohol, and at least 10 percent used opioids, city data shows, based largely on self-reporting. The opioid antidote naloxone was administered twice, according to city data."[2]

It's vital that we address all people who struggle with any substances, but we cannot turn away from the overdose crisis that is claiming our friends, families, and neighbors lives. The stabilization center is not addressing opioids or people prone to overdose. The Mayor put $9.5 million in the FY24 budget for a second center last year before the first one opened its doors. We need to do something more than a stabilization center. New York is doing incredibly well[3], Rhode Island is opening a harm reduction center with safe consumption this year, and Minnesota has also authorized these services.

The harm reduction centers will have full-panel drug-checking machines, wrap-around services, including showers, connections to housing, a mailing address, mental health supports, a drop-in center, assistance with securing employment, legal services, ID documents, holistic health care offerings, peer support groups, mobile services, and more. And yes, we are specifically advocating for the authorization of supervised safe(r) consumption services where people will be inside with trained professionals rather than doing drugs in public or alone (which the latter increases risk of death). More than all that, these spaces will be no barrier safe havens, especially for people who are made to be hyper-marginalized.

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[1] I applaud the implementation of the harm reduction vending machines.
[2] https://www.washingtonpost.com/dc-md-va/2024/02/13/dc-opioid-sobering-center/
[3] 2023 Baseline Report from OnPointNYC.
https://onpointnyc.org/wp-content/uploads/2023/12/ONPOINTNYC_OPCREPORT_small-web1.pdf

The supervised safe(r) consumption services are a major facet of how these centers will be innovative and save lives. I must emphasize that this is only one feature of the centers. It will be a private room with trained health workers that is separate from the drop in center and other services. Anecdotally, staff from OnPointNYC who work in the safe consumption room said that most people get connected to treatment and decided to make further positive changes from that room.

This proposed harm reduction center will be staffed by Washingtonians with lived experience at living wages for the area - addressing a myriad of issues that our least invested in neighbors chronically face, like underemployment, housing costs, healthcare costs, and discrimination in the current systems they use to access them.

I know that the harm reduction centers will not magically solve all drug addiction and substance use disorder related issues. People also need access to safe and affordable housing, nutritious food, affordable, culturally and structurally-competent healthcare, educational opportunities, and community spaces to connect and collaborate. However, the evidence proves that safe consumption services alleviate suffering, improve health outcomes, foster social bonds, reallocate resources toward humane and effective strategies, address racial and class disparities, and enhance collective safety.

Our constituents and their families are impacted daily by the harms of drug criminalization, stigma, and a failure to center public health. To save lives, use funds more efficiently, and re-imagine public safety and health, D.C. Council should urgently support the creation of harm reduction centers. And because of the drug-free zones I must also name that strongly support the DecrimPovertyDC's effort to remove criminal penalties for personal use drug possession, address life-long consequences of convictions, and invest in life-saving and stabilizing support and resources instead of punishment. Together, District residents, this Council, and the Department of Behavioral Health can end the overdose crisis.

Thank you for your time, consideration, and the work that you do. I am happy to answer any questions you have regarding the overdose crisis and/or the harm reduction centers. Additionally, I can be reached at the contact information below.

LJ Sislen
Campaign Organizer
DecrimPovertyDC
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DisordeRThePlay.blogspot.com
"DisordR, The Play," about Pakrat Patty, the self-identified Hoarder who comes out of the Clutter closet uses humor to educate about Mental Health. Stop stigma, & advocate Recovery. http://mentalhealthsf.org/join-us-18th-conference-on-hoarding-cluttering/

Hilary Kacser

SAG-AFTRA Actor, Educator, Speaking Coach, Advocate

(she/her/hers;
last name: "KACK-sir")

PRELIMINARY TESTIMONY FOR COUNCIL OF THE DISTRICT OF COLUMBIA COMMITTEE ON HEALTH

Councilmember Christina Henderson, Chair
Fiscal Year 2025 Budget Oversight Hearing
Department of Behavioral Health
Wednesday, April 10, 2024

DC Council Committee on Health Chairperson Councilmember Christina Henderson, and Councilmembers of the Committee on Health and Staff, thank you for this opportunity to submit written testimony about the Department of Behavioral Health's FY24 budget to you. I am Hilary Kacser, a DC resident, product of DC Public Schools, and long time District advocate for behavioral health.

Hoarding disorder has been defined as a behavioral health diagnosis by the American Psychiatric Association in the DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders) ***for over a decade***.

The most important thrust of testimony that would have been presented live today is strongly to urge Councilmember Committee on Health Chair Henderson and the Committee on Health to:

- Ask Dr. Bazron and DBH what behavioral health supports and services -- if any -- DBH are directly providing for people in the District living with a diagnosis of "hoarding disorder" (HD).

A small investment -- in training DBH providers to recognize and mitigate harm (to the person with lived experience, to family members, to neighbors, to the community at large) associated with symptoms of HD -- would save significant taxpayer funds.

DBH should spend a little money to do a training on evidence based Peer Response Team treatment approach to the diagnosis "hoarding disorder." Low cost funding for DBH for peer training for HD would save money (and provide early intervention

and harm reduction), as opposed to what DBH do now. Now DBH refer folks living with HD out to Adult Protective Services. (APS is not a health care agency and does not provide behavioral health services for HD, which is a medical, health diagnosis.) APS work for HD is emergency, crisis intervention — far costlier than if DBH provided early intervention. APS performs costly heavy duty clean out, APS places people living with this untreated HD diagnosis under costly guardianships, and APS houses people living with late stage, crisis HD in costly long term nursing care — just because the individuals did not receive timely behavioral health support, that could reduce harm long before the case of HD reaches Stage Four.

Same with FEMS.

FEMS carries an unnecessarily large financial burden, because DBH inaction means FEMS face situations resulting from untreated HD diagnosis when the symptoms have reached Stage 4 emergency. Waiting until Stage 4 -- instead of providing trauma informed, person centered and driven, early behavioral health support -- costs DC taxpayers far more dollars -- and far more human capital.

HD support not only saves money for FEMS, but also reduces harm for FEMS first responders and for DC residents.

If DBH won't address early intervention that could prevent a bad -- and costly -- outcome, 911 is not activated until it is too late.

"1 in 40 people in the US has a hoarding disorder," says December 21, 2023, National Geographic article, and people living with this diagnosis "are compelled to hold onto the majority of their belongings, even when doing so means severely cluttered surroundings that decrease their quality of life and jeopardize their safety through increased risk of fire, mold or rodent infestation, ..." (https://www.nationalgeographic.com/premium/article/new-virtual-reality-hope-hoarders-declutter-clean)

"Containing a fire in a home where hoarding is an issue can take twice as many fire fighters and twice the time." (https://www.iaff.org/wp-content/uploads/Fire_Fighter_Quarterly/2012-Jul- Aug.pdf -- International Fire Fighter, Journal of the International Association of Fire Fighters, July/August 2012)

--END--

PARENTS AMPLIFYING VOICES in EDUCATION

Ty D. Andrews
Committee on Health Department of Behavioral Health
Wednesday, April 10th, 2024

Hello, Councilmember Pinto and DC Council staff. My name is Tyesha Andrews. I am a Ward 8 resident, and I serve as a PAVE Citywide and Ward 8 PLE Board member. I am also a parent, and my children currently attend Mary H. Plummer Elementary and McKinley Tech High Schools.

Thank you all for being here today and holding this hearing. I want to start by saying that the $11.6 million in funding cut from the Department of Behavioral Health in the Mayor's Fiscal Year 2025 Budget needs to be given back immediately. I believe that to function to its total capacity and serve DC students, DBH needs all the funding and support it can get. Student mental health, the recruiting and hiring of mental health clinicians, and social-emotional learning are so important. Not only do these things, when implemented correctly and continuously, make kids feel and cope better, but they also help decrease absenteeism and peer-to-peer violence.

I am testifying today to advocate for SBMH program funding. My advocacy for School-Based Mental Health (SBMH) support stems from personal experience. As a native Washingtonian, growing up, I felt high levels of stress and anxiousness, especially when I was in school. Despite these feelings being so visually apparent, my family, teachers, and schools did nothing to help. This is why I fight for kids in the District as a PAVE parent leader; I want all our kids to receive the mental health support that I never did.

My advocacy only grew stronger following my oldest son's high-functioning autism diagnosis. When he was first diagnosed, specialists explained that he was reaching all his developmental milestones. However, aspects of his behavior needed to be addressed with the help of mental health professionals. Approximately seven years later, I was told, yet again, that my second son also was a high-functioning autistic. While I'm fortunate that my husband and I are working alongside both my sons' teachers and school staff to manage their behaviors, the resources to do so are limited.

Due to the recent pandemic, Mental health will continue to be the core focus for families and teachers to provide a successful educational experience for all students. Funding for mental and behavioral health services in the city needs to increase. Mental health supports come in a wide

variety of ways, and all children's mental health issues are different, which means that their reactions to similar situations would be different as well. As of now, both of my children's schools do not have enough mental health clinicians or support to meet my children's needs, and my sons are two of many students in their respective schools with a learning disability and an IEP. The school-Based Mental health supports other families need is beyond what many of our schools can provide. This is why we need a change.

Providing Children and Youth Behavioral Health Services is essential in this city. We must provide increased access to mental health professionals locally. PAVE conducted a 2021 Fall Back to School Survey, where we learned that 55 % of caregivers are unsatisfied with the mental health and social-emotional support DC Schools give their children with IEPs. Outside of that, the National Survey of Children reports that almost 50% of children in the US have experienced at least one type of severe childhood trauma.

Mental health clinicians are instrumental elements of a child's education and development. Many parents across the District and I have advocated for years about the need for these providers in DCPS because of their positive impact on students. I urge each of you to reconsider the budget cuts to DBH and mental health clinicians and to find a way to protect and expand these programs.

Thank you for allowing me to share my ideas and vision for students and families in our District.

Sincerely,

Ty D. Andrews

Ty D. Andrews

Citywide and Ward 8 PLE Board Member, PAVE (Parents Amplifying Voices in Education)

1400 EYE STREET, N.W. • SUITE 1200 • WASHINGTON, DC 20005
PHONE (202) 296-5469 • FAX (202) 296-5427

The Honorable Chair Phil Mendelson
Committee of the Whole
Council of the District of Columbia
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Dear Chairman Mendelson,

On behalf of the Campaign for Tobacco-Free Kids, I urge your support of incorporating legislation into the FY2025 Budget to raise the tax on cigarettes by $1.50 per pack, increasing the tax on e-cigarettes and other tobacco products in parity with the cigarette tax, and raising and allocating 25% of the tobacco tax revenue to programs proven to help adults addicted to cigarettes quit and prevent youth from becoming addicted.

This is a tremendous opportunity to reduce tobacco use and dramatically improve public health, while at the same time raising much-needed revenue to address budget issues and help save vital programs here in DC.

Very simply, raising the tobacco tax by $1.50 per pack is a win-win for DC. It's a win for public health because it will reduce tobacco use and its devastating health effects. This is why we support the tobacco tax. It's also a win for the District's budget because, despite declines in consumption, the new tax rate will raise revenues to a higher level that will be maintained for years to come. By encouraging smokers to quit, the higher tax will also reduce health care cost burden on the District.

Public Health WIN

Despite declines in tobacco use over the years, tobacco use still exacts a heavy toll on DC today. According to the U.S. Centers for Disease Control and Prevention (CDC), tobacco use takes the lives of 800 of your fellow residents – your mothers, fathers, brothers, sisters, friends, and other loved ones – every year.[1]

This horrible toll will continue unless we act aggressively. Without action, about 600 kids in DC will try smoking each year and will risk a lifetime of associated health problems and premature death.[2]

By raising the tobacco tax by a significant amount, such as $1.50 per pack, DC *will* reduce smoking, and all its attendant devastation, especially among kids. And setting taxes on all tobacco products equal to the state's cigarette tax rate will further drive down tobacco use. While we may not intuitively believe that $1.50 is enough to make a difference to today's kids, who seem to have more money than any of us ever did as children, the data simply do not lie. When tobacco product prices go up significantly, tobacco use goes down, especially among kids.

The science could not be clearer. Based on more than 100 studies, experts have concluded that raising tobacco taxes is one of the most effective measures we can take to reduce smoking.[3] The 2014 Surgeon General's Report, *The Health Consequences of Smoking—50 Years of Progress*, found that, "Raising prices on cigarettes is one of the most effective tobacco control interventions."[4]

In addition, the National Cancer Institute, the CDC, the Institute of Medicine of the National Academy of Sciences, the World Bank, Wall Street tobacco analysts, and even the tobacco companies agree – raising tobacco prices reduces tobacco use.[5]

Now there aren't too many things that public health advocates and the tobacco companies agree on, but this is one. And that's why health groups like mine, along with the American Cancer Society, the American Heart Association, the American Lung Association, and many others, support the tobacco tax increase and why the tobacco companies oppose it.

It's also important to increase the tax on other tobacco products. Some people may argue that we need to keep prices on certain products lower than others, but the truth is the data aren't out there to demonstrate how much less harmful certain products might be compared to others. We should make sure the prices of all tobacco products – through a tax increase – are high enough to keep them out of kids' hands.

Financial WIN

Aside from the public health impact, there is another reason that states continue to increase their tobacco taxes. Even with the declines in tobacco use that occur as a result, substantial tobacco tax increases always result in significant revenue for the state. Simply put, every state that has raised its tobacco tax significantly has seen revenues increase dramatically even as consumption declines.

According to a 2024 analysis by the American Cancer Society Cancer Action Network, Campaign for Tobacco-Free Kids and Tobacconomics, raising the tobacco tax by $1.50 would deliver significant public health benefits, including:

- Reducing youth smoking by 10.6%
- Preventing 400 youth from starting to smoke
- Spurring 1,600 adult smokers to quit
- Preventing 400 premature smoking-caused deaths
- Saving the Medicaid program $540,000 over the next five years
- Generating $24.83 million in long-term health care cost savings from the resulting smoking declines.

It's time to raise the tobacco tax in DC by a meaningful amount. We look forward to working with the members of the Council and urge your support for a raise in the cigarette tax of $1.50 per pack, an increase the tax on e-cigarettes and other tobacco products in parity with the cigarette tax raise, and allocation of 25% of the tobacco tax revenue to programs proven to help adults addicted to cigarettes quit and prevent youth from becoming addicted.

Sincerely,

Kristin Jimison

Kristin Jimison
Regional Advocacy Director, Mid-Atlantic
Campaign for Tobacco Free Kids

[1] U.S. Centers for Disease Control and Prevention (CDC), *Best Practices for Comprehensive Tobacco Control Programs—2014,* https://www.cdc.gov/tobacco/stateandcommunity/guides/pdfs/2014/comprehensive.pdf.

[2] Estimate based on U.S. Dept of Health & Human Services (HHS), *"Results from the 2022 National Survey of Drug Use and Health: Summary of National Findings and Detailed Tables*," with the state share of the national number estimated proportionally based on the projected number of youth smokers ages 0-17 reported in U.S. Department of Health and Human Services (HHS), *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General,* 2014, https://www.cdc.gov/tobacco/sgr/50th-anniversary/index.htm.

[3] See, e.g., Chaloupka, FJ, "Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine and Tobacco Research* 1(Suppl 1):S105-9, 1999; other studies at http://tigger.uic.edu/~fjc/; Tauras, J, "Public Policy and Smoking Cessation Among Young adults in the United States," *Health Policy* 6:321-32, 2004; Tauras, J, et al., "Effects of Price and Access Laws on Teenage Smoking Initiation: A National Longitudinal Analysis," Bridging the Gap Research, ImpacTeen, April 24, 2001, and others at http://www.impacteen.org/researchproducts.htm. Chaloupka, FJ & Pacula, R, *An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies*, National Bureau of Economic Research, Working Paper 6541, April 1998; Emery, S, et al., "Does Cigarette Price Influence Adolescent Experimentation?," *Journal of Health Economics* 20:261-270, 2001; Evans, W & Huang, L, *Cigarette Taxes and Teen Smoking: New Evidence from Panels of Repeated Cross-Sections*, working paper, April 15, 1998; Harris, J & Chan, S, "The Continuum-of-Addiction: Cigarette Smoking in Relation to Price Among Americans Aged 15-29," *Health Economics Letters* 2(2):3-12, February 1998, http://www.mit.edu/people/jeffrey/HarrisChanHEL98.pdf. U.S. Department of Health and Human Services (HHS), *Reducing Tobacco Use: A Report of the Surgeon General*, Atlanta, Georgia: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000, http://profiles.nlm.nih.gov/NN/B/B/L/Q/_/nnbblq.pdf. HHS, *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General,* Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014, http://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html. See also, Campaign for Tobacco-Free Kids (CTFK), *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (and the Cigarette Companies Know It)*, http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf.

[4] HHS, *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General,* Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014, http://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html. Additional statements in support of tobacco tax increases are attached to this testimony.

[5] National Cancer Institute, World Health Organization, *The Economics of Tobacco and Tobacco Control*, Monograph 21, 2016, https://cancercontrol.cancer.gov/brp/tcrb/monographs/monograph-21. Institute of Medicine (IOM), *Ending the tobacco problem: A blueprint for the nation*, Washington, DC: The National Academies Press, 2007, https://nap.nationalacademies.org/catalog/11795/ending-the-tobacco-problem-a-blueprint-for-the-nation. IOM, *Taking Action to Reduce Tobacco Use*, Washington, DC: National Academy Press, 1998, https://nap.nationalacademies.org/catalog/6060/taking-action-to-reduce-tobacco-use. World Health Organization (WHO), WHO technical manual on tobacco tax policy and administration, 2021, https://www.who.int/publications/i/item/9789240019188. The World Bank, *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, May 1999, https://documents1.worldbank.org/curated/en/914041468176678949/pdf/multi-page.pdf. See also, Campaign for Tobacco-Free Kids (CTFK), *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (and the Cigarette Companies Know It)*, http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf.

DCNA Oversight Draft Testimony Glucose Monitoring and Medical Supplies

Good morning,

My name is Darryl Stewart. I am a board-certified Adult-Gerontology Nurse Practitioner at St. Elizabeths Hospital. I am an At-Large Board Member of the District of Columbia Nurses Association and represent both Registered Nurses and Nurse Practitioners at the Department of Behavioral Health. I have been the non-psychiatric medical provider for two units at SEH, an adult male unit, and a mixed-gender gerontology unit and employed at SEH for over 4 years. I have several Individuals in Care (IIC) who are diabetic requiring insulin therapy. The administration of insulin therapy requires point-of-care glucose readings (otherwise known as "finger sticks) with the use of a glucometer, for measuring the concentration of glucose in the blood, as the medical provider responsible for the management of diabetes for these IIC, it is of the utmost importance that glucometer readings be reliable, accurate and validated.

Over the past year I have received information regarding the validity of the glucometer readings. I have been told that glucometers have not been calibrated and that they are used across units which may also reduce the reliability and validity of the readings. From attending various meetings with hospital administration, it was stated that the glucose monitoring system at SEH is more than ten years old, and is incompatible with our current electronic health record

software known as myAvatar, which is an electronic health record (EHR) specifically designed for organizations that provide behavioral health and addictions treatment services in community-based, residential and inpatient programs. Nursing staff, currently, must manually enter point of care glucose readings obtained from the glucometer in 4 different places: the medical record, progress notes, vital sign entry record and a report sheet. I utilize the vital sign entry record to printout the aggregate point of care glucose readings to determine the dosing for insulin.

For example, if an IIC requires a point-of-care (POC) glucose reading before breakfast, lunch, and dinner, then I would expect to see three POC glucose readings for that day on the printout. Often, I do not see this information as some days are missing or not all POC glucose readings are listed for that day. For example, I can see all 3 readings listed for today, but not the next day. However, if I manually go into the IIC record, I can see the results for the missing day because the POC readings were only in the record but not the vital sign entry form which would allow me to print out the readings in aggregate order (date, time). This requires that I now manually must go into my avatar to view the data in the IIC record and hand-record the data and average which is not the best practice and results in a delay in treatment due to the time it takes to manually calculate the values and then dose the insulin accordingly. It is still not clear to me why nursing

staff must enter this number in 4 different places when all I need is the information to be entered in one place for the provider to have access to ALL readings in succession rather than in 3 other places that are not utilized for treatment planning.

In addition, there have been labile point of care glucose readings for which the validity is questionable. For example, I have increased an IIC before breakfast insulin only to see the before lunch point of care glucose reading continue to increase. This is not logical, because any increase in insulin should result in a decrease in the after point of care glucose reading. This is when I begin to consider how our glucometers are managed on the units. I have asked about the calibration process for glucometers and how they are tested for accuracy, but I have not received this information. The numbers that I pull from myAvatar that show inconsistent, labile readings leads me to question the reliability and validity of the point of care glucose readings; thereby resulting in inaccurate insulin dosing that can result in too much insulin being administered that can lead to a hypoglycemic event and adverse outcome.

The most serious chronic medical condition that I must manage is diabetes. It is imperative that I have the most up-to-date software and glucometers to obtain the best IIC outcomes. The best resolution for this is to have the glucometer talk to the myAvatar system as a normal functionality that occurs in hospitals across the US. Evidence-based practice shows that the streaming of information from the

glucometer to the medical record is standard of practice and the most effective and practical way to reduce human error and ensure appropriate patient care. The current software and equipment in place are substandard and should be replaced with the most current. SEH is no longer just a behavioral health facility for which the current myAvatar software is designed. The IIC population has changed with more chronic medical conditions that require more medical skills to treat and manage rather than just psychiatric conditions with example of the challenge of managing diabetes that I refer to above.

As a steward of DC government services, I take my responsibility as a Nurse Practitioner to provide the best medical care to our residents as a representative of DC government. I am asking the DC Council to use its oversight to address the immediate need to overhaul the current electronic health record and provide a state-of-the-art point of care glucose monitoring system.

In addition to lack of an updated glucose monitoring system, I would also like to bring to the attention of the council lack of a medical supply chain at St. Elizabeths Hospital. Over the past year, I have experienced several delays in obtaining medical supplies ranging from wound dressings to durable medical equipment such as a walker. Currently, we had been using a Department of Behavioral Health (DBH)/SEH intranet-based order system known as site FM that has not been available for months. The alternative has been to email request for

supplies to designated employees. However, more often than not, either the designated employee advises no responsibility for the request, or the request is not filled and no communication is provided regarding status. I have often had to send repeat email requests for the status of a supply with no reply. Most recently, I attempted to order a walker for an IIC who had been evaluated by our physical therapy team who determined that he will need and benefit from a walker to reduce his risk for falls due to a gait abnormality. The physical therapy team provided and photocopy of the type of walker this IIC will need. The initial request with all the above information was made in January 2024. As of this date, April 10, 2024, the IIC care still has not had this walker delivered. There were repeated attempts to get a status on this walker from the Chief Nursing Officer to no avail until I had to escalate to the CEO. I then received communication from the CNO regarding a status, but it still remains unresolved 3 months later and this IIC is slated for discharge within the next 2 weeks with the need for the need for the walker remaining. This was the 2nd time I had to escalate a medical services issue to the CEO when those responsible failed to address.

I have experienced similar experiences for obtaining medical supplies such as compression stockings for treatment of venous insufficiency, Band Aids or heel protectors just to name a few. After over 4 years of employment, I still have no idea who is in charge of ordering medical supplies, what supplies are currently

available and who is responsible for maintaining and updating the inventory. I do not know of any medical personnel involved in the medical supply inventory process, and I would think that medical providers would be better able to know what medical supplies are needed to take care of IIC urgent, acute and chronic needs. This places both our IIC and employees at risk when an injury occurs and we have no supplies available or no definitive supply chain. This issue has been addressed in meetings with management, but I have not seen any improvement and today warrants this testimony.

The administration at SEH should develop a supply chain process to address patient care needs and have the available supplies so that there is no delay in treatment for an identified medical illness. The council should compel administration to develop a medical supply chain with identified personnel responsible as well as include medical providers in the process of determining what medical supplies are needed and ordered for patient care.

Thank you,

Darryl Stewart, DNP, AGPCNP-BC

[Type here]

""

Good afternoon

I am Nancy Boyd, Vice President of the District of Columbia Nurses Association. I am a nurse Educator at Saint Elizabeth's Hospital where we serve The District of Columbia's most vulnerable populations. I today represent and speak on behalf of the nurses of the Department of Behavioral Health.

I have an extremely active role as a union leader and Nurse Educator at Saint Elizabeth's Hospital and frankly, the union has become quite frustrated and has lost all confidence in leadership. We have been bringing our concerns to leadership at shared governance meetings since 2017 and nothing has changed. We have provided data resolutions and research and still management remains stagnant in implementing initiatives that benefit the patients and the Hospital.

DCNA has identified resources are the biggest issue at Saint Elizabeth's Hospital! Nurses are unable to conduct patient care and do their jobs properly due to a lack of resources.

First, technology provided at SEH and other facilities like CPEP is counterproductive and causes the hospital to lose more money because we are not investing in the appropriate technology. We are functioning as if we are in a different period. The systems are slow, there are dead spots with no Wi-Fi, and none of the machines communicate to reduce error and align patient care. Any modern technology brought in cannot work because the systems we are utilizing are old and outdated. We are decades behind compared to our counterparts in other psychiatric facilities and hospitals. Our equipment to provide patient care does not talk to our electronic medical record, therefore everything must be recorded by hand instead of having the system talk to the machines we use and input accurate data. We have consistently requested a new GLUCOMETER system, as well as a medication and vital signs system that communicates with the My Avatar medical record, so nursing does not have to document multiple places and can engage and treat the patients.

Secondly, there is a lack of supplies and/or severe delays in supplies. There are no understandable PAR systems in place because we consistently run out of detergent, toothpaste, paper, medication cups, underwear, and other patient care items. It has been brought to the Facilities department and it was dumped on Nursing to identify the PAR levels and manage the operations of supplies, this is not a nursing function. Specialized items for Individuals in care take months to receive, the hospital can go several months without eyeglasses for patients, walkers, and specialized care items for patients creating a delay in treatment. Individuals are often discharged without the items they were supposed to have while in our care and it is a gross delay and or absence of treatment. At the beginning of the year, nurses were told by the Director of Nursing that expired AED pads are ok to use on patients and staff if they have a Cardiac Arrest. We crossed our fingers for 90 days hoping no one would need this life-saving equipment.

Thirdly the units do not have furniture for the individuals in care to sit on. The computers are working very slowly and take prolonged periods to connect to the system. The units are not identical, and its management is not providing a mission of safety. The union has asked multiple times that all nurses be enclosed for safety, but this continues to be ignored. Individuals can assault us while we are documenting, by jumping over the nurse's station and grabbing staplers and books that can be used as weapons. We have consistently requested security for every unit, and they refuse to create the positions to maintain the units and assure safety. It is the responsibility of nurses to assure proper care is administered and to not be violently assaulted while providing that care.

Lastly, nursing training pauses every year from October to December due to no money to pay for hospital-required training. Nursing Education cannot conduct our jobs to ensure staff are professionally trained. We lack supplies and training equipment because it needs to be used in the unit for patient care. Education does not have the supplies needed for the lab to maintain appropriate training for the nursing staff.

The union reports quarterly to Mr. Chastang the hospital CEO and the administrative team regarding staffing being mismanaged, leaving nursing and nursing out to dry being severely understaffed, and then being found to be criticized and disciplined when something goes array We have pleaded for help and assistance, but the practice gaps have become too wide to say it all today. There needs to be some sort of audit because none of the improvements being implemented are for the betterment of patient care. Every year we get new Cameras to monitor and watch staff, but there are no plans to have new glucometers, updated computer systems, computers, appropriate supplies for patients and staff, and or furniture on the unit.

Thank you for listening to the Nurses of the Department of Behavioral Health

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Testimony Before the District of Columbia Council
Committee on Health
April 10, 2024

Public Hearing:
Budget Oversight Hearing
Department of Behavioral Health

Amber Rieke
Policy Lead, *A Path Forward*
Children's Law Center

Introduction

Good Morning, Chairperson Henderson, and members of the Committee on Health. My name is Amber Rieke, and I lead the *Path Forward* project at Children's Law Center.[1] Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism, and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Children's Law Center chairs the Strengthening Families Through Behavioral Health Coalition – a diverse group of advocates focused on education, juvenile justice, child welfare, and health, as well as representatives of the provider community and community-based organizations (CBOs). We share a commitment to improving DC's behavioral health care system so that all DC children, youth, and families have timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and enables them to thrive.[2] CLC also partners with the Early Childhood Innovation Network, co-chairs Under 3 DC's Family Supports Committee, and are

members of the Every Student Every Day coalition, the Ward 8 Health Council, and the Fair Budget Coalition.

Thank you for the opportunity to testify about the proposed Fiscal Year 2025 (FY25) budget. Over the last decade, the District's growing economy has supported significant, progressive investments in housing, behavioral health, child welfare prevention, and educational supports. Unfortunately, this year the District is considering cuts to the budget at a scale the city has not seen since the Great Recession.[3] Many fear that these impressive advancements – including the expansion of mental health support for young people – will come to a halt. However, Children's Law Center believes the District still has a choice.

In a time of economic difficulty, the DC Council can choose to take the long view; it can choose to protect important investments in our community's future health and economic development. As you consider spending to drive business and tourism, recognize that the growth and vitality we want in our city requires multi-dimensional investments inclusive of all parts of our community. We must act from the District's values, including "upholding the belief that safe and affordable housing and access to healthcare are critical building blocks on the pathway to the middle class."[4] Even with budget pressures, we urge this Council to not forget what residents have repeated in public hearings over the last year – that public safety, academic achievement and

economic development require sustained investment in access to housing, education, and healthcare.

While the proposed cuts may appear to balance the budget books, they will likely destabilize DC families. Children's Law Center sees firsthand how losing one service can have a cascade effect for clients – losing a trusted clinician to turnover or having to relocate housing placements due to moldy ceilings can disrupt a family's entire equilibrium. The programs on the chopping block might be *the one thing* helping a family make it work when everything else seems to be working against them. The programs that are being cut are the programs supporting the more than half of DC students who are economically disadvantaged.[5] We cannot achieve long-term stability without a budget that prioritizes the well-being of DC residents.

In addition to the impact on families, there will be consequences for the District's economy in the long run. Just as eviction is a short-term fix that is ultimately more costly than prevention services like rental assistance, it is ultimately better to sustain programs through a tough budget year than to try to rebuild them later. Critically, the District cannot afford to disinvest from our labor market. We are already desperate to retain and expand our education, social service, and healthcare workforces. Cutting their jobs will only worsen the existing and future crises in these fields.[6]

To ensure a budget that prioritizes District residents' health, I will be testifying on the proposed FY25 budget for the Department of Behavioral Health (DBH). Children's

Law Center's clients often have significant behavioral health needs, and most access services through Medicaid or DBH – or attempt to. Despite our diligence, our clients are frequently unable to find the services they need, or the waitlist for an appointment is prohibitively long. Their greatest obstacle is the lack of behavioral health care professionals practicing in public programs. Even when our clients successfully connect with a provider, they encounter issues with quality and cultural competence, and frequent turnover.[7] According to the American Academy of Pediatrics, behavioral health is the largest unmet health need for children and youth in foster care nationally.[8]

From early childhood through high school, we believe this budget will undercut the capacity for caring professionals to deliver tailored behavioral health interventions to children and teens, at a time when public health data urges us to *increase* investment. To reinforce the significant investments the District has already made in the behavioral health system in recent years, the Council should take the following actions:

1. Fortify the School-Based Behavioral Health (SBBH) program by adequately compensating clinicians with a grant of at least $98,465 per CBO.
2. Maintain Healthy Futures funding and program evaluation and planning.
3. Increase DBH payments to community-based behavioral health providers, who are critical to the success of public programs, to $59 Million total.
4. Reinstate funding for 24/7 ChAMPS service to the FY 2023 level ($1,867,000 total) and preserve dedicated non-police response to behavioral health crises calls.

Amidst conversations about school attendance and engagement, community safety, and the ongoing opioid crisis, robust behavioral health supports for youth become more essential every day. If we believe DC children deserve support through difficult moments and the opportunity to build skills for emotional well-being, we must invest in the professionals who deliver it.

School-Based Behavioral Health Clinician Grants Must be Higher to Sustainably Support DC Students and Teachers

If we care about helping kids attend – and thrive – in school, we must invest in School-Based Behavioral Health. While the youth mental health crisis continues to escalate locally and nationally,[9] children and youth face major barriers to accessing the care that they need, when they need it.[10] DCPS' Chief Integrity Officer testified on December 12, 2023, that "student health, including student mental health and COVID concerns or diagnoses, is the most common barrier to regular attendance."[11] Research shows that students with behavioral health challenges miss more school than their peers; more than 10% of all absences are due to behavioral health issues.[12]

The School-Based Behavioral Health program (SBBH) removes barriers to behavioral health services and facilitates social-emotional skill-building by embedding dedicated, skilled professionals in every DC school.[13] The Multi-Tier System of Supports model (MTSS)[14] includes classroom lessons (Tier 1), evaluation, small group work (Tier 2) and one-on-one therapy (Tier 3), administered by a licensed clinical social worker or therapist, hired by the school in partnership with a CBO.[15]

As of March 2024, 168 of 254 schools (66%) are staffed with a full-time CBO clinician.[16] Where staff are in place, and referrals are made, recent surveys of students, caregivers, school staff and Coordinators show high satisfaction with services. Most students (61%) and families (92%) reported comfort seeking help from a therapist or counselor at school.[17] Two-thirds of staff surveyed by DBH (66%) had referred students for SBBH services in the last school year.[18] School staff who referred students for behavioral health services believed the students benefited from treatment services**;** more than half saw increased coping skills from students, decreased behavior incidents, improved symptoms, and better connection to school.[19]

Clinicians are connecting with thousands of DC students. In the 2022-23 school year, DBH recorded at least 13,860 sessions of Tier-1 and Tier-2 programming (classroom lessons and skill-building) for 475,481 students, addressing important topics such as suicide and violence prevention, anger management, coping with anxiety, bullying, conflict resolution skills, empathy, executive functioning skills, grief and loss, healthy relationships and boundaries, LGBTQ+ awareness and inclusion, self-esteem, self-care and stress management, and drug use prevention, among others.[20] Schools without a full-time CBO clinician – due to attrition or difficulty hiring – almost all receive service coverage from a DBH clinician or Clinical Specialist, from another school's clinician, or from CBO supervisors. In other words, nearly all DC schools are receiving some level of support through this program, including prevention, early intervention services, and

treatment or referrals. We appreciate that DBH has been working with schools to staff up to increase the reach of the program, including piloting different funding methods with interested schools.[21] Ultimately, the success of the program can only be sustained – and expanded – with more investment in the clinical workforce.

To this end, DC must maintain the CBO's ability to offer competitive pay, incentives, and professional support for these essential roles, especially in an extremely competitive market for these professionals.[22] That is not currently the case. Despite having years of higher education, extensive supervision, and being on-site and on-demand every day, SBBH clinicians make below the 10th percentile of salaries for clinical social workers in the DC market.[23] This is much lower than they could make working in the private market or even a DC agency. We must make these jobs more attractive and sustainable so people take the positions and become fixtures in school communities. Trust-building is essential for a therapist – especially with children and teens – but is undermined when a clinician cannot afford to stay in their position. Persistently underfunding the program's grants will result in our students losing out on services.

One reason the program has been underfunded is that the initial funding model overestimated the proportion of work that would be billable to insurance. Since the first cohort of schools were staffed with clinicians over six years ago, we have learned that the original funding model overestimated the extent to which clinicians would be able to bill for their services. In reality, the proportion of clinicians' time spent on billable services is

much lower, especially as clinicians find themselves needing to dedicate more time to Tier 1 and Tier 2 – and triaging emergent situations – which are not billable activities.[24] Further, several private insurance companies have refused to reimburse for school-based services.[25] Given these facts, the DBH grant must be higher to support the reality of the program.

As with all developing programs, we revise our thinking with experience. To support this re-assessment, the Council wisely required DBH to study the true costs of the program; a year and four months past the statutory deadline for the report to be shared with the Council, we still do not have the cost study.[26] We are also waiting on several years of evaluation reports from ChildTrends to be shared with the public.[27] In the meantime, the Strengthening Families Coalition consulted provider organizations about the cost of doing business in the SBBH program to inform our advocacy.[28]

We ask the Committee and the Council to maintain and expand critical investments in SBBH in FY 25 by increasing grants for community-based clinicians. Setting aside the too-low and patchwork funding they have received to-date,[29] CBOs require at least $98,465 per CBO clinician – a base salary of at least $74,033, plus fringe, overhead, and supervision costs.[30] This increase puts clinician compensation at the modest goal of the 10th percentile of salaries for our market, rather than below it. The total cost to do this for each of the 254 schools in the program is $25,010,110. Unfortunately, the mayor proposes to give CBOs only $80,819 per clinician - a full $17,645 less than

required. It also appears the Mayor only funds 233 of 254 schools with $18,854,523. The Council now must find $6,155,587 to increase CBO grants for every school. Re-basing and increasing the clinician salary will allow both clinicians and CBOs more financial stability.

DBH must also maintain investments in program evaluation and data collection (which appears to be funded in FY25) as well as the Community of Practice (which is cut). The Community of Practice was essential to workforce sustainability, as it brought together providers, staff, and school leaders in a collaborative learning environment to share best practices, support and participate in learning activities. We are surprised and disappointed that the budget abruptly cut the entire contract.[31] In addition to making the CBO grants whole, we hope the Committee can restore the funding to the FY24 level ($593,780) for this contract.[32]

In a letter to the Mayor in December 2023, SFC also advocated for two additional system improvements to expand the program's effectiveness and reach: (1) compensation and guidance for the SBBH Coordinator role, so that every school's Coordinator is equipped to effectively connect staff, students, and families with school behavioral health resources, and (2) a pilot adding non-clinical staff positions to SBBH teams to expand social-emotional learning and skill-building components.[33] With dedicated staff for the implementation of Tier 1 and 2 services, the entire school community can benefit from the health promotion and prevention activities that are core to the SBBH model.

Unfortunately, we do not see these items in the budget. While these workforce investments are still needed, we understand they may not be possible in the current budget context. Clinician compensation is the most fundamental need and a higher priority for program success. We will continue to work with DBH and partners to find avenues to enact these projects and other ongoing improvements in the constrained financial environment.

Healthy Futures Funding Must be Maintained at FY2024 levels to Allow Expansion of the Program to Continue

Healthy Futures is a DBH program that provides early childhood mental health consultation (ECMHC) in District's child development centers (CDC) and home providers. The goal of ECMHC programs is to minimize the use of exclusionary discipline in childcare centers and preschools by providing resources and supports to teachers.[34] The Birth-to-Three for All Amendment Act of 2018 (Birth-to-Three) requires Healthy Futures to be in every eligible CDC and home provider.[35] The current funding levels allows Healthy Futures to fully expand to 182 sites – over half of all eligible CDCs and home providers.[36] Currently there are 111 Healthy Future sites.[37]

We are glad that the Mayor's FY25 proposed budget maintains the FY24 funding levels.[38] The existing Healthy Futures sites continue to provide significant support to CDC and home provider teachers and directors. In FY23, the early childhood mental health specialists served 3,025 children across 111 centers, provided 203 staff workshops, 2,531 teacher consultations and 1,795 director consultations.[39] We, therefore, ask this

Committee to ensure no cuts to the FY2025 proposed funding for the Healthy Futures.[40]

Additionally, we ask this Committee to work with DBH to clarify any funding needs for the pilot Healthy Futures treatment program.[41] Healthy Futures, over the past two years, has piloted the use of early childhood clinicians to provide evidence-based treatments and programs directly to children and families at eight existing Healthy Future sites.[42] The funding for this pilot program came from the American Rescue Plan Act (ARPA) which expire at the end of FY24.[43] DBH has yet to share the future plans for this program.

It is critical to understand the full scope of Healthy Futures in the District, including the treatment pilot program, to be able to identify what the expansion of Healthy Futures will look like in the coming years. We ask this Committee to ensure any funding for the pilot treatment program does not take away from the existing funding for Healthy Futures consultation. It is critical to maintain funding for existing and future Healthy Futures sites expansion to ensure stability and that the current work of the program continues. Finally, we look forward to working with DBH to appropriately utilize the results of the evaluation to determine the future of expansion Healthy Futures in the District.[44]

The District Must Enhance Rates for Community-Based Behavioral Health Service Providers to Maintain Access in Public Programs

If the District hopes to provide residents with meaningful access to public behavioral health services and programs, it must address its behavioral health workforce

crisis. As noted above, there is high demand for services and a limited pool to provide them. Our clients wait far too long for services due to constrained availability. It is critical that the District recognize this market reality and sufficiently pay professionals to offer services in public programs like Medicaid and DBH Core Service Agencies. Just as SBBH and Healthy Futures need sufficient grant funds, providers must be sufficiently paid for services in hospitals, health centers, primary care, and private practice offices. Mayor Bowser's own Healthcare Workforce Task Force recommended in 2023 to "address current supply and demand challenges in the healthcare workforce" by, among other strategies, increasing provider compensation.[45]

We join the members of the Fair Budget Coalition in asking for, at least, $59 million in DBH's budget for community-based provider payments.[46] Some rates have been increased through DHCF's recent rate study and adjustments, but further increases are needed across therapies. Unfortunately, rather than bolster this important investment to meet the providers' needs and patient demand, DBH's Director Barbara Bazron told the Committee that only $53.9 million in local funds for community-based services.[47] This leaves a $5.1 million gap for provider rates that we ask the Committee to fill.

Research by the National Bureau of Economic Research reveals that more competitive Medicaid reimbursement rates are tied to better access to care and outcomes for children.[48] Members of DC's behavioral health workforce have long identified financing deficiencies as a major issue for longevity – people will not stay in a profession

with such high emotional burden if they have to take two jobs to make ends meet or cannot count on a grant to be renewed year to year.[49] If we expect to attract and retain providers in the public network, DBH and other public players must improve payment for providers so that children and families can access timely services, and the provider network is supported through adequate, reliable, and up-to-date financing.

The Committee Should Reinstate Funding for 24/7 ChAMPS Service and Preserve Dedicated Non-Police Response to Answer Behavioral Health Crises Calls

The Child and Adolescent Mobile Psychiatric Service (ChAMPS) is one of the few crisis response options in DC, specifically for youth. This on-call unit is uniquely equipped to respond to behavioral health crisis calls for young people. It is often dialed by families and schools who need immediate response, de-escalation, or transport to a hospital. ChAMPS, contracted through Catholic Charities, used to be available to callers 24 hours a day, seven days a week, which is the national best practice for a child and adolescent crisis system to.[50] Funding for this vital service was reduced from FY23 to FY24, resulting in services being cut to exclude nights and weekends. In its place, DBH tasked the Crisis Response Team (CRT) to cover these hours for youth.[51] The Mayor's proposed budget entrenches these service cuts ($1,366,544) for the contract - it does not restore funding for ChAMPS to its previous level ($1,867,000).

We remain unsatisfied with the reliance on CRT to respond to youth calls. As we decried during the FY23 performance oversight hearing, CRT is overstretched in its work to respond to adult crises; the agency's oversight responses showed that call volume for

CRT has increased 37% from last year, with only 60% of CRT positions staffed.[52] Disturbingly, the average time from 911 call to CRT arrival is 91 minutes versus the average ChAMPS response time of 38 minutes.[53] This data show that CRT is *not* a reasonable substitute or supplement for ChAMPS. Our clients are seeing real impacts from the reduction in ChAMPS, with police often responding to their calls, which is often inappropriate and detrimental. We ask the Committee to restore ChAMPS remains funding to FY23 level (at least $1,867,000), about $500,000 more than proposed, so that youth crisis calls remain distinct from adult calls 24-hours a day, seven days a week.

Second, we ask DBH and the Committee strive to preserve youth services. We note that DBH reorganizes the ChAMPS line item to a new cost center, bringing it under other Crisis Services.[54] While we do see potential benefits for the ChAMPS team to be overseen alongside – and better coordinated with – other crisis response services, we are concerned that represents a further slide to inappropriately merging youth and adult services. We hope that DBH's plan to create a new position directing Children's Crisis and Community Trauma Response means that DBH recognizes that youth in crisis need specialized and dedicated response.

Also of note, it appears the Access Helpline line item is losing four FTEs and $357,000.[55] However, the DBH budget narrative reports "the proposed Local increase of $4,968,169 and 48.0 FTEs across multiple divisions is to fund the Community Response Team and Access HelpLine staff that support Crisis Services initiatives, including the

Behavioral Health 911 Diversion program."[56] In light of recent complaints about the service quality and scope of the HelpLine, it is critical to understand the dedicated number of FTEs being gained or lost by Access Helpline. We are very concerned that capacity is being reduced to refer patients to CSAs and other services. The Committee must act as a backstop to ensure DBH is appropriately and robustly serving residents in crisis or seeking support. ChAMPS and Access HelpLine are literal lifelines; their functionality, staffing and funding must be preserved.

Conclusion

In a year of tough choices, we urge you to continue to prioritize mental health supports for young people and to double down on your work to build accessible, impactful, well-coordinated care across the full spectrum of services for the diverse and pressing issues young people face in DC.

Effective behavioral health services provide opportunities for children, teens, families, and school communities to thrive. Please take action to stabilize the service providers who the District increasingly depends on and reject these cuts. We ask the Committee on Health to increase funding for SBBH clinicians, maintain Healthy Futures, pay behavioral health providers sufficiently, and maintain programs that prevent and respond to residents in crisis. During a mental health crisis and a critical moment for the provider network, behavioral health care is an investment in the District's current and future well-being.

[1] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District,* (December 2021), *available at:* www.pathforwarddc.org. In 2021, Children's Law Center co-authored a report with numerous community experts, including Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition. This report is a blueprint for creating a successful public behavioral health system, one that supports children and families and, in doing so, strengthens our entire community.

[2] The mission of the Strengthening Families Through Behavioral Health Coalition is to bring together a diverse group of advocates focused on education, juvenile justice, child welfare, and health, as well as representatives of the provider community and community-based organizations. Learn more at: https://www.strengtheningfamiliesdc.org/mission-vision.

[3] Yesim Sayin, *In Fiscal Year 2025, the District of Columbia is Facing Tough Choices. Without Making Difficult Decisions now, Future Years Will Only get Harder,* (April 2, 2024) *available at:* https://www.dcpolicycenter.org/publications/fiscal-year-2025-dc-facing-tough-choices/.

[4]Mayor Muriel Bowser, *#DC Value Playbook, available at*: https://mayor.dc.gov/sites/default/files/dc/sites/mayormb/publication/attachments/DC%20Values%20Playbook.pdf.

[5] Economically disadvantaged, which is defined by the Office of the State Superintendent (OSSE) as students who qualify for Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), have been identified as homeless during the academic year and/or who under the care of the Child and Family Services Agency (CFSA or "foster care"). *See:* DC School Report Card, *available at*: https://schoolreportcard.dc.gov/homl; Office of the State Superintendent, Data and Reports, Quick Stats: Public Schools in the District of Columbia, *available at*: https://osse.dc.gov/page/data-and-reports-0.

[6] Makeda Vanderpuije, *No Aide in Sight: Workforce Shortage Cripples District's Long-Term Care System,* (February 6, 2024), *available at:* https://www.leadingagedc.org/2024/02/06/no-aide-in-sight-workforce-shortage-cripples-districts-long-term-care-system/. *See also:* Lauren Lumpkin, *D.C. Teachers are Leaving Their Classrooms. Here's Why,* the Washington Post, (December 1, 2023), *available at:* https://www.washingtonpost.com/education/2023/11/30/dc-teachers-turnover-public-charter-schools/#:~:text=Across%20the%20nation's%20capital%2C%20more%20than%201%20in%204%20teachers,teachers%20remained%20at%20their%20schools; *See also:* Petula Dvorak, *Want to Fix the Social Worker Shortage? Start With the Licensing Exam*, the Washington Post, (Mach 18, 2024), *available at:* https://www.washingtonpost.com/dc-md-va/2024/03/18/social-work-licensure-flawed/#:~:text="In%20the%20past%20four%20years,social%20workers%20who%20understand%20them.

[7] Megan Conway, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Megan-Conway-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf; *See also:* William Cox, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Wil-Cox-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf; *See also:* Rachel Ungar, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and*

Family Services and Health, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/RU-Draft-Testimony-EM-updated_-narrative_final.pdf.

[8] American Academy of Pediatrics, *Mental and Behavioral Health Needs of Children in Foster Care,* (2021), *available at*: https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/; *see also:* Children's Law Center, Testimony before DC Council Committee on Health and Committee on Facilities and Family Services, (December 6, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-behavioral-health-for-children-and-youth-in-foster-care/.

[9] Symptoms of poor mental health, including depression and suicidal ideation, have been steadily increasing among American youth for over a decade. The results of the 2021 Youth Risk Behavioral Survey (YRBS) revealed a wide range of behavioral health concerns: a stunning 28% of DC middle school students and 18.3% of high schoolers have seriously thought about killing themselves. About 12% of middle and high school students had taken prescription pain medicine without a doctor's prescription. One-fifth (20%) of high school students went without eating for 24 hours or more to lose weight or to keep from gaining weight. Over 19% of middle school students and over 25% of high schoolers reported that their mental health was "not good" most of the time, or always (including stress, anxiety, and depression). Nearly half (47%) of DC's children have had adverse childhood experiences (ACEs), such as being exposed to violence or abuse. *See:* U.S. Office of the Surgeon General (OSG), U.S. Surgeon General Advisory: Protecting Youth Mental Health, p. 8 (December 7, 2021), *available at*: https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf; OSSE, 2021 DC Youth Risk Behavior Survey (YRBS) Data Files (2021), *available at*: https://osse.dc.gov/node/1635216; *See also*: *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District*, (December 2021), p. 10, *available at:* www.pathforwarddc.org.

[10] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District*, (December 2021), p. 10, *available at:* www.pathforwarddc.org.

[11] *Public Hearing on Chronic Absenteeism and truancy in the District of Columbia: Testimony of Cinthia Ruiz, Chief Integrity Officer, District of Columbia Public Schools,* Before the Committee of the Whole, (December 12, 2023), *available at:* https://dcps.dc.gov/sites/default/files/dc/sites/dcps/release_content/attachments/23.12.12%20-%20DCPS%20Public%20Hearing%20Testimony%20on%20Chronic%20Absenteeism%20and%20Truancy.pdf.

[12] Christopher A Kearney, et al., *School Attendance Problems and Absenteeism as Early Warning Signals: Review and Implications for Health-Based Protocols and School-Based Practices*, 8 Frontiers in Educ., at 4 (Aug. 30, 2023), *available at:* https://www.frontiersin.org/articles/10.3389/feduc.2023.1253595/full; *See also:* David Lawrence, et al., *Impact of Mental Disorders on Attendance at School*, 63.1 Austl. J. of Educ. 5 (Mar. 14, 2019), *available at*: https://journals.sagepub.com/doi/full/10.1177/0004944118823576.

[13] Strengthening Families Coalition Factsheet: DC's School-Based Behavioral Health Expansion Program Bridges Gap Between Students and Vital Services, *available at*: http://bit.ly/SFC_SBBH_factsheet.

[14] SBBH is intended to enable DC public schools to provide a full array of behavioral health supports at three tiers: (1) Tier 1 encompasses mental health promotion and prevention for all students; (2) Tier 2 includes focused interventions for students at risk of developing a behavioral health problem; and (3) Tier 3 is comprised of intensive support/treatment for individual students who are experiencing a behavioral health problem. *See:* Department of Behavioral Health, *Guide to Comprehensive Behavioral Health*, pages 2-4, *available at*:

https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/PRIMARY%20GUIDE_SCHOOL%20BEHAVIORAL%20HEALTH_JUNE%202019.pdf.

[15] More specifically, DBH contracts with CBOs that have the capacity to provide all tiers of services. DBH then works with DCPS, OSSE, and the Public Charter School Board (PCSB) to match CBOs with individual schools. Once a school has been successfully matched with a CBO, a full-time CBO clinician is placed in the school to provide full-time behavioral health services. Once the clinician is in place, they work with the school's leadership, administration, and other behavioral health personnel (such as the school-based behavioral health coordinator, school social worker, or psychologist) to complete the School Strengthening Tool and Work Plan. These documents guide the development and implementation of integrated and comprehensive behavioral health services, designed specifically for that school community. *See:* Department of Behavioral Health, Guide to Comprehensive Behavioral Health, pages 5-6, *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/PRIMARY%20GUIDE_SCHOOL%20BEHAVIORAL%20HEALTH_JUNE%202019.pdf.

[16] Video Recording: Coordinating Council on School Behavioral Health, held by the Department of Behavioral Health of the District of Columbia, timestamped at 13:01: (March 18, 2024), https://dcnet.webex.com/recordingservice/sites/dcnet/recording/3d891c6ac75d103c92df005056811ad1/playback

[17] DBH Coordinating Council on School Behavioral Health slides, presented May 15, 2023, on file with the Children's Law Center.

[18] *Id*.

[19] DBH Coordinating Council on School Behavioral Health slides, presented May 15, 2023, on file with the Children's Law Center.

[20] DBH, FY2023 Oversight Performance Oversight Responses, response to Q67, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247

[21] Video Recording: Coordinating Council on School Behavioral Health, held by the Department of Behavioral Health of the District of Columbia, timestamped at 13:44: (March 18, 2024), https://dcnet.webex.com/recordingservice/sites/dcnet/recording/3d891c6ac75d103c92df005056811ad1/playback. *See also* DBH, FY2023 Performance Oversight Responses, response to Q70, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[22] Theresa Vargas, *The Kids Are Not Okay, And D.C. Schools Stand to Lose Crucial Therapists,* Washington Post, (April 19, 2023), *available at*: https://www.washingtonpost.com/dc-md-va/2023/04/19/schools-therapists-dc-budget/.

[23] Data from Salary.com (accessed January 2024).

[24] DBH, FY2023 Performance Oversight Responses, response to Q70, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[25] *Id.*

[26] D.C. Law 24-167. Fiscal Year 2023 Budget Support Act of 2022. Sec. 5122. Analysis of School Behavioral Health Program and costs.

[27] DBH, FY2023 Performance Oversight Responses, response to Q70, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[28] Strengthening Families Coalition, *Letter to Mayor Muriel Bowser regarding School-Based Behavioral Health Budget for Fiscal Year 2025*, (December 1, 2023), *available at*: https://static1.squarespace.com/static/61fc198478b173509177a060/t/659eb6ec4f60b73a019c67db/1704900332399/SFC+FY25+Letter+to+Mayor+Bowser+Dec+2023.pdf.

[29] In past fiscal years, the CBO grant amount was a patchwork of vacancy savings, American Rescue Plan ACT (ARPA) funds, and a persistently low base salary for clinicians, totaling $99,371. *See:* Coordinating Council on School Based Behavioral Health slides, presented February 2023, on file with Children's Law Center.

[30] Base salary for clinicians of $74,033 is based on the bottom 10th percentile of salaries in DC (data from Salary.com as of November 13, 2023). Fringe and overhead calculated at 25% ($18,508 for each). Supervision cost is calculated based on a supervisor's salary of $80,766 (bottom 25th percentile of salaries in DC from Salary.com as of November 13, 2023) plus 25% each fringe and overhead, shared between six clinicians. An estimated average of insurance billing revenue for each clinician is about $37,016. An inflationary adjustment of 4.5% for SY 2024 is based on the most recent 2023Q2 Medicare Economic Index (Forecast, Productivity Adjusted).

[31] Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-35

[32] FY 2024 Department of Behavioral Health, RM0, Attachment I - Contracts & Grants, *available at*: https://dccouncil.gov/wp-content/uploads/2023/03/RM0_FY24_Attachment-I.pdf.

[33] Strengthening Families Coalition, Letter to Mayor Muriel Bowser, December 1, 2023, *available at*: https://static1.squarespace.com/static/61fc198478b173509177a060/t/659eb6ec4f60b73a019c67db/1704900332399/SFC+FY25+Letter+to+Mayor+Bowser+Dec+2023.pdf.

[34] In FY 2023 there were three expulsions of the 3,025 children served from child development facilities where the Healthy Futures Program was implemented; no children have been expelled from a child development center in FY 2024 to date. *See* DBH, FY2023 Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247. ECMHC use early childhood clinical specialists (referred to as consultants) to provide in-classroom support to teachers to identify when their students might be at risk of or is displaying signs and symptoms of social, emotional, or other mental health problems. Project LAUNCH, Washington D.C. Project LAUNCH -Healthy Futures Program, *available at*: https://healthysafechildren.org/sites/default/files/WDC_Healthy_Futures_Program_Brief.pdf. The consultants work with teachers to help understand students who are exhibiting difficult behaviors and provide tools that allow students to thrive in the classroom.

[35] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[36] Office of the State Superintendent of Education, Child Development Facilities Listing, February 2024, *available at*: https://osse.dc.gov/publication/child-development-facilities-listing.

[37] DBH, FY 2023 Performance Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[38] Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-23.

[39] DBH, FY 2023 Performance Oversight Responses, responses to Q53, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[40] The goals of the program are: (1) building professional skills and capacity of caregivers to promote social emotional development and prevent escalation of challenging behaviors (2) reducing the number of early childhood expulsions and (3) increasing appropriate referrals for additional assessments and services to
support child and family functioning. *See* DBH, FY 2023 Performance Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[41] The budget includes no mention of either of these items. Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-23.
[42] DBH, FY 2023 Performance Oversight Responses, responses to Q57, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.
[43] DBH, FY 2023 Performance Oversight Responses, responses to Q57, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.
[44] DBH is moving forward with an evaluation of Healthy Futures. In Fall 2022, DBH awarded the evaluation contract to Georgetown University Center for Child and Human Development (GUCCHD) to conduct the evaluation for a period of two years. GUCCHD evaluated Health Futures between 2011 and 2015. Department of Behavioral Health (formerly "Department of Mental Health"), Healthy Futures Year One Evaluation of Early Childhood Mental Health Consultation, September 30, 2011, available at: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Children%20Youth%20and%20Family%20Services%20Healthy%20Futures%20Year%20One%20Report.pdf; Department of Behavioral Health, Healthy Futures Year Two Evaluation of Early Childhood Mental Health Consultation, September 30, 2012, available at: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Children%20Youth%20and%20Family%20Services%20Healthy%20Futures%20Year%20two%20report.pdf; Department of Behavioral Health, Healthy Futures Year Three Evaluation of Early Childhood Mental Health Consultation, September 30, 2013, available at: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/HealthyFuturesThreeYearEvaluationReport.pdf; Department of Behavioral Health, Healthy Futures Year Four Evaluation of Early Childhood Mental Health Consultation, September 30, 2014, available at: https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures_Year4Report-executive-summary.pdf; and Department of Behavioral Health, Healthy Futures Year Five Evaluation of Early Childhood Mental Health Consultation, September 30, 2015, available at: https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures-Year-5.pdf. Over the last year GUCCHD has diligently moved the evaluation forward, including interviews with the consultants, educators, and parents. Given how much has changed since the last evaluation in 2015, not only do we believe this will be an invaluable tool to understand the challenges the program faces and what it needs to move forward and be successful.
[45] DC Health, *Report and Recommendations of the Mayor's Healthcare Workforce Task Force* (September 2023), *available at:* https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2023-09-Healthcare-Workforce-Report-web.pdf.
[46] *Safety is Investing in the Community,* Fair Budget Coalition FY2025 Budget Platform, *available at*: https://fairbudget.org/wp-content/uploads/2024/03/Desktop-View.pdf.
[47]*Public Hearing on Proposed FY25 Budget for DC Department of Behavioral Health: Testimony of Barbara Bazron, Director,* Before the DC Council Committee on Health, (April 11, 2024).
[48] McKnight R., *Increased Medicaid Reimbursement Rates Expand Access to Care, National Bureau of Economic Research*, National Bureau of Economic Research, October 2019, *available at*: https://www.nber.org/bh/increased-medicaid-reimbursement-rates-expand-access-care.
[49] *Id.*
[50] DBH, FY 2023 Performance Oversight Responses, responses to Q44, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.
[51] DBH, FY 2023 Performance Oversight Responses, responses to Q44, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.
[52] *Id.*

[53] DBH, FY 2023 Performance Oversight Responses, responses to Q44, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.
[54] Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-23 and E-24.
[55] Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-24.
[56] Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-35.

DISTRICT OF COLUMBIA NURSES ASSOCIATION

Department of Health Oversight Hearing

Children's School Services

TESTIMONY

April 10, 2024

My name is Deborah Thomas, I am a Nurse Consultant employed by the District of Columbia Nurses Association. We represent Registered Nurses and Licensed Practical Nurses in Children's School Services. This testimony is being resubmitted, there have been increasing incidents of near misses and inappropriate responses to children in need. Parents of children with needs are fearful that medical IEP will not be followed safely without assessment and input from professional nursing. This is a request to DOH oversight to amend the budget to include an additional thirty million dollars to begin the process of assuring a nurse in every school. To provide funding and education to CSS on education and training of paraprofessional personnel, that their jobs will be commissure with their job description and gives the BON authority over their practice. There was one incident last month, a child was not given the appropriate treatment and had to be hospitalized. Please consider that we are playing Russian

roulette with our children and breaking the law. Our children deserve better, they have a right to an environment of safety. Thank you.

The testimony to follow was presented January 16, 2024.

On November 22, 2023, we sent a letter to the DC Board of Nursing (DCBON) seeking assistance in looking at the Cluster model which was unceremoniously started in September 2023. This letter outlined growing concerns that CSS administration has been allowed to circumvent The DC Nurse Practice Act and HORA. Creating a model that would allow unlicensed personnel to have greater responsibilities in the Health Suites and require the professional nursing staff to provide remote delegatory support to three to four schools in each Cluster, this leaves most schools without professional nursing support. Delivery of service is being inappropriately delegated to unlicensed personnel who have not been trained as set forth by the DC BON Trained Medication Employee program (TME).

This model violates *The Public-School Amendment Act of 2017*, which states in part beginning August 1st, 2018, a Registered Nurse shall be assigned to each public and public charter school for a minimum of 40 hours per week. The DC Nurse Practice Act which states, DC Code 38-621 (a) A registered nurse shall be assigned to each DC elementary and secondary school a minimum of 12 hours per week, then increase 16-20 hours per week beginning 2 years later. *DC law 17-1707*, The Student Access to Treatment *Act of 2008(SATA*) states in part, Allied health professionals perform

selected tasks, including medication administration, under the supervision of Registered or Licensed Practical Nurses.

There are violations of the Americans with Disabilities ACT (ADA) as well in providing care to children with chronic illnesses such as Diabetes and Asthma. This ignorance points to a lack of knowledge of nurse practice in this setting and the legal liability associated with DOH allowing CSS to violate the law, most importantly, the safety of our most vulnerable children. Let the record show that the DC City Council sanctioned these actions in June 2023 Budgetary hearings without consulting the DC BON or the DCNA, these are your experts. CSS has lost at least 30% of their professional staff since September 2023. Mostly to schools in Prince Georges County, which provides a level of respect and stability. There is maddening chaos in the schools now, the unlicensed personnel are confused about their responsibilities, nurses are practicing remotely without satisfying their professional responsibilities.

This report was sent in by a school nurse on January 12th ,2024 and it illustrates these points vividly.

“One RN cannot properly do case management and make sure plans are implemented for that number of students. In most of the care plans I and other DCPS nurses do. We have never seen the students because there is not enough time to go to every school and assess the students. I am not at any one school long enough to follow up. Techs cannot follow-up with major diagnosis. One RN cannot oversee a tech with no license working remotely, one RN cannot respond to emergencies at various locations while already caring for students at your assigned locations. My tech wants more time with me, they thought they were collaborating with the nurse, not replacing

them. The telehealth system cannot substitute for nurse assessment. Many of my colleagues left for Maryland schools where the administration understands the role of the nurse and laws that govern healthcare."

In conclusion this is a request that the DC City Council Committee on Health intervene on this issue before a child suffers from our lack of legal accountability. We have an opportunity to create a model of change, A nurse in every school is just the beginning. We can attract and create a pool of trained personnel; the city has the resources in education systems to do just that, but CSS must at least be held to the standards of appropriate care delivery as outlined in DC law. We need leaders that have experience in school health and understand the needs of all our children.

Thank you,

Deborah Thomas, RN, BSN, CDES

Nurse Consultant, DC Nurses Association

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DISTRICT OF COLUMBIA NURSES ASSOCIATION

Department of Behavioral Health Oversight Hearing

TESTIMONY

April 10, 2024

Deborah Thomas, RN, BSN, CDES, Nurse Consultant, DCNA

The DCNA represents all Registered Nurses in DBH. I am here on behalf of these members to discuss how we can assist management in creating a safe environment for nurses to practice. In January of 2019 one of our nurses was brutally attacked by a patient. This created an outrage in the health community forcing the hospital to begin to look at serious strategies of prevention. We commenced a meeting with administration as directed by the City Council (Vincent Gray) to produce a plan to deal with acute issues and to provide long-term solutions.

We began monthly meetings February 2019 with a multidisciplinary team from the administration nursing, psychiatry, and other union personnel. A plan was presented to look at the most acute problems that needed addressing immediately. This has continued since that time. There has been extraordinarily minor change since then. The

conditions of work currently foster all levels of risk for nurses and the patients they serve**. Is there a budget crisis in DBH?**

The first and major unsolved issue is overall safety. The hospital placed cameras on the units to observe nurses but has refused to place security barriers on each unit to protect nurses. During emergencies we are forced to work with limited resources for our security without the help of an emergency response team. The staffing matrix at the hospital was created years ago and is not applicable to the needs of a variety of clients. The nursing administration has refused to change this to reflect a new and different population.

Despite working very closely with administration no demonstrative change has occurred. The hospital has cut overall nursing education reflecting in poorly trained personnel and decrease in mandatory education, this includes CPR. All these factors contribute to an environment that is nontherapeutic and unsafe.

Secondly, there is a lack of supplies and or severe delay in supplies creating chaos daily. We consistently run out of supplies of daily living such as soap, toothpaste and detergent and underwear. Specialized items such as glasses and walkers take months to receive, creating gross delays of treatment and or discharge.

Thirdly, the lapses in technology have created a system that is creating errors in documentation and delivery of safe treatment. This is a departure from federal guidelines which mandated all hospitals create electronic charting systems to keep down errors and to provide appropriate internal communication among providers. The Avatar computer system cannot talk to the glucose monitoring system. The glucose monitoring system is over 20 years old. The system for validation of results is flawed

due to age. Research shows that validity of these system is related to age and the process of validation of results. Over 80% of St. Elizabeths patients have Diabetes Mellitus. Antipsychotic medications as a rule usually contribute to Diabetes development and treatment. This is the only system in house and there are no other systems to provide validation of results. Treatment is based on its results and its accuracy is highly questionable. Durable medical equipment and other supplies are hard to come by. The hospital has no method on how supplies are ordered, tracked, and kept at safe levels.

This is a request that the council in its oversight direct DBH to begin the process of looking at a new glucose monitoring system and the technology to support it. This is to include a review of systems for monitoring supply- chain issues to keep appropriate levels of supplies on hand. The creation of an expert panel to look at changing the staffing matrix and the creation of an emergency response team. The placement of safety barriers on all units and the standardization of safety policies on all units. There is supplemental testimony being submitted by our RN and Nurse Practitioner Staff.

Thank you,

Deborah Thomas, RN, BSN, CDE, Nurse Consultant, DCNA

Nancy Boyd, RN, MSN

Nurse Educator, St Elizabeth Hospital

Darryl Stewart, DNP, AGPCNP-BC

NP Primary Care, ST. Elizabeth Hospital

Testimony of Jeannie Y. Chang Pitter, MD FAAP
Board-Certified Pediatrician, Washington D.C.

Budget Oversight Hearing: Department of Behavioral Health

Committee on Health
Council of the District of Columbia

Written Testimony Submitted for the Public Record
Re: DC MAP - Mental Health Access in Pediatrics Program

April 2024

Dear Chairperson Henderson and Members of the Committee on Health,

For the record, my name is Jeannie Y. Chang Pitter and I have served as a general pediatrician and Assistant Professor of Pediatrics for residents in the District of Columbia since 2007.

As the Committee is well aware, behavioral, and mental health concerns are increasingly prevalent and now estimated to affect 1 in 5 U.S. children and adolescents[i]. Unfortunately, the American Academy of Pediatrics Mental Health Leadership Work Group estimates 75% of children with mental health disorders go untreated, as the majority of pediatricians do not feel prepared to treat such disorders[ii].

I was one of the many pediatricians unprepared to treat mental and behavioral health disorders when the COVID-19 pandemic and subsequent mental health epidemic hit. Pediatric visits for mental health concerns are estimated to have risen to one-quarter to one-third of all visits in 2020[iii]. In 2020, I relied heavily on the DC MAP (Mental Health Access in Pediatrics) program to expand my skills rapidly and successfully in diagnosis and treatment including psychopharmacology for mental health conditions in children and teens.

During that time, I was able to consult with the highly qualified experts in child psychiatry and psychology at DC MAP nearly every week (~3-8 patient referrals per month). I knew the schedule of the DC MAP psychiatrists by heart and sought guidance based on their areas of expertise, such as in neurodiverse children and teens. Through DC MAP's same day consultation line and educational events, I became well versed in diagnosing behavior concerns including among children on the autism spectrum, managing medications for moderately complex children and teens with ADHD, anxiety, OCD, PTSD, and depression, handling in-office and telehealth mental health crises and creating safety plans for suicidal children and teens, and referring patients to appropriate community services tailored to their needs, such as intensive day treatment for severe depression, trauma-focused CBT, etc.

At that time, DC MAP also provided invaluable and high-quality care coordination to my patients and families in need of behavioral health referrals. I knew when I submitted a care coordination referral that my families would receive a list of referrals appropriate to their needs, insurance, and geographical location. DC MAP also made follow up calls to patients, and I was kept abreast of referrals by a highly competent care coordination team who maintained a robust and up-to-date resource list.

A subset of my patients were also able to benefit from direct services with DC MAP staff. For example, DC MAP's psychologists helped my patients navigate psychoeducational services in and outside of school, providing much appreciated step-by-step assistance to parents in need. A DC MAP coordinator helped facilitate a single case agreement with an insurance company to ensure uninterrupted psychiatric care for my teen patient with diabetes and repeated admissions for suicide attempts. Through this process, I also gained skills to help future patients and families navigate school and insurance issues.

Back then, I participated in essentially all DC MAP provider education events. Educational activities were high impact, high quality, widely publicized, frequent, and conveniently timed. Speakers were uniformly practicing within the District and thus intimately familiar with the needs of D.C. children and families and the District's resources.

In the winter of 2021, as emergency room visits for suicide attempts among females ages 12-17 increased 51% compared to the same time period in 2019[iv], the contract for DC MAP changed hands to Paving the Way, MSI.[v] The transition of these essential services to this less experienced organization proved to be extremely unfortunate timing.

Like many of my colleagues, I engaged with DC MAP under the new contract organization hoping for the same high-quality support in same-day treatment advice, care coordination, and provider education. Unfortunately, like many of my colleagues, I soon stopped consulting with them at all as some advice by the new child psychiatry consultants was in conflict with expert management, I had learned from prior trusted DC MAP psychiatrists. When parents told me in frustration that therapists listed by DC MAP did not even accept their insurance, they and I felt it was a waste of time to engage with DC MAP. Follow up protocols to ensure patients were successfully served also seem lacking compared to prior DC MAP follow up protocols. Most of my colleagues in my pediatric practice (>12 pediatric primary care providers) echo that their utilization of DC MAP now is similarly non-existent or only a small fraction of their referrals prior to November 2021.

With regard to educational events, despite being a registered user with the new DC MAP in 2021, the only educational event series I have ever been invited to was in 2024 and was being held from 11 am-12 pm, which is a time when most pediatricians provide clinical care. None of my pediatric colleagues have known of nor attended a DC MAP educational event under new leadership either. Now, I attend and refer to events hosted and recorded by many former DC MAP psychiatrists via Pediatric Health Network (PHN)'s Behavioral Health Initiative (BHI) instead[vi]. Since none of my colleagues have heard of or attended any DC MAP educational events, I would wonder how, and which DC pediatric primary care providers are being served.

Since 2022, I have been deeply engaged in improving pediatric mental health knowledge and skills of pediatric residents and faculty and developed a mental health curriculum for trainees while enrolled in the George Washington University Master Teacher Leadership Development Program. In 2023, I piloted this curriculum and now collaborate nationally on this topic. Despite my level of engagement in pediatric mental health care, I have unfortunately had to look to alternate local and regional resources for support and expertise given the void of a functional DC MAP in the last 3 years.

In 2024, DC MAP now lags significantly behind its counterparts in the region as I and my colleagues often look to the quality services that VMAP[vii] and BHIPP[viii] (VA and MD mental health access programs in pediatrics) provide. The original DC MAP, like VMAP and BHIPP,

was modeled after the successful Massachusetts Child Psychiatry Access Program and are part of the National Network of Child Psychiatry Access Programs.[ix] VMAP has published an incredibly useful Guidebook[x] which is now a core resource for our D.C. pediatric trainees. VMAP hosts regular Continuing Professional Development which some of my D.C. colleagues have joined, supports longitudinal small group training for providers, and funds pediatric providers to receive Virginia-based training with the REACH Institute, a non-profit with highly effective, intensive training in pediatric mental health care. BHIPP offers telemental health consultations for limited direct consultation and care coordination and co-locates social work interns at pediatric practices to provide integrated care coordination. Websites under PHN BHI, VMAP and BHIPP are robust. In contrast, DC MAP's website under Paving the Way, MSI is lean and not particularly useful other than their contact information; it does not include any recorded or novel educational content or DC-specific mental health resources.

Recent attempts to engage with DC MAP to see if they may be able to expand their support of pediatric providers like VMAP and BHIPP has been slow. Responsiveness seems limited in part by the fact that it appears the DBH contract is being implemented in part by an out of District/out of region organization. The sub-contractor we contacted was knowledgeable about integrated health in general but was not in a position to offer any support since they were not actually DC MAP.

The void in the last three years of a quality mental health access program in pediatrics has truly been a significant set-back for District pediatricians, like myself. I strongly recommend the Committee evaluate the current state of the program and its quality under the current vendor, as compared to regional and national leaders in the provision of mental health care access programs.

I sincerely hope that the Committee will work to provide needed oversight and support to Paving the Way MSI to improve its quality of services to pediatric providers and to their families. We have a long way to go to reach the prior high-quality service provided by DC MAP from 2015 to 2021 under the DC Collaborative for Mental Health in Pediatric Primary Care (DC Collaborative) [xi]. Granted, the DC Collaborative was a public-private partnership built over years that includes Children's National Health System, MedStar Georgetown University Hospital, the Children's Law Center, the DC Chapter of the American Academy of Pediatrics as well as a community advisory board with representation from more than 25 child-serving organizations, parents, and community groups. In my view, DC MAP in its current form would ideally include DC Collaborative partners rather than out of District consultants to ensure District-based service organizational capacity is strengthened to meet the objectives of supporting DC providers and families.

Thank you for the opportunity to submit written testimony. I commend the Department of Behavioral Health for prioritizing mental health care for children through ongoing DC MAP support, an important and effective model found in > 45 states.

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[iii] Meyers N., Maletz B., Berger-Jenkins E., Lane M, Shindle E., Costich M., et al. (2022). Mental health in the medical home: a longitudinal curriculum for pediatric residents on behavioral and mental health care. MedEdPORTAL, 18: 11270.

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Performance Oversight Hearing: Department of Behavioral Health

Committee on Health
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Testimony of Dr. Patrick Canavan of Capital Integrated Care, LLC

To the DC Council Committee on Health

Budget hearing for the Department of Behavioral Health

April 10, 2024

Good morning, Chairperson Henderson and members of the Committee on Health. My name is Dr. Patrick Canavan and I am here today as a founder of Capital Integrated Healthcare, a health care management group in the District. Our leadership includes long-time DC professionals, including an emergency medicine physician and a finance and administration leader with 20 years of experience working at DC CSAs and FQHCs. We are from here and we care about the whole health of individuals who live in the District. We would like to highlight the need for urgent care for people in behavioral health crisis in the District.

DBH has been in the process of transformation for some time, and made changes in their data collection, access, and care authorization processes, as they prepared for moving services to the 3 DC MCOs. Since this realignment has been delayed again – with no timeline for it being accomplished – we are concerned that those who are most vulnerable will have even more difficulty accessing care that is, as Dr. Bazron and others say: "Right care, right time." Her vision of an agency that uses data to focus on the right priorities for people who need high quality services, to ensure high quality providers are certified, and to nimbly address emerging care needs, is the right vision. I hope the District will take this issue with the seriousness it deserves, gather and review data, and focus on priorities that matter. This issue deserves proper attention, as it not "just another issue," in a difficult budget year. In fact, tough budgets have a way of clarifying whether existing services are filling the needs that exist or not, and whether there are other services that would better serve our neighbors.

One fifth of all Americans suffer from mental illness and only half of them receive any treatment. Access to behavioral health is complicated, so many individuals use the emergency department for their routine behavioral healthcare. But emergency departments are not a good place to receive high quality care that is timely and appropriate. Wait times can be up to 12 hours in the District of Columbia and often do not result in meaningful care. While the District has many behavioral health services, they are siloed and not coordinated. And hospital emergency care is expensive compared to other services that are better suited to address behavioral health issues.

Individuals who need either emergency or routine behavioral health services can be treated in a behavioral health urgent care center (BHUC). Not only will the BHUC decrease hospitalizations and ED visits, but it has also been shown to improve follow up care and increase both patient and staff satisfaction.

We propose an EmPATH model for emergency behavioral health care. The unit will be freestanding and treat adults 18 and over who do not have a history of dementia or other medical issues requiring hospital care. The unit will be open 24 hours a day seven days a week, with highly trained peer specialists, who have lived experience, playing a major role in care and follow up.

There are differences between a CPEP and an EmPATH unit. CPEP is designed to evaluate and treat those in need of acute psychiatric services. There are three key differences between the behavioral health urgent care center we propose and CPEP. First, care delivery via our BHUC will be both tailored to the individual's needs and definitive: if a client needs acute care for their suicidal ideation, they will receive multimodal therapy via the EmPATH unit and warm handoffs to trusted outpatient community services. If they need bridge therapy for their anxiety until their outpatient appointment, they can receive care as well. CPEP offers very limited treatment options beyond medication management. Secondly, the behavioral health urgent care is designed to address whole person care: there will be onsite and/or virtual MOUD and physical health providers as part of routine treatment. Lastly, there is strong evidence that EMPATH units have resulted in decreased ED visits and inpatient hospitalizations, and increased patient and provider satisfaction and outpatient services utilization.

Once assessed at the BHUC, the individual will receive appropriate care: if they are in psychiatric crisis, they can be managed at the BHUC until the crisis resolves and they can return to their regular support system, or more likely be connected to a system of care that supports their recovery without using expensive emergency services.

For more routine concerns, for instance, individuals who need medication refills or who are experiencing a crisis that does not require an intensive level of intervention, the BHUC is ready to help. The people experiencing a behavioral health emergency often can be managed effectively with brief crisis intervention, medication refills, medication for opioid use disorder, and outpatient referrals. The goal with these individuals is to connect them to existing services in the community that supports their behavioral health recovery. They can also have access to primary care and other services, especially ones that are needed after hours or on weekends.

This level of care could compliment the services of the Stabilization Center since I am told there are a lot of clients with MH and SUD diagnoses; once these clients have stabilized on the substance use side, it would be the perfect time to provide the support of urgent BH services, especially since many are not currently connected.

We ask the Committee to consider funding a pilot EmPATH in FY25. In addition, we believe there should also be a comprehensive gap analysis of existing programs. This analysis could determine utilization of 35 K, Howard Road, the Urgent Care Clinic at the DC Superior Court, hospital EDs, and at CPEP. It could also identify level of care gaps, particularly between 35 K, Howard Road and CPEP. The level of care provided at the BHUC would complement the services of the Stabilization Center since data suggests they are seeing clients who are dually diagnosed, with both a Substance Use and mental health

diagnosis. So once they have stabilized on the substance use side, these neighbors may benefit from the support of urgent BH services and get appropriately connected to care.

I appreciate this opportunity to talk about Behavioral Health urgent care and I look forward to your questions.

Joel Cohen - Pathways to Housing DC

Testimony of Dr. Joel Cohen

FY 2025 Department of Behavioral Health Budget Oversight Hearing

Committee on Health

April 10, 2024

Good afternoon Chair Henderson, members of the Council and Committee staff. My name is Dr. Joel Cohen, I am a Ward 3 resident and the Medical Director at Pathways to Housing DC. The Court Urgent Care Clinic is a partnership between DC Superior Court, the DC Department of Behavioral Health and Pathways to Housing DC.

I felt a sense of surprise and sadness since I learned about the defunding of the Court Urgent Care Clinic. I have been a clinician practicing psychiatry in DC since discharge from the Army/Walter Reed in 1973; to then be the treating psychiatrist in a newly formed Adolescent Day Program which also involved evaluating adolescents for the Court.

Presently my involvement with the court urgent care clinic is as a clinician with direct patient involvement. We are a small, cohesive and active clinic consisting of only five people. Over the course of this past year we have become exceedingly busy working with crisis management and addressing frequent behavioral health related unusual incidents in the Court. I cannot speak about the numbers and administration with great knowledge. What I do know is that we are working face-to-face daily with people, many of them young and frequently in crisis and we are busy. The youngest person I have seen at the court was 12 years old, the oldest 75. There is no substitute for being at the court in person to work with patients and court staff from judges and marshals to the administrative staff as well as the attorneys and law enforcement.We also are on site to provide emergency forensic child evaluations at the Court when there is a concern by the Judge that a child is a danger to themselves or others. I believe that our greatest service is to try to engage people and offer them help with navigating the system, assessing their mental health needs and motivating and guiding them into treatment when indicated; as well as consulting directly with the court system to give them rapid feedback about the mental health status of individuals. Again, this is all done on site.

In my almost 3 years at the Urgent Care Clinic I have seen the results of trauma, loss, poverty, racial bias, and substance use, particularly on our young people. We have seen many young people with gun related charges who frequently have sparsely treated or untreated emotional sequelae from the deprivation of their childhood. We are present to engage these young people and provide a supportive understanding setting to try to involve them in directive and supportive mental health treatment. Simply put we see a vast array of people with the goal of assessing and getting them the help that they might need and thus preventing reinvolvement with the legal system and increased safety for all.

We are on site to see expeditiously all people. Finally some of the situations we have been on site to deal with have included: Emergency FD-12 of a teenager, assessing and testifying to ensure the hospitalization of a 12 year old involved in a carjacking, evaluating and motivating for treatment many visitors/trespassers to the White House grounds with information for the President, ensuring that mentally ill people have access to their medication while involved with the Court or have been released from incarceration, or discharged from the hospital, or just ran out; defusing agitation and bizarre interactions between chronically mentally ill people and Court staff and unusual incidents of various sorts. Finally I do believe that it is of paramount importance and cost effective for what it accomplishes for the safety and mental health of all District

residents to have professional staff available in

person in the form of a mental clinic at the Court.

I thank you Chair Henderson for conducting this hearing and am available to answer any questions that you may have.

Comments on Proposed Fiscal Year 2025 Budget
DC Department of Behavioral Health
For the Committee on Health
April 22, 2024

Community of Hope (COH) is a non-profit Federally Qualified Health Center and homeless services provider. We provide medical, dental, pharmacy, and behavioral health services, along with a robust set of maternal and child health care services, including evidence-based home visiting and WIC, and operate the District's only free-standing birth center. We also provide housing and supportive services to individuals and families experiencing homelessness. Last year, we served over 1,700 households in our homeless services programs, and 15,790 patients at our health centers.

Community of Hope provides counseling services for children, teens, and adults, and with funding from the DC Department of Behavioral Health, we offer school-based mental health services at Moten Elementary School (Ward 8), Ketcham Elementary School (Ward 8), and Theodore Roosevelt High School (Ward 2). All are classified as high need schools and all have experienced significant violence either within or directly outside the school. Our clinicians provide one on one counseling services to students and their family members, and group services to students, teachers and parents to improve school atmosphere, and help teachers support student achievement.

At the Public Oversight Hearing for the Department of Behavioral Health in February Janet Campbell, one of Community of Hope's School-Based emotional wellness therapists based at Roosevelt High School testified about the importance of having therapists available to students during the school day, and the realities of day-to-day casework for school-based clinicians. Carrying a caseload of 15 students, Janet regularly engages with students who are not on her assigned caseload, and she often provides assistance and resources to students' families. These interactions with parents and guardians are not included in the DBH tracker, but provide helpful insights into students' lives outside of school, which informs their in-school needs. Many school-based clinicians regularly perform these tasks in addition to their assigned caseloads, and the demanding nature of this work, combined with current salaries can create difficulty in filling vacancies.

The $4.8 million decrease to school-based behavioral health supports in the Mayor's proposed FY25 budget is concerning for a variety of reasons. These proposed reductions to school-based services pose a threat to the program's future, and stand only to exacerbate an already precarious staffing situation for clinicians. It is crucial to find a more sustainable way to fund school-based behavioral health supports, and it is difficult, if not impossible, to close vacancies without offering competitive compensation. Clinicians have active caseloads in 168 schools, and through the other resources in the program, only a handful of schools are not receiving any support from the program. Finding a way to set the program on a more sustainable path is imperative. CBOs have a cost of over $130,000 per school to operate the program and, on average, can expect to recover approximately $35,000 per year in claims billing. It is estimated that grant amounts need to be rebased to $98,500 per CBO clinician per school. This level of funding would allow CBOs to increase clinician salaries to approximately $74,000, the 10th percentile of pay for licensed clinical social workers in the District, instead of the current $64,000 that CBOs reported paying in DBH's most recent CBO clinician salary survey.

The proposed budget also eliminates a fifteen-year investment in providing behavioral health urgent care services at the DC Courthouse, naming the vendor in the reduction narrative, rather than describing the nature of the contract. The "Mayor's Proposed Budget" section of "Reduce" includes the clause "$922,833 for the Pathways to Housing contract." Pathways to Housing has been the successful awardee of this competitively bid contract three times, but the contract is not a "Pathways to Housing" contract. The contract is for a behavioral health urgent care clinic at the DC Courthouse, one of two distinct sets of behavioral health services slated to be eliminated by the proposed FY25 budget. The Council should scrutinize how the District can afford to eliminate critically needed behavioral health services in our schools, in the criminal-legal system, and for some of the people whose conditions are most severe but who are the hardest to reach.

It is possible to address current budget pressures without sacrificing the emotional wellbeing of District residents. We acknowledge the work that DBH has done to create and maintain programs and partnerships aimed to advance quality, whole-person care for District residents with mental illnesses and want to caution against reversing these hard-won improvements with the reductions proposed in the FY25 budget.

Good morning Chairperson Henderson. My name is Dr.Sarah Goldman and I am a practicing emergency medicine physician here in the district. I am here because with every passing day I become more alarmed with the growing behavioral health crisis we are facing. And let's be clear: our failure to provide meaningful care to our most vulnerable members have powerful ramifications for everyone. People with serious mental illness suffer from higher rates of homelessness & extreme poverty and are more likely to be the victims of violence. On average, they die 25 years earlier than those without significant BH diagnoses. In rare but tragic instances, they may inflict violence on others. Like many providers in the city, I was hopeful the carve in would result in the start of a meaningful transformation – only to have that process fall through as well.

The truth is the worst place a patient in crisis can go to receive care is the emergency department. Wait times can be 8 hours or longer and while in the ED they never receive any definitive psychiatric treatment. Patients who are not deemed sick enough for admission are discharged to navigate the confusing outpatient behavioral health world on their own. As a provider who speaks to patients and their families daily, I can tell you that many outpatient appointments may take weeks or longer to obtain. This contributes to why I see the same patients cycling through the ED time and time again.

Born out of my sincere desire to see patients receive better care, I joined the organization Capital Integrated Care. We are proposing the implementation of a behavioral health urgent care center with the goal of providing whole person care for members with acute behavioral health needs. We do not want to supplant integrated outpatient services; rather the intent is to break the ineffective current care paradigm by providing evidence-backed and data driven acute care services and linkages back into high quality, outpatient care.

Patients with acute care needs, such as those with Suicidal ideation, will be evaluated and treated in the EmPATH unit. EmPATH or Emergency emergency psychiatric assessment, treatment, and healing (EmPATH) units exist throughout the country and have proven successful in providing compassionate, effective care demonstrated via decreasing ED return visits, inpatient admissions, and cost of care. They have also proven successful in linking clients into outpatient care. Because every patient receives definitive therapy in a calming environment, these units have higher rates of patient and provider satisfaction.

We also know that definitive care cannot be provided unless we implement solutions to address our siloed physical health, social health, and MOUD services. This urgent care center will offer

bridge mental, physical health and MOUD services for patients unable to obtain timely appointments. Again, the goal is not to supplant outpatient services but to address gaps to ensure care continuity. We will also work with MCOs and committed social service providers to help ensure safe discharges.

This urgent care center offers a definitive pathway to addressing each and every aspect of the ongoing crisis I outlined in my opening statement. In addition, because this BHUC will result in decreased inpatient admissions, increased outpatient utilization, and better integrated whole person care services, cost of care will drop.

I appreciate your time and continued support of our community.

Dr.Sarah Goldman
Capital Integrated Care, LLC

Shannon Walsh - Pathways to Housing DC

Testimony of Shannon Walsh

FY 2025 Department of Behavioral Health Budget Oversight Hearing

Committee on Health

April 10, 2024

Good morning Chair Henderson, members of the Council and Committee staff. My name is Shannon Walsh, I am a Ward 8 resident, a licensed clinical independent social worker, and the Clinical Director of the Court Urgent Care Clinic. The Court Urgent Care Clinic is a partnership between DC Superior Court, the DC Department of Behavioral Health and Pathways to Housing DC.

Each year the Court Urgent Care Clinic provides hundreds of adults with mental health and substance use challenges with SAME DAY assessment and treatment of complex behavioral health challenges. The Clinic was one of the first and remains one of the only of its kind in the country. On staff, we have a Psychiatrist, two Mental Health Clinicians, a Certified Addictions Counselor and an Intake Coordinator. Our office is in a unique position to provide services to individuals regardless of if they have an ID, insurance or residency status in the United States, at no cost. We are conveniently located inside the DC Superior Courthouse to provide services to individuals involved in the court, who often fall into one or more of these categories. Although we are located in the courthouse, we are able to provide services to anyone in the district regardless of court involvement.

Unfortunately, Mayor Bowser has proposed to cut our entire program for FY25. This would be a tremendous loss to our clients and community. 84% of our clients report their interactions with the Court Urgent Care Clinic positively impacts their judicial disposition, 73% of our clients are discharged with a positive outcome (connected to a long term mental health, substance use services, etc), and 53% of our clients are referred for a housing assessment due to experiencing homelessness or housing instability. We work closely with the Civil Actions Branch as well as Mental Health Court to provide support to clients who would otherwise require police intervention due to their mental health symptoms.

The benefit of having our office in the courthouse is that clients can be seen on the same day they are in court and experiencing acute mental health symptoms. If our program is closed, our clients will likely have to travel to another location which is an added barrier and will likely result in the person not getting treatment. The Court Urgent Care Clinic also provides forensic child evaluations at the request of the court to determine if a child needs to be hospitalized. We have been able to avoid

hospitalizing a child after gathering the needed information and coordinating with the hospital, the child's probation officer, family, and Core Service Agency to be prescribed the appropriate medication and avoid hospitalization. Our office "stands in the gap" for clients who may already be connected with mental health providers but are in need of immediate psychiatric intervention, including emergency medication, counseling and involuntary hospitalizations.

As a DC resident, I am acutely aware of how crime has impacted our community. The building I live in has had multiple shootings, including a murder on Easter morning. Cutting mental health services will exacerbate the public safety issues already impacting our community.

I thank you Chair Henderson for conducting this hearing and am available to answer any questions that you may have.

Testimony of Betty Gentle, Senior Advocacy & Community Engagement Specialist
SOME, Inc. (So Others Might Eat)
To the Committee on Health
Department of Behavioral Health Fiscal Year 2025 Budget Oversight Hearing
April 10, 2024

Greetings, Chairperson Henderson and members of the Committee. My name is Betty Gentle. I am the Senior Advocacy and Community Engagement Specialist at SOME, Inc. (also known as So Others Might Eat). Thank you for the opportunity to submit this testimony to the Committee on Health for the **Department of Behavioral Health Fiscal Year 2025 Budget Oversight Hearing.**

Since 1970, SOME has been working to break the cycle of poverty, homelessness and hunger through our comprehensive "Whole Person" approach. Our continuum includes a full range of high-quality healthcare services that are people-centered, trauma-informed and grounded in equity. This includes behavioral health services where our staff supports adults in stabilizing and maintaining their mental health and a range of substance use disorder treatment options that empower adults to break the cycle of addiction.

SOME is a member of the SUD Provider Coalition, the D.C. Behavioral Health Association (DCBHA), and the Fair Budget Coalition. We strongly support the comments and recommendations presented on behalf of all DCBHA members and the Fair Budget FY25 healthcare budget priorities.

Today, I'd like to begin my testimony with a story about "Sasha,[1]" whose journey embodies the transformative power of a robust Substance Use Disorder (SUD) program within our community.

> Despite Sasha completing SOME's program five years ago, the challenges of the pandemic led to a relapse. However, her return and engagement with our intensive outpatient program (IOP) and our Kirwan "Safe" House underscore the critical support such programs provide during crisis moments.
>
> During her stay in the residential program in West Virginia, affectionately called 'Miracle Mountain,' Sasha demonstrated remarkable commitment to her recovery journey. She recognized the need for additional time to address underlying issues of trauma and grief, requesting and receiving an extension. This dedication to self-exploration and healing highlights the depth and effectiveness of our programs.
>
> Her transition back to D.C. from through the Leland "Transitional" Program exemplifies how comprehensive support systems can empower individuals to rebuild their lives. Today, Sasha is not only employed and stably housed in SOME's Single Adult Housing but is also an active participant in her ongoing recovery through regular outpatient appointments. She is looking forward to her upcoming Spring Graduation, tomorrow, April 11, 2024.

Sasha's story is a testament to the life-changing impact of a strong SUD program, fostering hope, resilience and community reintegration. Sasha's success underscores the vital role such programs play in our community's well-being, offering not just treatment but pathways to long-term recovery and societal contribution.

[1] Name has been changed to protect confidentiality.

As we examine Mayor Bowser's Proposed FY25 budget for the Department of Behavioral Health, we must ensure that strategic investments are made that ensure deserving residents like Sasha, who may be battling an addiction they thought they'd already defeated, living without a safe place to call home and seeking mental stability while being consumed with grief and trauma, have a comprehensive and individualized behavioral system available to them, which is why it is crucial to adequately and equitably fund community-based providers, as they form the backbone of D.C.'s behavioral health ecosystem.

I. A Snapshot of Who We Serve and the Impact on the Community

SOME stands among numerous providers dedicated to D.C. residents, and we aim for our impact to be a compelling snapshot of the broader behavioral health provider network's profound influence.

In 2023, SOME served 216 clients across our Addiction Continuum. Of the 124 D.C. residents who moved into our Residential Treatment in West Virginia, 86 first spent an average of 24 days at Kirwan Safe House, where 76% successfully entered treatment. Overall, 103 residents positively discharged from Residential Treatment, after spending an average of 5 months to obtain their sobriety, with a remarkable 78% completion rate at Leland Transitional Program. Of the 69 persons who positively discharged, 52 moved into SOME's housing.

SOME knows that investing in a robust SUD system not only empowers individuals to heal and rebuild their lives but also fosters a safer, healthier and more empathetic community.

SOME also highlights Jordan House, one of D.C.'s two Crisis Stabilization programs, which serves as a crucial psychiatric diversion program, intervening during the most vulnerable moments for clients facing acute crises. In 2023, it assisted 155 clients, achieving an impressive 97% positive discharge rate with reduced acute symptoms. This program not only prevents unnecessary psychiatric hospitalizations but also facilitates smooth transitions back to the community, significantly reducing the need for repeated hospitalizations among vulnerable individuals. By providing a less institutionalized and trauma-informed setting, Jordan House not only aids in crisis recovery but also cements these gains by connecting clients to ongoing services, resulting in an 86% positive discharge rate to appropriate permanent housing settings.

To demonstrate the important role of Crisis Stabilization programs in D.C., we also share this story from our Jordan House Program Director about her crucial work with "Sean."[2]

> In late January 2024, we admitted Sean just 12 weeks after their discharge from Jordan House. Over two months, Jordan House and the CSA collaborated to improve his health literacy and overall well-being. Upon his return in January, he reported foot pain and insomnia, which our team promptly addressed. We worked with the CSA, advocating for a discontinued medication, which he received and was successfully titrated during his stay until discharge.
>
> The Jordan House Team addressed Sean's thought processes and advocated for his concerns, arranging podiatrist appointments and educating him about medications. By the end of his stay, he knew and could take 50% of his medications independently. With support, he became more involved in health discussions and improved his communication and behavior significantly, showing increased insight and judgment.
>
> While Jordan House stabilized Sean's mental health, the CSA secured his new Community Residential Facility (CRF) placement and extensions for titrating medication and lab work. They supported him through interviews, despite facing five denials. Collaborating with Jordan House, they assessed his progress and readiness for a CRF level step-down, eventually leading to acceptance into a group home.

[2] Name has been changed to protect confidentiality.

Every practitioner, from paraprofessionals to psychiatrists, played a crucial role in Sean's journey, and their contributions were deeply appreciated. By consolidating his healthcare providers into one location, he felt truly heard and supported by every doctor he encountered. His insurance enabled enrollment in an intensive health case management program, enhancing his self-sufficiency and recovery. Additionally, he gained access to a day program, further empowering his progress towards wellness.

II. The Impact of Housing on Behavioral Health Outcomes

Affordable housing is a cornerstone of sobriety and recovery, especially in combating the opioid crisis and addressing mental health needs. As this Committee crafts a budget to tackle these critical issues, we must prioritize the expansion of transitional and low-income affordable housing.

SOME's treatment continuum vividly illustrates the pivotal role safe transitional housing and affordable housing plays in sustaining sobriety. In 2023, 77% of graduates from Leland Transitional Program who transitioned to SOME Single Adult Housing (SAH) maintained sobriety for at least one year. Furthermore, 88% of all Leland graduates, regardless of their recovery journey duration, remained sober.

These statistics highlight the effectiveness of integrated programs like Leland in supporting long-term recovery outcomes. Notably, only 68% of SAH residents who did not undergo the Leland Program maintained sobriety. This underscores the profound impact of affordable housing coupled with comprehensive treatment interventions in fostering successful recovery and combating substance misuse.

III. The High Cost of Disinvestment in These Services to the Overall Community

The dire consequences of not funding SUD services are clear: D.C. residents will struggle to find the help they desperately need—some will even lose their lives, and providers, like SOME, will be forced to scale back critical services due to reduced funding.

Regarding mental health funding, the pandemic's upheaval has led to an alarming surge in demand for crisis services, resulting in untreated acute symptoms and dangerous delays in intervention responses. Funding uncertainties threaten to render vital services less sustainable for providers, like SOME, worsening the already dire lack of crisis response in our communities.

Too often, city budgets have ignored the pleas of providers, relying on their resilience to navigate increasing administrative burdens, certification requirements, Managed Care Organization transitions, and more. However, this approach is not sustainable and should not be repeated in the FY25 budget.

SOME appreciates the opportunity to offer these comments, and we are grateful for the role we play in helping our neighbors stabilize their mental health and heal from addiction with respect and dignity.

Testimony before the
Council of the District of Columbia

Committee on Health

FY25 Budget Oversight Hearing
for the
DC Health

* * *

Presented by
Jacqueline D. Bowens
President & CEO
April 10, 2024

Greetings Chair Henderson and members of the Committee on Health, my name is Jacqueline D. Bowens, and I am the President and CEO of the District of Columbia Hospital Association. I appreciate the opportunity to present testimony on DC Health's FY25 budget.

DCHA has been the unifying voice of the District's hospitals for over 45 years. We are committed to promoting policies and initiatives that strengthen our system of care, preserve access, eliminate disparities and promote better health outcomes for patients and our community. Our driving vision is to achieve an efficient and effective health care delivery system that supports a healthy, equitable and vibrant community.

As we look at DC Health's FY25 budget, ensuring investments are maintained across the vital services the Department provides to the city. Its investments in tackling

chronic diseases, improving maternal and infant health as well as ensuring the health system is adequately prepared for any emergency the city may face are all critical. We urge the Committee to continue infusing funding to target improved outcomes for our moms and infants, which DCHA is proud to partner with the department in these efforts. Specifically, we urge the Committee to fund the Count the Kicks Campaign as part of the work of the Perinatal Quality Collaborative.

As we look at the challenges facing health care, one of the most pressing is the need to continue our work of creating a pipeline of District residents ready to take on all the challenges that health care faces. This will take continued investment in loan repayment as well as the scholarship programs designed to support DC Residents seeking to get credentialed in health occupations most in need.

Another important tool to attract employees to healthcare in the District is a streamlined licensure process. We are grateful for the continued partnership with Dr. Bennett and the Health Regulation & Licensure Administration team. Its continued work to improve the licensure process is very much appreciated and needs to be continued. Investments in IT to make sure the process is easy for applicants is essential.

Over the last two years, the Committee on Health has made a significant investment in licensing specialists that should be preserved in this year's budget. We anticipate an increased number of applications being processed for the foreseeable future, especially with the newly licensed occupations included in the HORA revision. We must ensure an adequate number of licensing specialists are available and able to respond to applicants and process applications quickly. I

would especially like to thank Dr. Teresa Walsh and Antoinette Butler at the Board of Nursing for their partnership in trouble shooting applications.

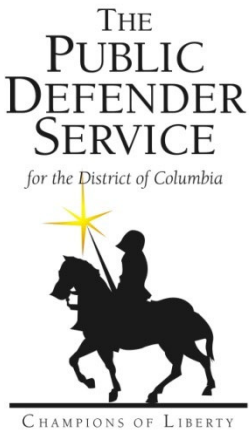
Additionally, we renew our call to ensure the Department allocates staff to improve customer service by answering calls to reduce the number of complaints received about not being able to talk to someone within health professional licensing.

Continued investment in emergency preparedness is essential as we seek to ensure our health system is resilient in case of emergencies or disasters. This is a new ASPR grant cycle for the Hospital Preparedness Program budget period, and we are committed to providing assistance to DC Health to ensure the new grant period is a success.

Finally, we know the Committee plans to hold a hearing on the Certificate of Need process in the near future and we

believe the CON BSA subtitle should be handled through the normal legislative process.

Thank you for the opportunity to testify and I am happy to answer any questions.



TESTIMONY OF THE PUBLIC DEFENDER SERVICE
FOR THE DISTRICT OF COLUMBIA

Concerning

BUDGET OF THE DEPARTMENT OF BEHAVIORAL HEALTH

Presented by

Katerina Semyonova

before

COMMITTEE ON HEALTH
COUNCIL OF THE DISTRICT OF COLUMBIA

Chairwoman Christina Henderson

April 25, 2024

Heather N. Pinckney, Director
Public Defender Service
633 Indiana Avenue, N.W.
Washington, D.C. 20004
(202) 628-1200

Thank you for the opportunity to submit written testimony for the budget hearing for the Department of Behavioral Health (DBH). I am Katerina Semyonova, Special Council to the Director on Policy and Legislation at the Public Defender Service for the District of Columbia.

By way of background, PDS represents adults and youth facing charges in the criminal and juvenile legal systems and persons facing involuntary hospitalization or commitment in the mental health system. PDS's Office of Rehabilitation and Development (ORD) works with PDS lawyers in advancing the rehabilitative and programmatic needs of clients. ORD frequently formulates reentry plans for clients transitioning out of detention, connects clients with mental health treatment, and supports their mental health needs as they navigate the criminal and juvenile legal systems.

PDS's testimony will address: DBH's proposal to close the Urgent Care Clinic at D.C. Superior Court, the proposal to cut 11.6 million dollars in community mental health care funds, and the need to allocate more funding to school-based mental health services.

Urgent Care Clinic at D.C. Superior Court

Since 2008 the Urgent Care Clinic at D.C. Superior Court has been essential to providing individuals with the services that they need to address mental health issues. While it is clear that mental illness does not make someone inherently dangerous or make them engage in criminal behavior, the overlap between individuals with mental illness and individuals in the criminal legal system is noteworthy. Each day hundreds of people who need mental health services pass through D.C. Superior Court. Superior Court's creation of the Mental Health Diversion Court, the Juvenile Behavioral Diversion Program, and the high incidence of mental illness for individuals detained at the D.C. Department of Corrections provide strong evidence of the mental health needs of court-involved individuals.

The Urgent Care Clinic at D.C. Superior Court addresses mental health care needs for individuals who come into contact with the legal system and who would otherwise be released without services. Pathways to Housing manages the Urgent Care Clinic through a grant, and has done an excellent job serving individuals and partnering with appropriate agencies. The Urgent Care Clinic accepts referrals directly from judges for children and adults who present in court with signs and symptoms of mental illness and for individuals who are in need of substance abuse treatment assessment. The Urgent Care Clinic also conducts forensic screens for children who need inpatient mental health treatment, therefore eliminating this service will mean children wait longer for, or do not receive, these court-ordered evaluations. The Urgent Care Clinic accepts walks-ins and PDS has frequently brought clients there for assessment, connection to services, and for coordination of same-day transportation to substance abuse treatment. Clients that PDS has referred to the Urgent Care Clinic have been able to meet with psychiatrists and immediately receive prescriptions for medication. Every clinician at PDS has utilized the Urgent Care Clinic numerous times with our clients.

Mental health resources are ineffective if they are not easy to access and treatment access should be broadening to address the increased mental health issues people are experiencing, not narrowing. Shutting down the Urgent Care Clinic will erect yet another barrier to care and will be a great detriment to the community. Just like shutting down the Access Helpline, closing the Urgent Care Clinic will mean that people will not get the services they need. Instead of leaving D.C. Superior Court connected to mental health services, including psychiatry, community members who are struggling to maintain stability will be left with more difficult and frustrating options in a system that already lacks the resources to provide help. The only other place, apart from the Urgent Care Clinic, where DBH has a walk-in psychiatric assessment center is at 35 K

Street. The site at 35 K Street is already overtaxed and frequently there are too many people waiting to be seen, such that individuals cannot receive same day assessment and prescriptions. Closing the Urgent Care Clinic will exacerbate this problem of overcrowding. Closing the Urgent Care Clinic will also result in funneling more people into CPEP and area hospitals, taking up police resources, hospital resources, and court resources should they be involuntarily detained in the hospital or criminally charged as a result of their decompensation without mental health services. The decision to close the Urgent Care Clinic will thus result in increased spending on hospitalization, incarceration, and emergency medical services, which are all more costly than providing treatment, and which create worse outcomes for the District's most vulnerable residents.

11.6 Million Dollar Cut to Community Based Services

DBH's proposal to cut 11.6 million dollars in community support services is also short sighted and will lead to worse health care outcomes for District residents and will also result in drastically increased spending for hospitalization, homeless services, and incarceration – all likely outcomes when individuals who struggle with mental illness are deprived of the community-based services that they need to maintain a functional level of stability. As explained in the testimony of the District of Columbia Behavioral Health Association, an 11.6-million-dollar reduction in District spending will result in the District forfeiting 27.1 million in matching federal dollars.[1] The net result is a loss of nearly 39 million dollars in services that should be directed to community based mental health care for residents who have no other

[1] See written testimony of the District of Columbia Behavioral Health Association, hearing record, FY 2025 Budget Oversight of the Department of Behavioral Health.

options for receiving those services. According to the District of Columbia Behavioral Health Association, this cut would eliminate 326,000 hours of care for DBH enrolled consumers.[2]

This proposed budget reduction would create an unconscionable decrease in services at a time when District residents need more help, not less. It also inexplicably erases all funding for telemedicine. Community support services are essential to providing direct care to consumers. Consumers use community support services for case management, psychiatry, medication management, and for nursing. Community support workers are the first line of defense that help residents who are struggling with mental illness stay in their homes, keep their jobs, and support their families. Individuals qualify for the level of care that these workers provide because they present with social-functional deficits. These consumers need therapy once or twice a week to deal with relationships at home or anger management issues. They need help with major mental illness, substance abuse, and intellectual disabilities. Community service providers help with Medicaid and food stamp applications, make sure Medicaid remains turned on, navigate the coordinated entry system for housing, and they help with managing both Supplemental Security Income and Social Security Disability Insurance, with provider agencies often serving as representative payees and helping consumers with budgeting. This involves ensuring rent and other bills are paid, groceries purchased, medication co-pays covered, and other monthly needs accounted for, thereby keeping individuals in their homes and off the streets and out of shelters. Community service providers help hold people's lives together and in turn are an integral part of holding the community together. DBH does not propose an alternative way to provide these services – they would simply be eliminated. This will impact both mental health and physical

[2] *Id*.

health and set people on a spiral of decompensation, costing residents and the District more in actual dollars and in poor outcomes.

Reduction to School Based Mental Health Services

Youth in the District already face a crisis in terms of their access to mental health care. PDS clients who are in the community and have acute mental health care needs wait weeks for intake appointments. Youth then spend weeks and sometimes more than a month on waiting lists to start treatment. For example, the Wendt Center is the District's only provider of grief therapy and it has a waiting list that is more than six months long. As Disability Rights D.C. has explained, the District provides "at most, a limited array of services on a limited basis with limited effect."[3] "…District children with serious mental health disabilities lack the community-based mental and behavioral health services necessary to enable them to remain in the community. As a result of the system's limitations, children cycle in and out of institutions—between hospitals, residential facilities and detention."[4]

Because they are minors, youths' access to treatment almost always depends on a parent being able to take them, despite the likelihood that the parent has been impacted by similar trauma and the likelihood of having competing demands from employment and other children on their time and transportation resources. Poor youth, who in the District are most often youth of color, are the most at risk of never receiving mental health treatment. A study of barriers to access for mental health services that focused on Wards 7 and 8 found that environmental factors

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[3] Disability Rights DC, *Fixing the District's Behavioral Health System, Ending the Cycle of Institutionalization and Achieving True Community Integration through Intensive Community-Based Services*. Available at: https://www.uls-dc.org/media/1258/fixing-the-districts-youth-behavioral-health-system.pdf page 4

[4] *Id*.

such as discrimination, poverty, the lack of nearby providers and facilities, and lack of access to transportation all resulted in residents receiving fewer supports and services despite having a greater need.[5] This unmet need for mental health treatment then drives school absenteeism, which only deepens the crisis by detrimentally impacting employment and life outcomes.

A critical component of addressing the behavioral and mental health care needs of District youth is providing school-based services. Budgeting for school-based behavioral health services must be expanded rather than reduced. Funds must be allocated in order to allow for providers to be sufficiently compensated in order to fill vacant provider positions. Funding increases are necessary to bring school-based behavioral health clinicians into just the 10th percentile of salaries for clinical social workers in the D.C. market.[6] An increase in funding is also required to ensure that there is at least one clinician in each school.

School-based mental health care services are essential to addressing health care access disparities and guaranteeing that all children have access to the services regardless of parent time, transportation, provider availability, insurance, and family capacity. As succinctly expressed by a senior director of behavioral health services: "The more mental health services are embedded in schools, the lower the threshold for access and the better the student outcomes."[7] DBH must prioritize funding for improved outcomes.

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[5] O. Ganz, et al., *Barriers to Mental Health Treatment Utilization in Wards 7 and 8 in Washington, DC: A Qualitative Pilot Study*. Health Equity, 2018. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6128444/

[6] See written testimony of the District of Columbia Behavioral Health Association, hearing record, FY 2025 Budget Oversight of the Department of Behavioral Health.

[7] Kate Rix, *The Benefits of Mental Health Programs in Schools*, U.S. News and World Report, November 15, 2022. Available at: https://www.usnews.com/education/k12/articles/the-benefits-of-mental-health-programs-in-schools

Thank you for the opportunity to submit written testimony on these important issues and PDS welcomes any questions the Committee may have.

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UNITY HEALTH CARE
Healthier You. Healthier Communities.

Testimony Before the Council of the District of Columbia
Committee on Health
Christina Henderson, Chair

Fiscal Year 2025 Budget Oversight Public Hearing
Department of Behavioral Health
April 10, 2024

Andrew Robie, MD
Chief Medical Information Officer
Unity Health Care, Inc.

Introduction

Good Morning, Chairperson Henderson and Members of the Committee on Health. My name is Dr. Andrew Robie, Chief Medical Information Officer for Unity Health Care ("Unity"), the largest network of community health centers in the District, serving 1 in 8 residents. I also oversee Unity's Integrated Behavioral Health program and the J. Willard and Alice S. Marriott Foundation Behavioral Health Fellowship. As a practicing Family Medicine Physician specializing in Medication Assisted Treatment/Substance Use Disorders, I am deeply committed to the well-being of our community.

Thank you for holding today's Fiscal Year 2025 Budget Oversight Hearing on the Department of Behavioral Health. I would like to begin my testimony by offering a sincere message of gratitude to the District's Department of Behavioral Health and its excellent team of professionals, led by Dr. Barbara Bazron.

I want to thank Mayor Bowser for her commitment to – and investments in – the health and well-being of District residents. As many of us have anticipated, the Mayor's proposed Fiscal Year 2025 budget for the Department of Behavioral Health exposes the financial realities of our city. During these challenging times, we are all leveraging the resources we do have to improve the lives of the individuals whom we serve.

For our part, Unity provides culturally and linguistically appropriate behavioral health services to nearly 10,000 patients per year in the City's most under-resourced communities. Services include care for depression, anxiety, trauma, serious mental illnesses, and substance use disorder (SUD). Unity is a patient-centered medical home committed to fully integrating primary care and behavioral health services to ensure coordinated care and seamless transitions for our patients. As the need for SUD treatment

grows, our primary care providers are continuously equipped with in-depth, evidence-based training in opioid addiction and SUD to manage, treat, and prevent addiction. Unity has long partnered with DBH, social service organizations, school systems, and the Department of Corrections, to boost access to comprehensive behavioral health care that evolves with patients' needs, including innovative ways to provide walk-in SUD training and implementing collaborative care models leveraging a team-based approach.

In light of the increasing demand for behavioral health care, my testimony will focus on two ways in which DBH's FY2025 budget can improve access to behavioral health services in our most under-resourced communities:

1. **Focused Funding and Support to Expand, Train, and Diversify the Workforce for Integrated Care Teams.**
2. **Increased Understanding and Financial Support for the Critical Role of Federally Qualified Health Centers (FQHCs) in Meeting the Rising Demand for Behavioral Health Care and Substance Use Disorder Services.**

Individuals of lower income and those covered by Medicaid exhibit a higher prevalence of behavioral health conditions, encompassing substance use disorders, mental health conditions, and related illnesses, compared to their counterparts with higher socioeconomic status or private insurance coverage. Moreover, these individuals are disproportionately reliant on FQHCs for their healthcare needs. For our part, we amplify the journey of my patient, Darryle Johnson. His story exemplifies the transformative impact of accessible, comprehensive behavioral health services offered by Unity. After battling for decades with addiction, exacerbated by personal tragedy, Mr. Johnson found support and guidance at Unity. Through the compassionate care provided by my team, Mr. Johnson embarked on a path toward recovery. Our holistic approach and

commitment to Mr. Johnson's well-being allowed for the development of a sustainable treatment plan, including regular visits for Suboxone. Mr. Johnson's transformation serves as a beacon of hope, illustrating the profound impact of personalized care and support offered by our health centers. His story underscores the importance of early intervention and comprehensive services in addressing the complex needs of individuals struggling with behavioral health and SUD.

1. **Focused Funding and Support to Expand, Train, and Diversify the Workforce for Integrated Care Teams.**

The District faces significant gaps in access with 16.1% of adults in D.C. reporting unmet needs for mental health care and 17.2% reporting unmet needs for substance use treatment. Workforce shortages exacerbate these challenges, with D.C. having only 97 mental health providers per 100,000 individuals, and needing at least 11 additional providers to remove the City's current Health Professional Shortage Area (HPSA) designation.[i] As reported by the Bowser Administration's Healthcare Workforce Task Force, DC's workforce shortage highlights the urgent need for strategies that enhance workforce development and expand access to quality healthcare services across the District. Outlined in their report, key recommendations to address healthcare workforce challenges in the District include expanding educational and training opportunities, enhancing workforce diversity, improving compensation and benefits for healthcare professionals, and strengthening partnerships between academic institutions and healthcare providers. The report underscores the importance of collaborative efforts to build a resilient and sustainable healthcare workforce that can effectively meet the evolving needs of the community.[ii]

In alignment with the Mayor's Healthcare Workforce Task Force, Unity has initiated several efforts to expand our behavioral healthcare workforce and increase access to District residents:

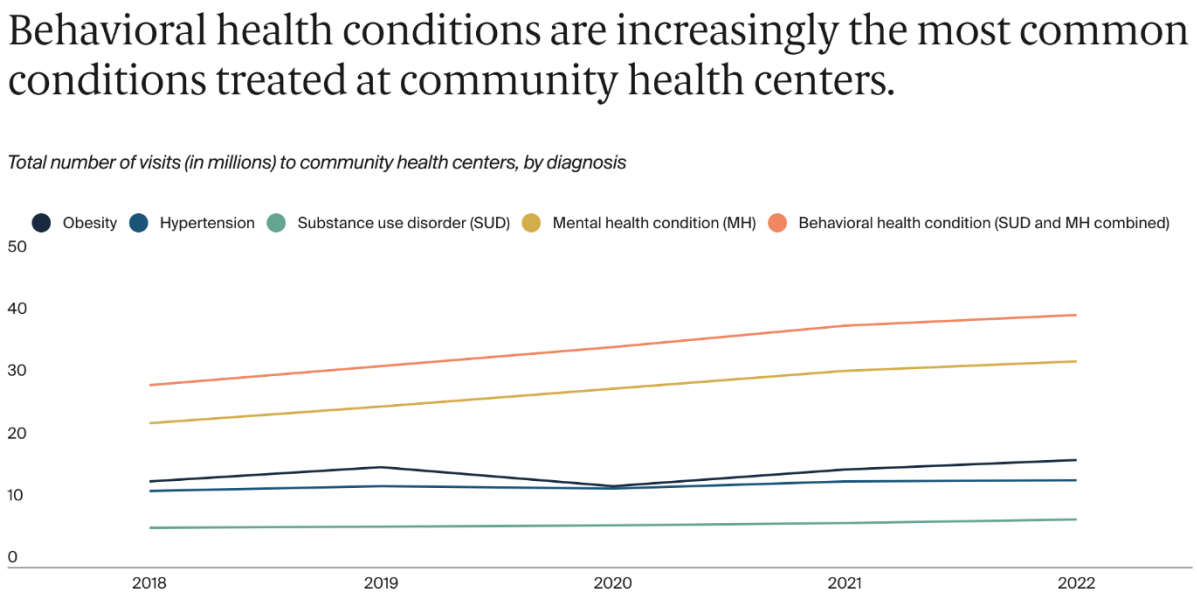
One of our most recent initiatives is the J. Willard and Alice S. Marriott Foundation Behavioral Health Fellowship Program, made possible by a multi-million-dollar grant from The J. Willard and Alice S. Marriott Foundation. This initiative is aimed at addressing workforce shortages, improving access to culturally competent mental health services in under-resourced communities, and fostering the integration of primary care and behavioral health. Unity has had to rely on private funding to launch this initiative to meet the growing demand in our City. We hope to have increased collaboration and support from the DBH to increase our capacity and expand our services. Additionally, more support from DBH to improve access to training and certification opportunities, along with increased investments in scholarships and loan repayment programs to incentivize recruitment and retention, would be beneficial.

With a mission to expand access to mental health services, particularly in Wards 5, 7, and 8, the Fellowship Program is strategically located within these severely under-resourced communities. These areas face numerous environmental factors associated with poor mental health outcomes and encounter barriers to accessing essential mental health services. Moreover, the program aims to spearhead model change by integrating and standardizing the collaboration between primary care and behavioral health and improving access and continuity of care by providing SUD treatments in various settings such as the DOC, low-barrier shelters, and Unity health centers across the District.

Despite these efforts, meeting the rapidly growing demand for behavioral health and SUD services requires a more robust, comprehensive approach. To address these challenges, we urge DBH and its sister health agencies to consider strategies that expand

the workforce, such as reimbursing for care delivered by trainees or the license-eligible workforce. However, addressing the shortages in clinical care alone may not suffice. Therefore, we also encourage DBH to explore emerging models of community-based behavioral health that can enhance the availability of behavioral health supports in the District, particularly in under-resourced communities such as Wards 7 and 8.

2. **Increased Understanding and Financial Support for the Critical Role of Federally Qualified Health Centers (FQHCs) in Meeting the Rising Demand for Behavioral Health Care Services.**



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[1] Figure 1 Notes: Substance use disorder (SUD) diagnoses include alcohol-related disorders, tobacco-use disorders, and other substance-related disorders. Mental health condition (MH) diagnoses include depression and other mood disorders; anxiety disorders, including post-traumatic stress disorder (PTSD); attention deficit and disruptive behavior disorders; and other mental disorders, excluding drug or alcohol dependence. Behavioral health diagnoses include all SUD and MH diagnoses.
Data: 2018–2022 National Health Center Program Uniform Data System (UDS) Awardee Data, Health Resources and Services Administration.

Source: Celli Horstman, "How Community Health Centers Can Meet the Rising Demand for Behavioral Health Care," *To the Point* (blog), Commonwealth Fund, Mar. 7, 2024. https://doi.org/10.26099/GPQG-ZM68

In recent years, there has been a notable surge in the demand for behavioral health care across the nation, a trend that has become increasingly evident within the District. As highlighted in a recent article by the Commonwealth Fund, federally qualified health centers (FQHCs) play a pivotal role in addressing this rising demand for behavioral health services.

CHCs provide comprehensive primary care services to individuals regardless of their socioeconomic background, catering particularly to those with low income, residing in severely under-resourced areas, or belonging to racial and ethnic minority groups. In recent years, CHCs have witnessed a significant uptick in the provision of behavioral health services, necessitating a substantial allocation of time and resources that we don't have.

Between 2018 and 2022, the number of behavioral health-related visits, including mental health and SUD care, at CHCs increased 39 percent.[iii] Unity has observed trends mirroring those described in recent years, with an increasing demand for behavioral health services among our patient population. Recognizing the diverse needs within our patient population, Unity has expanded and tailored our behavioral health services accordingly and is committed to integrating behavioral health and primary care services to effectively address this demand. As demonstrated in our testimony, we have implemented specialized programs and interventions to cater to unique groups ranging from maternal mental health, and substance use disorder treatments to serving those incarcerated and reentering our communities.

DC Preterm Birth Grant and DC Mother-Baby Wellness Program

Highlighting the significance of maternal mental health services, particularly in Wards 7 and 8 where 70% of pregnancy-associated deaths occur in the District, it's crucial to address perinatal mental health (PMH) conditions. These conditions are identified as

the leading cause of maternal mortality in the United States, accounting for 23% of such deaths, with disproportionately higher rates among Black and Native American patients. In collaboration with the DC Preterm Birth grant and DC Mother-Baby Wellness program, Unity provides mental health therapy services for pregnant and postpartum patients, ensuring timely and targeted resources for families with acute social and medical needs. Over half of Unity's prenatal patients availed themselves of these services in 2022, underscoring the impact of our commitment to accessible holistic care. This comprehensive approach to maternal mental health not only supports the well-being of mothers but also has a profound impact on the family unit and infant health, fostering healthier outcomes for all and subsequent generations.

Opioid Recovery Program

Unity's commitment to evidence-based practices is further demonstrated through our Opioid Recovery Program. The integrated behavioral health model connects primary medical and behavioral health clinicians to address mental health factors affecting well-being while reducing stigma. Meanwhile, Unity's Opioid Recovery Program offers comprehensive medication-assisted treatment (MAT), individual counseling, peer support, and case management to individuals with opioid use disorder, contributing to substance use treatment and harm reduction efforts within the community. We have opened women's and men's Wellness Units at the Department of Corrections, where we provide group therapy, Medication-Assisted Treatment, and trauma-informed care, to approximately 400 patients in an innovative setting.

Conclusion

In light of our testimony today, we urge the Council to prioritize increased support for integrated behavioral health programs and the community health centers championing them. Additionally, given the ongoing opioid crisis, we strongly advocate for

increased investment in substance use disorder (SUD) treatment and harm reduction programs to address the pressing needs of individuals struggling with addiction. Lastly, deeper investments in addressing workforce shortages to improve training, recruitment, and retention of existing and potential providers, such as removing barriers to training and certification opportunities and expanding scholarship and loan repayment programs to incentivize recruitment. These strategic investments will not only improve health outcomes but also promote health equity.

Unity remains committed to providing comprehensive behavioral health services to under-resourced communities, lowering costs for the District through preventive and robust offerings, and advancing health equity. We are dedicated to continuing our work in improving the overall well-being of all residents of the District. I want to thank you for the opportunity to provide testimony and welcome any questions.

If you have any questions or require further information, please do not hesitate to reach out to our policy lead, Fiona Mesfun, at fmesfun@unityhealthcare.org.

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[i] Bureau of Health Workforce, Health Resources and Services Administration, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2022.

[ii] DC Health, Healthcare Workforce Task Force, Report and Recommendations of the Mayor's Healthcare Workforce Task Force, as of May 2022.

[iii] Celli Horstman, "How Community Health Centers Can Meet the Rising Demand for Behavioral Health Care," *To the Point* (blog), Commonwealth Fund, Mar. 7, 2024. https://doi.org/10.26099/GPQG-ZM68

Testimony of Judy Ashburn, LPC, Director of Treatment, Samaritan Inns, Inc.
To the Committee on Health Fiscal Year 2025 Budget Oversight Hearing for the Department of Behavioral Health
April 9, 2024

Good afternoon, Chairwoman Henderson and members of the Committee. I am Judy Ashburn, Director of Treatment at Samaritan Inns (SI). Thank you for the opportunity to testify to the Committee on Health for the DBH Budget Oversight Hearing.

Samaritan Inns is one of only four remaining Substance Use Disorder (SUD) inpatient providers in Washington, DC. For the past four years we have been operating at below 50% capacity. The first two years it was due to Covid; and now the last two due to staff shortages and implementing several major changes required by DBH and DHCF. This has had tremendous financial implications for SUD residential treatment providers.

The opioid crisis rages on and with it comes an opportunity for the collective SUD provider community to unite so that we can win the war! The SUD Coalition, DC Behavioral Health Association, the Partners In Care Network and others are joining together to break down the DC silos and move DC overdoses and deaths from the top in the country to the bottom. We are asking for help in the following areas.

1) **Extended support for sober housing in a treatment environment as a demonstration project and funded by the Opioid Abatement Commission.** Inpatient treatment length of stay has been reduced by 50%. Gap funding is needed to cover room and board that would provide sober living support in a treatment environment with clients attending SUD Outpatient (OP) Treatment. This would provide more time for clients to find employment and continue mental health therapy addressing trauma, behavioral, and social issues. It would also increase the positive outcomes of SUD OP treatment as there would be greater accountability and safety in the client's living environment. **Budget needed:** 30 residential beds in Washington, DC for this gap period for $1,095,000 ($100/day for room and board = $3,000/day x 365 days in the year = $1,095,000/yr.). Clients could then transition to Single Room Occupancies (SROs) and other sober housing for longer term stays (1-3 yrs.); and then move to permanent housing for an extended continuum of care.

2) **Changing Chapter 63 regulations to increase participation of Peer Support Specialists (PSSs) and funded by the Opioid Abatement Commission.** Due to a 50% increase in high-level staff needed to provide inpatient services and documentation, the SUD provider community is asking for Peer Support Specialists (PSSs) to be able to conduct clinical services in inpatient treatment. Currently they are only able to provide Recovery Support Services (RSS) which does not count toward the 25 clinical hours required each week per Chapter 63. Clients receive the most help from PSSs as they bring a message of hope and reality from lived experience. Due to a decreasing number of Certified Addiction Counselor (CACs) in Washington, DC, it is difficult to reach the required number of clinical groups. **Budget needed:** 4 PSSs for SUD inpatient treatment providers along with a change in the Chapter 63 regulation. $70,000/yr. (including benefits) x 4 = $280,000/yr.

Thank you for the opportunity to submit testimony.

Testimony of Rachel White, Senior Youth Policy Analyst
Committee on Health
Department of Behavioral Health
Council of the District of Columbia
April 10, 2024

Good morning Chairman Henderson and staff of the Committee on Health. I'm Rachel White, Senior Youth Policy Analyst at DC Action. We use research, data, collective action, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

DC Action is home to four coalitions, including the Youth Economic Justice and Housing Coalition, which advocates with youth and youth-serving organizations in the District of Columbia for policies, funding, and programs that expand access to comprehensive support and services that youth experiencing homelessness need to successfully transition into stable and productive adulthood.

Together with our coalition partners, we have advocated for data- and accountability-driven solutions to end youth homelessness and disrupt the pipeline of young people entering into the District's adult homeless system. One way to mitigate homelessness and disrupt the trajectory of chronic homelessness is by making behavioral health supports more accessible.

The relationship between mental health and youth homelessness is complex and bidirectional, meaning that each can contribute to the other. In the District, 32% of youth experiencing homelessness reported impaired mental health. The most common diagnoses for youth experiencing homelessness include depression, anxiety, post-traumatic stress disorder (PTSD), a history of adverse childhood experiences (ACEs), and substance use disorders. These conditions contribute to homelessness, as individuals struggle to maintain employment, housing, or relationships due to mental health challenges.

Homelessness itself can be traumatic. The experience of living on the streets, in shelters, or in other unstable and unsafe environments can exacerbate mental health issues. Young people experiencing homelessness may face violence, sexual exploitation, and discrimination, all of which can lead to severe trauma. The lack of a stable and supportive social network can lead to feelings of extreme loneliness and depression. Many youth who experience homelessness may turn to substance abuse as a way to cope with the stresses and challenges of their situation, which leads to a higher risk of comorbid disorders.

Increasing access to behavioral health supports is a matter of urgency. While there are services available to unaccompanied youth experiencing homelessness through DBH, the existing supports are missing the mark as they are not fully accessible to youth experiencing homelessness. In conversations with DBH, they have acknowledged there is a gap in outreach efforts to reach youth experiencing homelessness. In addition to being unaware of the behavioral health services available to them through DBH, youth have also reported that, once they are connected to DBH, transportation is a barrier when they are referred to clinicians not in their vicinity. Often they are met with caseworkers and providers who are not linguistically and culturally competent or LGBTQ+ affirming. Youth homelessness service providers have reported there is a lack of accessible, youth-friendly, and culturally competent mental health services throughout the District, which is a major barrier to youth achieving long-term stability.

DBH behavioral health services are underutilized by youth experiencing homelessness. In 2022, DBH's programs provided behavioral health care to just 288 16 to 24 year olds experiencing homelessness, despite the District serving almost 1,700 youth in this age range through its homeless services operations. And the count of 1,700 does not include youth who are *not using* District shelters or other services. This large service gap further endangers unhoused youth, given their vulnerability and complex mental health needs.

Youth experiencing homelessness need consistent and proactive access to mental health services, such as DBH-hired or -funded counseling services embedded in youth drop-in centers and shelters, as well as counselors that can travel to a client on a regular basis, rather than making a young person come to them. The creation of a continuous care model designed to meet youth experiencing homelessness where they are will help reduce reliance on crisis response.

Lastly, despite there being over 8,000 youth experiencing homelessness within DC Public and Charter schools, and 57% of homeless students reporting higher rates of depression compared to 43% of housed students nationally, the mayor has decreased the School Based Behavioral Health (SBBH) program budget by $9.97 million. We stand in solidarity with Strengthening Families through Behavioral Health and urge the Council to restore funding to sustain compensation for school-based behavioral health clinicians and to make targeted investments to bolster other elements of the SBBH Program to enhance its reach and efficacy.

In closing, we are asking the Committee on Health to :

- Allocate funding to increase DBH's capacity to provide targeted outreach to youth experiencing homelessness to increase access to services.

- Coordinate with the Committee on Housing to share committee funds to increase funding for youth homelessness providers' contracts to expand capacity for embedded mental health services. Similarly, DBH could work with DHS to facilitate partnerships with these service providers to bring DBH-hired clinicians physically into youth housing programs on a regular basis to create a quasi-embedded model of mental healthcare where hiring and supervision are not falling on under resourced nonprofits.
- Allocate additional resources to DBH in this budget, to develop and execute a plan to increase the number of behavioral health professionals in the district that is akin to the District's targeted efforts to entice individuals to join the police force, including hiring bonuses, housing assistance, career pipelines, and access to vehicles.
- Allocate $1.7 million to fund a traveling behavioral health unit to bring services to youth experiencing homelessness where they physically congregate.

Making DBH services more convenient and proactive for youth experiencing homelessness would help youth transition seamlessly into DBH's broader array of community services for long-term support that can help address youth trauma, substance abuse, and medication management, all of which will decrease the likelihood of sustained or future homelessness. Recognizing that the children, youth, and families served by the public behavioral health care system in the District are primarily individuals of color, improving our system is a matter of equity. Improved access to behavioral health services is proven to be transformative for children and families and can boost the long-term overall health and productivity of communities.

Thank you for your time and consideration. I would be happy to answer any questions.

Rachel White, JD

Senior Youth Policy Analyst, DC Action

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KIPP DC
PUBLIC SCHOOLS

Testimony Before the Council of the District of Columbia

Committee on Health

at the Budget Oversight Hearing on the

Department of Behavioral Health

By Melissa Wade

Managing Director of Mental Health, KIPP DC

April 25, 2024

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Chair Henderson and Members of the Council Committee on Health,

My name is Melissa Wade and I serve as Managing Director of Mental Health at KIPP DC, where I work closely with mental health clinicians, partner organizations, and school leaders at our network's twenty-two schools and programs to provide students with meaningful access to mental health services and supports.

I would like to submit the following written testimony on the proposed Fiscal Year 2025 Department of Behavioral Health (DBH) budget. The proposal would cut $4.8 million from the School-Based Mental Health budget by eliminating vacant clinician positions and cut $700,000 by eliminating the School-Based Mental Health Community of Practice. **While KIPP DC fully understands the extreme pressures of this year's budget, we ask the Council to consider the significant negative impact that these cuts could have on student academic success and wellbeing across the District.**

For the past 2 years I have come to this committee to share that the need for school-based mental health services was at an all-time high and that we would have to increase the number of available clinicians in order to adequately serve that need. Earlier this year I was excited to share that in partnership with our Community Based Organizations (CBOs), Mary's Center and Catholic Charities, we have increased clinician staffing by 80% from a year ago and were only 3 hires away from being fully staffed at our schools. This added capacity has allowed the program to serve more than double its available caseload from a year ago. These are significant and meaningful improvements.

We continue to work with our CBO partners to find new and creative ways to fully staff the program. However, those efforts will be in vain if vacant positions are swept and all hiring is frozen. Schools that have historically not been served due to hiring challenges will continue without a needed clinician. Hiring for these positions continues to be challenging and I understand the inclination to balance the budget by cutting positions that have remained unfilled for multiple years. However, **I hope that the Council will see the efforts that schools, DBH, and CBOs have been making and retain funding for at least some of the positions as our hiring practices continue to improve and student need continues to be high.**

The number of student referrals to the mental health team has more than doubled over the past year. KIPP DC has invested heavily in our internal team of Mental Health Practitioners. However, even with that expanded capacity, we cannot serve every student in need of support. We continue to rely on this program to meet the mental health needs of our students.

Thank you to the council committee for including these comments in the record as you deliberate on this year's budget. I know that the coming year presents many budget challenges and I appreciate our shared belief that DBH's school-based mental health program is critically important, continuing to improve, and needs our continued support.

Statement on behalf of the American Civil Liberties Union of the District of Columbia
before the
D.C. Council Committee on Health Budget Oversight Hearing
by
Michael Perloff
April 24, 2024

Chairperson Henderson:

If last year's estimates are any guide, tens of thousands of mental health crises will occur in the District this fiscal year, including PTSD episodes, suicide attempts, and hallucinations.[1] How will our community respond? We fear not well enough.

The problems start when someone calls the District for help. Most D.C. residents seek assistance with a mental health crisis by dialing 911, and 911 staff respond to most mental health calls by dispatching the Metropolitan Police Department (MPD).[2] The District continues to limit the number of 911 calls diverted from police to the Access Helpline, a call center staffed with mental health professionals who can de-escalate crises over the phone or deploy Community Response Teams (CRTs) or Child Adolescent Mobile Psychiatric Services (ChAMPS) to do so at the scene. In FY23, Office of Unified Communications (OUC) routed only 644 mental health emergency calls to that service[3]—less than 2% of the total number of mental health emergency calls 911 ordinarily receives[4] and a small increase over the 470 calls diverted from 911 in FY22.[5]

The District's heavy reliance on MPD makes it unlikely that people with mental health disabilities will receive effective care and exposes them to serious risks of harm. "People with mental illnesses are not more likely to be violent than the general public,"[6] and yet, nationally, police use force against people with serious mental health disabilities 11.6 times more often than

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[1] D.C. Crisis Response Coalition Policy Platform 2 (April 2023) (stating that the District received over 36,000 911 calls primarily or exclusively involving mental health emergencies in FY2022), https://static1.squarespace.com/static/63ff8a6ed33bd4177c2715e6/t/6448e019a4f03d04b9b80cdb/1682497563516/D.C.+CRISIS+RESPONSE+COALITION+POLICY+PLATFORM+Cover+and+back.pdf

[2] *Id.*

[3] D.C. Dep't of Behavioral Health FY 2023 Performance Oversight Pre-Hearing Questions 112.

[4] *See* D.C. Crisis Response Coalition Policy Platform, *supra* n.1

[5] D.C. Dep't of Behavioral Health Responses to FY 2023 Performance Oversight Pre-Hearing Questions 112.

[6] Council for State Governments, Addressing Misconceptions about Mental Health and Violence 1 (Aug. 2021), https://csgjusticecenter.org/wp-content/uploads/2021/08/CSGJC_Field-Notes_Addressing-Misconceptions-about-Mental-Health-and-Violence_2019-MO-BX-K001_508.pdf; *see also* John S. Rozel & Edward P. Mulvey, The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice, 13 Annual Rev. of Clinical Psych. 445, 448 (2017), https://www.annualreviews.org/doi/pdf/10.1146/annurev-clinpsy-021815-093459

against other individuals,[7] and kill people with serious, untreated mental health disabilities at 16 times the rate they kill others.[8] Black people suffer the most from these disparities. For instance, nationwide, the *majority* of Black people with disabilities have been arrested by age 28, double the rate of the white disabled population.[9] Even when police do not use force or make arrests, D.C. mental health professionals tell us that they rarely see police provide appropriate or effective care. Thus, it is unsurprising that the D.C. Police Reform Commission, the D.C. Crisis Response Coalition, the Substance Abuse and Mental Health Services Administration, and even the Department of Justice have all called for relying on mental health professionals, rather than police, as the default first responders for mental health crises.[10]

Achieving this goal will require the District to employ more mental health professionals capable of responding to crises in person or over the phone. Workforce issues may not entirely explain the limited number of diversions to the Access Helpline (and therefore away from MPD), Other factors, such as restrictions on calls that are eligible for diversion and the need to improve training for OUC staff may contribute too. In the long run, though, staff capacity will be crucial.

Despite the great need for mental health professionals, the District has many unfilled positions. As of this past January, Access Helpline had 10 vacancies and CRT had 18, meaning that CRT operated at only 60% capacity.[11] The shortages help explain DBH's report that CRT took, on average, 91 minutes to arrive at the scene of Priority 1 mental health calls, despite a target response time of 30 minutes.[12] These delays result in concrete harm: According to local mental health professionals, when people in crisis wait extended periods for service, they often decompensate, withdrawing or becoming agitated in ways that will ultimately make it more difficult for them to receive care.

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[7] Ayobami Laniyonu & Phillip A. Goff, *Measuring disparities in police use of force and injury among persons with serious mental illness*, 21 BMC Psychiatry 1, 6 (2021), https://doi.org/10.1186/s12888-021-03510-w.

[8] Doris Fuller et al., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters*, Treatment Advocacy Center 1 (Dec. 2015), https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf.

[9] Erin McCauley, The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender, 107 Amer. J. of Public Health 1977 (Nov. 8, 2017), at https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304095

[10] *See* D.C. Police Reform Commission, De-Centering Policing To Improve Public Safety: A Report of the D.C. Police Reform Commission 36 (April 2021), https://dccouncil.gov/wp-content/uploads/2021/04/Police-ReformCommission-Full-Report.pdf; D.C. Crisis Response Coalition Policy Platform 4; SAMHSA, Nat'l Guidelines for Behavioral Health Crisis Care Best Practice Toolkit 13-23 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf; DOJ and Dep't of Health & Human Servs. Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities 3–4 (2023),https://www.justice.gov/d9/202305/Sec.%2014%28a%29%20%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf

[11] D.C. Dep't of Behavioral Health Responses to FY 2023 Performance Oversight Pre-Hearing Questions 7, 112.

[12] *Id.* at 7

We appreciate that the Department of Behavioral Health's (DBH) has made efforts to hire more staff. But there is much more recruitment work to do. For example, as of today, neither DBH's website, nor the District's career page, lists any open jobs specifically for CRT or the Access Helpline. (All the postings on DBH's career page state that the opening closed in 2022.[13] And, on D.C.'s career page, the closest position we could find was Job ID 25753, which conducts assessments for the Community Services Administration/Adult Services and makes referrals to programs such as Supported Employment.[14] The posting made no reference to CRTs.) Filling existing vacancies requires not only making the most of existing resources but also exploring creative strategies to encourage applications. The District must ensure DBH has the budget needed for this crucial promotional work.

Effective mental health crisis services extend beyond telehealth and in-person response, as some mental health crises cannot be resolved on the phone or at the scene. The Roadmap to the Ideal Crisis System, a white paper prepared by national experts on mental health crisis systems, recommends that communities develop three categories of places for people to go when they need additional care. First, behavioral health urgent cares (akin to medical urgent cares) serve individuals seeking voluntary assistance before a crisis becomes acute.[15] These programs offer individuals the opportunity to speak with a mental health professional about their symptoms, receive updated prescriptions, and receive connection to follow up care.[16] Second, crisis centers act as specialized emergency rooms for mental health crises. They serve people experiencing all forms of mental health crises—including people arriving both voluntarily and involuntarily—and provide comfortable environments for people to stabilize, undergo short-term observation, and receive medication and therapeutic interventions.[17] Finally, residential crisis programs provide extended care (usually up to a few weeks) for people who "do not need the full resources of a psychiatric inpatient unit or other secure treatment setting," but still need require supports.[18] Residential crisis programs come in three forms: high-intensity programs serve as "hospital step-downs" that "can shorten the length of [hospital] stay;" low-intensity "respite" programs serve people on the verge of crisis or people who exiting intensive care who still need a bit of support; and intermediate facilities accommodate people whose needs fall between those seeking aid at the other two.[19]

The ACLU-DC is currently working with a team of experts and community members to assess the extent to which the District provides these services. Our research is not yet complete but based on preliminary findings, we believe that, when it comes to providing people in crisis a place to go, the District has significant gaps. For example: the District's behavioral health urgent cares

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[13] D.C. Dep't of Behavioral Health, Employment Opportunities, https://dbh.dc.gov/employment-opportunities-0 (last accessed April 24, 2024).

[14] D.C..Gov, Behavioral Health Assessor, https://careers.dc.gov/psc/erecruit/EMPLOYEE/HRMS/c/HRS_HRAM_FL.HRS_CG_SEARCH_FL.GBL?Page=HRS_APP_JBPST_FL&Action=U (last visited April 24, 2024).

[15] Nat'l Council for Mental Wellbeing, Roadmap to the Ideal Crisis System (March 2021) 100, https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/

[16] *Id.* at 101

[17] *Id.* at 89–90. The Roadmap notes that, in some cases, people in crisis will need to receive care at traditional emergency rooms. *See id.* at 88–90.

[18] *Id.* at 108

[19] *Id.* at 108, 111–12

are open for far fewer hours than experts believe are required; community members dread referrals to the District's primary crisis center, the Comprehensive Psychiatric Emergency Program (CPEP); and the District has no crisis centers or residential crisis programs for children and adolescents. The D.C. Stabilization Center, which opened last year, represents a positive development; however, it focuses largely on substance use crises as opposes to mental health ones.

We look forward to sharing the results of our research on the District's emergency mental health facilities, and, more generally, collaborating with the Council and the administration to bolster the services D.C. provides people in crisis—work that is essential to ensuring the thousands of District residents with mental health disabilities receive the care they need and deserve.

DisordeRThePlay.blogspot.com
"DisordR, The Play," about Pakrat Patty, the self-identified Hoarder who comes out of the Clutter closet uses humor to educate about Mental Health. Stop stigma, & advocate Recovery. http://mentalhealthsf.org/join-us-18th-conference-on-hoarding-cluttering/

Hilary Kacser

SAG-AFTRA Actor, Educator, Speaking Coach, Advocate

(she/her/hers;
last name: “KACK-sir”)

TESTIMONY FOR
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH

Councilmember Christina Henderson, Chair
Fiscal Year 2025 Budget Oversight Hearing
Department of Behavioral Health
Hearing: April 10, 2024, Testimony Submitted: April 25, 2024

DC Council Committee on Health Chairperson Councilmember Christina Henderson, and Councilmembers of the Committee on Health and Staff, Thank you for this opportunity to submit written testimony about the Department of Behavioral Health’s FY24 budget to you. I am Hilary Kacser, a DC resident, product of DC Public Schools, and long time District advocate for behavioral health.

Hoarding disorder has been defined as a behavioral health diagnosis by the American Psychiatric Association in the DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders) ***for over a decade***.

Most important would be for Councilmember Committee on Health Chair Henderson and the Committee on Health to:

- Ask Dr. Bazron and DBH what behavioral health supports and services -- if any -- DBH are directly providing for people in the District living with a diagnosis of "hoarding disorder" (HD)!

What is DBH doing for HD?

Especially in this tight budget, early DBH intervention would be a cost saving -- not to mention life saving.

A small investment -- in training DBH providers to recognize and mitigate harm (to the person with lived experience, to family members, to neighbors, to the

community at large, including to our brave and essential first responders) associated with symptoms of HD -- would save significant taxpayer funds.

DBH should spend a little money to do a training on evidence based Peer Response Team treatment approach to the diagnosis "hoarding disorder." Low cost funding for DBH for peer training for HD would save money, and additionally provide early intervention and harm reduction. **"Randomised clinical trial of community-based peer-led and psychologist-led group treatment for hoarding disorder"** concludes, "Peer-led groups were as effective as psychologist-led groups, providing a novel treatment avenue for individuals without access to mental health professionals." https://pubmed.ncbi.nlm.nih.gov/30083381/

How about $50,000 for one week for stakeholders, including our Certified Peer Specialist cohort?

Such a low cost training would represent a stark contrast to what DBH do now. Now, DBH refer folks living with HD out to Adult Protective Services.

APS is not a health care agency and does not provide behavioral health services for HD, which is a medical, health diagnosis. APS work for HD is emergency, crisis, triage intervention — far costlier than if DBH provided early intervention.

- APS performs costly heavy duty clean out,
- APS places people living with this untreated HD diagnosis under costly guardianships, and
- APS houses people living with late stage, crisis HD in costly long term nursing care.

All of the above come at exceedingly high cost – both in dollars, and also in trauma for the person living with the health diagnosis -- just because the individuals did not receive timely behavioral health support that could reduce harm long before the case of HD reaches Stage Four.

DBH fashions itself as person centered, trauma informed, and recovery based. Where are these essential features of care for folks living with HD?

Same with FEMS.

FEMS carries an unnecessarily large financial burden, because DBH inaction means FEMS face situations resulting from untreated HD diagnosis when the symptoms have reached Stage 4 emergency. Waiting until Stage 4 -- instead of providing trauma informed, person centered and driven, early behavioral health support -- costs DC taxpayers far more dollars -- and far more human capital.
HD support not only saves money for FEMS, but also reduces harm for FEMS first responders and for DC residents.

If DBH won't address early intervention that could prevent a bad -- and costly -- outcome, 911 is not activated until it is too late.
"1 in 40 people in the US has a hoarding disorder," says December 21, 2023, National Geographic article, and people living with this diagnosis "are compelled to hold onto the majority of their belongings, even when doing so means severely cluttered surroundings that decrease their quality of life and jeopardize their safety through increased risk of fire, mold or rodent infestation, ..." (https://www.nationalgeographic.com/premium/article/new-virtual-reality-hope-hoarders-declutter-clean)

FEMS pays the price for DBH lack of early intervention -- or any behavioral health intervention -- costing FEMS, not only in dollars, but also in life and limb.

An article in ***Fire Fighter Quarterly***, called "**Hoarder Fires Pose Special Risks For Firefighters,"** says:

- Containing a fire in a home where hoarding is an issue can take twice as many fire fighters and twice the time.
- Fire fighters are discovering that — treasure or trash — too much of it packed into a structure will turn all of it into one thing: dangerous fuel.
- Fire fighters … are increasingly battling fires made vastly more dangerous by hoarding.
- Fire fighters in communities across the country say they are seeing more home dwellers packing their living spaces with stuff.
- Hoarding poses a dangerous challenge for fire fighters professionally committed to saving lives and property.
- Psychologists say that hoarding often is a symptom of deep-rooted mental trauma.
- Hoarders hail from across the economic spectrum.

https://www.iaff.org/wp-content/uploads/Fire_Fighter_Quarterly/2012-Jul- Aug.pdf

How many car wrecks do we need in order to put in a traffic light?

Finally, this testimony very much thanks this Committee on Health, Committee Chairperson Councilmember Christina Henderson, and committee staff for your receptivity to these important behavioral health concerns. The much appreciated and essential efforts on the part of this committee and committee staff must continue, so as to obtain detailed answers specifying what actual HD services DBH provides, beyond generalized assertions of ability to provide services and support to those struggling with HD through the DBH provider network. In point of fact, DBH Core Service Agencies have no mandate whatsoever from DBH to address HD, and front line, in home care providers, the Community Support Workers, have no support, no guidance, and no training in HD behavioral healthcare services.

Thank you again for this opportunity, and this witness is grateful to answer questions from you.

--END--

Good Afternoon, DC Council Committee on Health Councilmembers and Committee Chairperson Councilmember Henderson.

My name is Liza Chapkovsky. I am a therapist and case manager here in Washington DC. I work mostly with seniors and happen to specialize in hoarding disorder.

My business partner and I are wondering if there are any opportunities to work with DBH to be able to assist a broader scope of clients who have hoarding disorder.

In my 10+ years as a social worker (at Iona Senior Services and in my own private practice) I have come to realize just how common hoarding disorder is (especially among the older adult population). In this way, I have also noticed a deficit of resources available to assist clients in an ongoing manner and I would like to be able to dedicate more time and energy into supporting these clients.

Thank you for your time.

LIZA CHAPKOVSKY
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COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH

ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Department of Behavioral Health

And

DC Health

ON

Thursday April 11, 2024, 9:30 A.M.
Hybrid in Room 123 and Virtual via Zoom
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Department of Behavioral Health

1. Dr. Barbara J. Bazron, Director of DC Health

DC Health

1. Ayanna Bennett, Director of DC Health

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

Fiscal Year 2025 Budget Oversight Hearing

Testimony of
Barbara J. Bazron, Ph.D.
Director

Before the
Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson, Chairperson

April 11, 2024
9:30 a.m.

John A. Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

Good Morning, Chairperson Henderson, Councilmembers, and Council staff.

I am Dr. Barbara J. Bazron, Director of the Department of Behavioral Health (DBH). With me today is Adran Reid, Agency Fiscal Officer, Michael Neff, Chief Operating Officer, and Mark Chastang, Chief Executive Officer at Saint Elizabeths Hospital.

I am pleased to testify before you today on Mayor Muriel Bowser's proposed Fiscal Year 2025 budget that invests not only in a safer, stronger DC right now, but also looks ahead and includes investments that will accelerate our comeback and increase our capacity to make big investments in the outyears of our financial plan.

The Mayor's budget continues strategic investments in behavioral healthcare that allows DBH to maintain and expand its core functions to meet the needs of residents with serious and persistent mental illness and substance use disorders who rely on the public behavioral health system for quality care. Residents receive treatment and recovery supports primarily through the DBH-certified network of community-based providers. DBH provides crisis services, operates adult and child urgent care clinics, and manages Saint Elizabeths Hospital which provides 24/7 inpatient psychiatric care. As the state behavioral health authority, we also are responsible for addressing the mental wellness of all District residents.

Under the leadership of Mayor Bowser and the guidance of Deputy Mayor Wayne Turnage, DBH supports healthier and stronger communities by working to prevent the onset of mental and substance use disorders and providing a range of community-based treatment services and recovery supports.

Mental health is health. A person's mental health can change over time, depending on many factors and changing circumstances. Gun violence and safety concerns place additional stress for too many in our communities.

In FY 24, nearly 43,500 people received behavioral health treatment through DBH.
Mayor Bowser's proposed budget for DBH addresses the increased need and ensures that residents can get connected to the care they need—by phone, at home, in school or in the community. The proposed FY 25 budget continues supports started during the pandemic to meet the needs of residents with moderate or mild depression and anxiety.

The proposed FY 25 budget supports the transformation work underway with our partners to provide residents with an integrated, high quality, more equitable, culturally sensitive public health system and to address the mental health needs of all residents.

This transformation supports better care coordination and case management essential to whole person care to achieve optimal health. It also strengthens the provider network to support enhanced quality of care. The intended outcome of our transformation efforts is healthier people living longer, more fulfilling lives.

I will now present an overview of the proposed FY 2025 budget for DBH. We provided responses to the Committee's pre-hearing questions, and we appreciated the collaboration with Committee staff.

FY 25 Budget Overview

DBH's FY 25 budget formulation is driven by our absolute commitment to focus on our core mission, fund approved rate adjustments made in FY 23 and FY 24, and maintain essential services. The Mayor's proposed budget for DBH reflects these priority areas.

The proposed FY 25 gross operating budget is $385,536,240 which is a slight increase over the FY 24 approved budget. The proposed FY 25 capital budget is $7,280,000 for facilities projects at Saint Elizabeths Hospital.

Before I get into details of our budget, I want to take a moment to put our department and our budget in context. Just as we are requiring providers to achieve national accreditation to enhance the quality of care, we also are seeking accreditation for government operated services—our early childhood program, crisis services and the adult urgent care clinic.

In our close out meeting the Commission on Accreditation of Rehabilitation Facilities (CARF) team was amazed at the range of services provided including our unique 24/7 crisis response team. They also were impressed with the knowledge and dedication of our employees and the number of psychiatrists. They said they would love to hire some of them! I couldn't have been more proud.

These achievements are due to the historic investments by Mayor Bowser and the Council as well as past Mayors and Councils. I especially want to acknowledge Councilmember Gray who established the Department of Behavioral Health in 2013 to integrate treatment for mental health and substance use disorders for better health outcomes.

I will share a few budget highlights and provide more detail in our discussion.

- $53.9 million for mental health services which will support $180 million in services when matched with federal dollars

- $23 million in local behavioral health services for residents without insurance

- $28.9 million to maintain supported housing for about 1,700 residents

- $52.6 million for substance use disorder services

- $21.7 million for crisis services for children and adults. I note that since the launch of the three-digit 988 Suicide and Crisis Lifeline in July 2022, calls have increased by 76 percent.

- $50.4 million to support children, youth and families that includes $7.3 million for prevention and early identification services, and

- $112 million to support Saint Elizabeths Hospital

I would now like to discuss Mayor Bowser's enhancments to the proposed budget:

- $17.3 million for local matching funds for Medicaid eligible behavioral health services for a total of nearly $53.9 million. This amount will support nearly $180 million in total services when matched with federal dollars. The proposed increase supports new services including clinical care coordination and evaluation and management services and increased utilization. The additional funds also continue rate increases begun in the last two fiscal years for 22 services including nine evidence-based practices for children and youth.

- $4.9 million in local funds to stabilize funding for the Community Response Team, crisis services, and Intensive Care Coordination with the end of ARPA funding.

- $4.3 million for contractual obligations related to collective bargaining agreements and overtime costs within Saint Elizabeths Hospital.

- $2.5 million for CPEP to support 10 FTEs

- $1.8 million for additional services at 25 schools with the highest needs through grants to CBOs, and

- $600,000 to continue three targeted behavioral health outreach pilots in Wards 1, 5 and 7 established by the Council with one time funding in FY 24.

I will now detail the decreases in the proposed budget that result in major savings that allow us to make the best use of our funds and resources.

- $11.6 million to realign community support to reflect utilization trends. Upon enrollment, everyone will receive automatically 200 units or 50 hours of community support for a 180-day period. Another 200 units will be automatically granted with an updated treatment plan. Currently, 90 percent of consumers use less than 400 units a year. I want to emphasize that no one will be denied needed care. Additional units will be granted based on clinical guidelines.

- $5.9 million reduction in fixed costs and telecommunications.

- $4.8 million in the school-based program savings. The savings are funds that have gone unused for schools that have never been matched with a community-based organization and schools that have been unable to recruit a clinician.

Let me be clear, $28 million remains in the school-based program to support services and supports for all 254 schools as we re-imagine the service delivery model. This decrease does not affect any existing school partnerships or impact the funding of any existing school-based clinicians. I look forward to discussing this in more detail.

- $2.1 million due to the elimination of 31.1 vacant FTEs.

- $922,833 with the discontinuation of Urgent Care Clinic located at DC Superior Court due to low utilization.

Support for Children and Families

The proposed FY 25 budget continues support for children and families at home, in school, and as needed during crises. Children and young people have been particularly impacted by the pandemic as disruptions in routines and relationships have led to increased social isolation, anxiety, and learning loss. Studies show that use of social media also has created anxiety and depression for some young people as it presents a warped view of reality and presents challenges with body image and self-esteem.

The proposed funding of $28 million for the school-based program will support all 254 schools with more effective use of our clinicians and better interface with the school-hired behavioral health team in each school that could include the school social worker, a lead teacher, a school nurse, and a parent and is led by the School Behavioral Health Coordinator.

To guarantee the delivery of prevention and early intervention services that are not eligible for Medicaid reimbursement, DBH today provides $80,819 per clinician for salaries. The funds also support workforce development and supervisory support. This number will not change in the proposed FY 25 budget.

I am excited about reimagining the model and evaluating two pilots now underway that give more flexibility and ensure we are using our significant resources in the most effective way to reach the students and families who need support.

Update on LiveLongDC Plan

The FY 25 budget includes authority for $36 million in the State Opioid Response Program Live.Long.DC which supports evidence-based prevention, harm reduction, treatment, and recovery strategies to fight the opioid epidemic. The budget also includes authority for $14 million for the Opioid Settlement Fund in anticipation of additional revenue. While the dollar amount may change, the authority will allow us to spend once the budget is approved.

Driven by the deadly synthetic fentanyl, opioid overdose deaths continue to climb. The Chief Medical Examiner reports that 518 overdose deaths in 2023—the majority were DC residents and most in their own homes or the homes of family and friends. We are steadfast in our resolve to reduce opioid use and related deaths. During 2023, Fire and EMS and community partners

report about 8,500 suspected overdose reversals using naloxone—that's hundreds and hundreds of lives saved, often the lives of people who had no idea their drugs contained fentanyl.

DC is leading the nation in the distribution of free Naloxone. Free to anybody. We are doubling down on making naloxone easy to get at home, in schools, pharmacies, community sites and faith homes because we know it saves lives.

When our community-partners distribute the harm reduction tools, they also engage with users and build relationships and trust that might get them to start or restart treatment.

Support for Consumer Leadership and Peers

I want to end my testimony as always by recognizing the essential leadership of peers and their integration throughout the system of care supported by the proposed budget. Three in person peer certification trainings are scheduled each year. Peer specialists now work in the provider network with treatment teams, in community hospital emergency departments, our emergency care facility, and at Saint Elizabeths Hospital. Consumers conduct the annual consumer satisfaction survey. In addition, DBH funds four peer operated centers.

In conclusion, Mayor Bowser's proposed FY 25 budget for DBH provides ongoing and new investments that support the opportunity for residents with behavioral health needs to live longer, healthier lives.

Madam Chair, we appreciate our partnership and the work of the Committee and look forward to our continued work together. I am ready with my team to answer any questions. Thank you.

ATTACHMENT
J

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
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https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Department of Behavioral Health

In-Person

1. Anne Amber Rieke, Children's Law Center
2. Kerry Savage, Senior Director of Policy and Advocacy, PAVE
3. Jaclyn Verner, Supervising Attorney, Disability Rights DC at University Legal Services
4. Kristin Ewing, Policy Counsel, DC Appleseed Center for Law and Justice
5. Leonard Stevens, Public Witness

6. Ann Chauvin, Executive Director, Woodley House
7. Rachel White, Senior Youth Policy Analyst, DC Action
8. David Freeman, PsyD, Senior Director, Community Connections
9. Marie Morilus-Black, CEO, MBI Health Services LLC
10. Johnny Bailey, Hot Spot Manager, HIPS
11. Brianne Dornbush, Executive Director, District Bridges
12. Patrick Canavan, Capital Integrated Care, LLC
13. Dario Martinez, Director of Community Navigation, District Bridges
14. Fredericka Ford, Public Witness
15. Jamese Johnson, Youth, DC Doors
16. Lanai Buskey, Youth, DC Doors
17. Amaya Cook, Youth, DC Doors
18. Rob Hofmann, State Policy Manager, American Atheists

Virtual

19. Mark Robinson, FMCS, Inc.
20. Nicole Travers, Senior Director of School Support & Program Data, DC Charter School Alliance
21. Hilary K., Public Witness
22. Tifphane Riley, Deputy Director, Wanda Alston Foundation
23. June Crenshaw, Executive Director, Wanda Alston Foundation
24. Dominique Moore, PAVE
25. Quiana Lamons, PAVE
26. Simone Scott, PAVE

27. Andrea Jones, PAVE

28. Katrice Fuller, PAVE

29. Mark LeVota, Executive Director, District of Columbia Behavioral Health Association

30. Shane Sullivan, Harm Reduction Coordinator, HIPS

31. Laura Mainzinger School-Based Mental Health Therapist, Latin American Youth Center

32. Gregory Anthony Dear Jr, Public Witness

33. Patricia Quinn, Vice President, DC Primary Care Association

34. Jamila White, Public Witness

35. Elizabeth Mohler, Social Services Department, Latin American Youth Center

36. Sarah Goldman, Public Witness

37. Andrew Robie, MD, Chief Medical Information Officer and Vice President of Population Health, Unity Health Care, Inc.

38. Philip Carpenter, Public Witness

39. Seojin Kim, Public Witness

40. Carmen Brito, Public Witness

41. Christy Respress, President & CEO, Pathways to Housing DC

42. Will Doyle, Vice President of Housing First, Pathways to Housing DC

43. Shannon Walsh, Clinical Director, Pathways to Housing DC

44. Joel Cohen, Psychiatrist, Pathways to Housing DC

45. Nyla Anderson, Youth Advocate, Young Women's Project

46. Nadia Gold-Moritz, Executive Director, Young Women's Project

47. Denzel McKinley Ibilunle, Youth Advocate, Young Women's Project

48. Michael Massey, Public Witness

49. Betty Gentle, Senior Advocacy and Community Engagement Specialist, SOME, Inc.

50. Dr. David Freeman, PsyD

51. Ayominde Miller-Aganyemi, Youth Advocate, Young Women's Project

52. Morgan Smith-Davis, Youth Advocate, Young Women's Project

53. Tyesha Andrews, PAVE

54. Sharnetta Boone-Ruffin, PAVE

55. Takia Shire, PAVE Parent Leader

56. Katrice Fuller, PAVE

57. Karla Reid-Witt, PAVE

58. Sarah Venable, SPACEs In Action

59. Carolyn Babendreier, Public Witness

60. Judy Ashburn, Program Director, Samaritan Inns

DC Health *(12 noon or immediately following the DBH budget hearing)*

In-Person

61. Mary Katherine West, Program Manager for Early Childhood, DC Action

62. Leah Castelaz, Policy Attorney, Children's Law Center

63. Alexander Moore, Chief Development Officer, DC Central Kitchen

64. Fernanda Ruiz, Public Witness

65. Rachel Johnston, Chief of Staff, DC Charter School Alliance

66. Sarah Buckley Fernanda Ruiz, Public Witness

67. Deja Williams, SPACEs In Action

68. Hope Joyner, Organizer, SPACEs In Action

69. Destynee Bolton, Childcare Organizer, SPACEs In Action

70. Dean Brenner, Chairman, National Capitol Area Chapter Board, Alzheimer's Association

71. Camila Perez, Family Support Worker , Mary's Center

72. Shellie Bressler, Secretary, DC Tobacco Free Coalition

73. Deja Williams, Health Equity Organizer, SPACEs In Action

74. Kristin Ewing, Policy Counsel, DC Appleseed Center for Law and Justice

75. Jacqueline Bowens, President & CEO, DC Hospital Association

76. Nathaniel Beers, Executive Vice President of Community and Population Health, Children's National Hospital

Virtual

77. Carrie Stoltzfus, Executive Director, Food & Friends

78. Casey Dyson, Food & Friends, Inc.

79. Travis Ballie, Public Witness

80. Peter Wood, ANC 1C03

81. Micaela Deming, Policy Director DC, Coalition Against Domestic Violence

82. Abayea Pelt, Senior Director of Maternal and Child Health, Community of Hope

83. April Weeden, Director, Perinatal Services, Community of Hope

84. Stephanie Maltz, Public Witness

85. Luis Chavez, Director of Operations and Community Engagement, The Family Place

86. Teresa Williams, Public Witness

87. Melody Webb, Executive Director, Mothers Outreach Network

88. Camelia Belt, Public Witness

89. Kowshara Thomas, Executive Director, Joseph's House

90. Hugh Mighty, SVP of Health Affairs, Howard University Hospital’s Centers of Excellence

91. Ruth Pollard, President and CEO, DC Primary Care Association

92. Ryan Buchholz, MD, Chief Medical Officer, Unity Health Care, Org.

93. Juanita Blassingame, Market Champion, FRESHFARM

94. Kimberly Price, Market Champion, FRESHFARM

95. Marie Brown, Market Champion, FRESHFARM

96. Hugo Mogollon, Executive Director, FRESHFARM

97. Alex Baca, D.C. Policy Director, Greater Greater Washington

98. Heidi Ellis, Coordinator, DC LGBTQ+ Budget Coalition

99. Lily Horn, Public Witness

100. Chyna Holloway, Public Witness

101. Clementine Kovacs, Youth Advocate, Young Women's Project

102. Felix Hernandez, Public Witness

103. Kimberly Price, Market Champions , Fresh Farm

104. Kaitlyn Wilson, Public Witness

105. Janet Phoenix, Campaign to Reduce Lead Exposure & Asthma

106. Nia Bodrick, Pediatrician, DC Chapter of the American Academy of Pediatrics

107. Amanda Quiroz-Guajardo, Public Witness

108. Yasmina Konate, Youth Advocate, Young Women's Project

109. Brooklynne Payne, Youth Advocate, Young Women's Project

110. Julienne Summer Sardona, Youth Advocate, Young Women's Project

111. Gloria Gomez, Public Witness

112. Zainab Kamara, Public Witness

113. Ana Lemus, Public Witness

114. Wayne Goodwin, Public Witness

115. Geoff Gilbert, Legal & Technical Assistance Director, Beloved Community Incubator

116. Felix Macaraeg, Public Witness

117. Carolyn Babendreier, Public Witness

Antoine Harris

Greetings Council Members,

My name is Antoine Harris, and I am a newly hired school-based social worker at Roosevelt Stay Opportunity Academy. I have the pleasure of waking up every day and working with some of the world's most brilliant and innovative educators. However, the work we do at Roosevelt Stay can be physically and emotionally exhausting. Working in one of the District's only alternative education programs has its own set of unique challenges, which include many of our scholars struggling with the lack of basic resources, housing instability, and a lengthy history of traumatic life experiences which have led many students to turn to substances as a mean to escape the hurt and pain associate to their traumatic life experiences. As I write this letter, I can't help but reflect on the second day of the 2023/2024 academic year, when I was called to meet with a student due to staff having suspicion of the student being under the influence. Within five minutes of meeting with the student, they became unresponsive and required CPR. Shortly after DC EMS responded, it was discovered that the student had consumed fentanyl before walking into the building. Thankfully, the student's life was saved thanks to the quick actions taken by staff. However, let me make it very clear that this situation could've led to the student's death if the staff did not act as swiftly as they did.

As someone who has previously worked with individuals experiencing substance use disorders, I have firsthand knowledge that the District of Columbia is currently battling a public health crisis due to the increasing usage of substances such as prescription pain medication, opioids, fentanyl, K2, and many of our youth unknowingly ingesting marijuana that is laced with fentanyl. I find it extremely concerning that Roosevelt Stay Opportunity Academy has been pleading with the District for the past year for the nurse but has been unsuccessful with our attempts despite many government officials knowing the current struggles many of our students face. Having a dedicated nurse assigned to Roosevelt Stay is a vital need for our students, who range from ages 16 –24 years old and come from many communities in the District that are heavily impacted by many social determinates of health such as economic instability, community violence, limited access to healthcare, and limited access to healthy food items. Today, I am pleading for members of the council to address my expressed concerns by providing Roosevelt Stay with a full-time nurse to help service our scholar's medical needs.

Sincerely

Antoine
Harris, LICSW

JOINT BUDGET COMMITTEE ON HEALTH
TESTIMONY OF WARD 8 FARMERS MARKET, INC. (a 501(c)(3))
By John Gloster, Chairperson of the Board

April 10, 2024 (12 pm)

Good afternoon, Chairperson and members of the Joint Budget Committee on Health.

I am John Gloster. I am the founder and Board chair of the Ward 8 Farmers Market. The Ward 8 Farmers Market is the creation of Ward 8 residents who banded together after the last supermarket in the Ward closed in 1997. It was a bold, self-empowerment move at a time when the Ward's residents felt disempowered, cast off by business interests, and forgotten and neglected by our government. Today, we live in the eerie déjà vu of an Alabama Avenue Giant with empty shelves, poorly run by management that is so afraid of shoplifters that they seem intent on running the store into the ground.

Back in August of 1998, when the Ward 8 Farmers Market began operation, there were no farmers markets in Ward 8. There were no farm stands. There was not even a converted school bus pulling up with produce. Eventually, other markets would pop up. Established nonprofits from across the River came and raised a flag in Ward 8. Some continue to help bridge gaps in the Ward. Some may have come principally because it had become fashionable to do so and was useful in raising funds. But we have remained an authentic Ward 8 product: created by Ward 8 residents, for Ward 8 residents. We are more than a service; more than a place and time for transactions. We are a community.

Along the way, we have served hundreds of Ward 8 families, providing the substance of many tens of thousands of healthy meals. Many years ago, WE pioneered a program of putting healthy fruits and vegetables in corner stores. We have had innumerable healthy cooking demonstrations, free blood pressure readings, free dental exams, free yoga classes, meditation, massages, line dancing and more. Many of our vendors have traditionally been Ward 8 residents, providing some a means to tryout and grow their entrepreneurial aspirations. For others, it is more about a way to connect with the community.

Perhaps it should not be surprising that we have done this all on a shoestring all these years. We have never quite reached that critical mass where we could attract enough funding to hire a fulltime market manager all-year around, so that we could properly grow the organization. Instead, we have to reinvent ourselves each new season, reminding our customers where we are, and pulling up stakes every few years for lack of a permanent location.

Our problem is not confined to the Ward 8 Farmers Market. Other grassroot nonprofit efforts struggle in the same way to reach that critical mass that would inspire more confidence in grantors and qualify us for another tier of funding.

We would like to make a suggestion and a request. We ask this Committee and the Council to place a requirement on related grants requiring that grantees provide a minimum percentage of their awards in subgrants or subcontracts to local, small nonprofits in the communities they serve (especially in Wards 8 and 7). By small nonprofits, we mean those with annual budgets of less than $250,000. The concept is the nonprofit analog to the CBE requirements placed on construction contracts. In this way, the government, through the Council, can tap the larger nonprofits to help mentor and nurture smaller, grassroots nonprofits toward sustainability. In this way, more of those ideas and energies that come directly from the community can reach their highest expression. We hope that you share and value this

ideal. If you do, please take action in **this** budget cycle. Fund healthy lifestyle transformation, particularly East of the River, and pair it with a mandate to partner with small, local nonprofits. Thank you.

Karen Kassekert

Dear Esteemed Members of the Council:

Thank you for holding this hearing today and providing us an opportunity to speak on behalf of the Garnet Patterson (formerly Roosevelt STAY) community. My name is Karen Kassekert. I have worked at GPS for seven years, currently serve as the LSAT Chair, and am a proud Ward 1 resident.

I am writing to implore you to go above and beyond to provide healthcare workers in every DCPS school, particularly GPS. Our population is furthest from opportunity in many respects, and healthcare is definitely at the top of the list. Our students often do not have permanent residences, and it is challenging to stay connected to one medical provider during times of transition. Additionally, our students are at the cusp of moving from pediatric providers to adult providers. Our students face medical issues such as asthma, allergies, substance use, and pregnancy. The majority of our students struggle to navigate bureaucratic systems, including finding providers, making appointments, and following up on medical care. Due to this, many rely on Emergency Rooms as their primary means of healthcare. We can all agree that this is ineffective, not in the best interest of our students, detrimental to those who need actual emergency services, and not good stewardship of our city's financial resources. Those who do not go to the ER may forego medical care altogether, thus exacerbating what could be a minor medical issue such as a sprained ankle.

We desperately need a medical professional in our building to provide care for every day concerns as stomach pains and minor injuries, but also a trusted adult who can provide quality advice on how, when, and where to go for additional medical support. This is in the best interest of our students, the larger community, and our city's financial well-being.

I understand that many claim that a national nursing shortage is the cause of GPS and other schools not have medical professionals in the building. As I stated at the beginning of my testimony, I humbly beg you all to think of solutions that can be enacted in DC to solve this problem. Can we pay school nurses more? Have we conducted exit interviews to learn why medical professionals are leaving our schools? Are there perks or incentives that can be provided for these amazing humans? While I am here to advocate for GPS, I do not want any school in the district to go without this essential resource.

Thank you for your time and your service.

Sincerely,

Karen Kassekert

American Heart Association.

Testimony of the American Heart Association
Stuart Berlow, State Government Relations Director
DC Council, Committee on Health
FY25 DC Health Budget Hearing
April 10, 2024

The American Heart Association recommends investment in several essential health initiatives along with revenue generation to protect the health of all District residents. In the FY25 budget, the Committee on Health and the Council should:

- Increase the District's cigarette tax by $1.50/pack and dedicate 25% of revenue to tobacco control at DC Health.
- Provide $7 million to fund and implement Universal Free School Meals for all students, as proposed in B25-35.
- Provide $25,000 to continue implementation of required CPR training in high schools, as directed in the FY17 Budget Support Act.

Tobacco Tax Increase

To address the District's budget challenges and to protect the health of all residents, we recommend **raising the tax on cigarettes by $1.50 per pack, and increasing the tax on e-cigarettes and other tobacco products in parity with the cigarette tax**. We also encourage dedicating 25% of this revenue to tobacco control programs at DC Health and other agencies.

According to a 2024 analysis by the American Cancer Society and others, raising the cigarette tax by $1.50 would significantly enhance public health in the District:

- A 10.6% decrease in youth smoking
- 1,600 adult smokers would quit
- 400 premature smoking-caused deaths would be prevented
- $540,000 in Medicaid program savings over five years
- $24.83 million in long-term health care cost savings from smoking declines

The Council last increased the District's tobacco tax in the FY19 budget. As anticipated, that increase resulted in short-term revenue gain and long-term reduction in tobacco consumption. That tax increase along with raising the age to purchase tobacco products to 21 and restricting the sale of flavored tobacco has driven down tobacco use in DC. Data from DC Health demonstrates that these policies work. But still, too may residents, particularly those in Wards 7 and 8 bear a dipropionate burden of tobacco addiction and associated illness.

According to the Campaign for Tobacco Free Kids, currently in the District:

- 10.6% of adults and 3% of kids smoke
- 10% of kids use e-cigarettes

- 600 kids try tobacco for the first time each year
- 800 people die each year due to tobacco use

Raising the cigarette tax by $1.50 could generate nearly $1 million in new revenue each year. Relatedly, in their FY25 budget, our neighbors in Maryland raised their cigarette tax by $1.25/pack, to $5. We should not fall behind Mayland and other states in protecting our residents from the harms of tobacco.

CPR Training in Schools

Among the most important lessons DCPS students learn is how to save a life. In the FY17 BSA, the Council enacted the Public Safety Telecomunicator and District School CPR and AED Training Act of 2016, which **requires training in hands-only CPR as part of the high school health curriculum**. All District students now learn to save a life by providing hands-only CPR before they graduate.

For this training to continue, it is crucial that DCPS has the necessary funding to purchase, replace, and maintain CPR in Schools training kits, so a health teacher or other instructor can provide this essential lesson. One-time funding was provided to DCPS in the FY17 budget, but more is needed now.

The American Heart Association recommends **a small investment of $25,000 for DCPS to purchase new CPR in School training kits**, which can be shared across schools and classrooms to provide the training. These kits would include all the necessary components for students to practice hands-only CPR in a classroom, including manikins, videos, teaching manuals, and more.

What could be more important to fund in the budget than school-based training that literally could save a life, particularly in schools and communities where we see the most inequities in provision of bystander CPR?

Universal Free School Meals

All children in the District need and deserve equitable access to nutritious food throughout and after the school day. Through emergency federal funding, all kids received breakfast and lunch at no cost, regardless of family income during the pandemic. As this federal benefit has expired, the District must continue to provide this necessary nutrition program, by **including and funding B25-35 as a subtitle in the BSA.**

Prior to the pandemic, most District kids already received free meals at school, much of that cost covered through federal reimbursements. In fact, **nearly all costs of a universal school meals program would be covered by existing reimbursements**, according to the DC Food Policy Council. Given the District's high rate of participation in free meals programs, OSSE estimates the additional costs to extend this benefit to all District kids would only be approximately $7 million – a small cost for such an important program.

Free school meals are so important, not just for health, but for overall wellbeing. According to the DC Food Policy Council, kids who receive free school meals have :

- Improved academic achievement
- Lower rates of unhealthy weight
- Increased consumption of fruits and vegetables
- Lowered risk of behavioral issues

Other benefits of universal school meals include:

- Reduced financial and administrative burdens for both families and schools
- Reduced stigma for kids receiving free meals

States around the country have enacted and invested in universal school meals for all their children. The District has been a leader in school health for decades and must not fall behind. **With a $7 million allocation in the FY25 budget, all kids at all schools can have free access to the healthy food they need to be fed for success**.

Recommendations:

The American Heart Association recommends investment in several essential health initiatives along with revenue generation to protect the health of all District residents. In the FY25 budget, the Committee on Health and the Council should:

- Increase the District's cigarette tax by $1.50/pack and dedicate 25% of revenue to tobacco control at DC Health.
- Provide $7 million to fund and implement Universal Free School Meals for all students, as proposed in B25-35.
- Provide $25,000 to continue implementation of required CPR training in high schools, as directed in the FY17 Budget Support Act.

We look forward to working with this Committee and the Council to ensure these essential health programs are funded and implemented in FY25 and that health equity remains a priority in the District of Columbia.

As the Program Manager of Mary’s Center Healthy Family America’s Home Visiting Program, I am reaching out to you with a sense of urgency and hope for our community's future.

Our Home Visiting Program has been a beacon of support for families in need for over 30 years. We have witnessed firsthand the transformative impact of our services on the lives of vulnerable families. Through our dedicated team of trained professionals, we provide crucial support and guidance to parents and caregivers during the critical early years of their child's development.

However, despite our unwavering commitment, we find ourselves facing a significant challenge. The funding that sustains our program is at risk, jeopardizing the vital services we offer to families who rely on us for support.

Our program is not just about making ends meet; it's about investing in the future of our community. By empowering families with the knowledge and resources they need, we break the cycle of poverty, abuse, and multigenerational trauma and create a brighter tomorrow for generations to come.

With your support, we can continue to provide essential services such as:

1. Early Childhood Development: Ensuring children receive the nurturing care and stimulation they need for healthy development.
2. Parenting Education: Equipping parents with the skills and knowledge to create a nurturing and supportive environment for their children.
3. Access to Resources: Connecting families with community resources such as healthcare, education, and social services to address their unique needs.
4. Emotional Support: Offering a compassionate ear and guidance for families facing challenges such as postpartum depression, domestic violence, or substance abuse.

Your investment in our Home Visiting Program is an investment in the future of our community. Together, we can ensure that every child can thrive and reach their full potential.

I urge you to consider supporting our program. Funding will make a tangible difference in the lives of families who need it most.

Thank you for your time and consideration. Together, we can build a stronger, healthier, and more prosperous community for all.

Amanda Guajardo

Committee on Health
FY2025 Budget Oversight Hearing
April 10, 2024

Chairperson Henderson and Members of the Health Committee, my name is Shellie Bressler and I am the DC Advocate of Parents Against Vaping e-cigarettes. As the first and only national parent organization fighting the vaping and tobacco industries, Parents Against Vaping educates parents and communities and empowers them to take a stand and safeguard the health of our children by teaching them to advocate for local, state, and federal legislation to end sales of flavored tobacco products that are hooking millions of kids. We are so grateful to the Council for enacting legislation to end the sale of flavored tobacco in the District. This law has made the District a national leader in addressing a leading cause of cancer and other health issues. As a parent, and a 27-year resident of Ward 6, I am asking the Council to do more to keep our children from becoming life-long customers of Big Tobacco and vape manufacturers.

I come before you today in my role as the Secretary of Board of the DC Tobacco Free Coalition (DCTFC). We are requesting that the Council include an increase in the District's tobacco tax be included in the Fiscal Year 2025 Budget.

The DCTFC is a partnership of the DC Tobacco Free Coalition and the District of Columbia Department of Health (DC Health). The Coalition was created in 2006, with financial support from District's tobacco settlement funds. We currently have over 100 organizations and individuals as part of our coalition, and we have representation and participation from groups in all eight wards of the District. The Coalition's mission is to improve the health of the District of Columbia residents by decreasing the morbidity and mortality associated with tobacco use and exposure through education, public policy, and advocacy using culturally & linguistically competent approaches.

The current tax on a pack of cigarettes in $5.03 a pack. We are asking that the Council to include in the budget a $1.50 increase, raising the tax to $6.53 per pack, and to increase the tax on e-cigarettes and other tobacco products to be in parity with the cigarette tax.

We are also asking that the FY2025 Budget include language to allocate 25% of the tobacco tax revenues to go to programs proven to help adults addicted to cigarettes quit and for education programs aimed at preventing youth from initiating tobacco use and avoid becoming addicted.

According to a 2024 analysis by the American Cancer Society Cancer Action Network, Campaign for Tobacco-Free Kids and Tobacconomics, raising the tobacco tax by $1.50 would deliver significant public health benefits in the District including: a 10.6% decrease in youth smoking; 1,600 adult smokers would quit; 400 premature smoking-caused deaths would be prevented; $540,000 in Medicaid program savings over the next five years; and $24.83 million in long-term health care cost savings from the smoking declines as a result of the tax increase.

Raising tobacco taxes is win-win-win for the District Government and for society. First off, tobacco tax increases are one of the most effective ways to reduce smoking and other tobacco use, especially among kids and others who are price sensitive. Raising the price will lead to fewer cigarette and tobacco products being sold. Second, it is estimated that the District will collect around a million dollars a year in additional revenues from the increase in the tax. And third, with fewer people smoking, long term care and Medicaid expenditures on tobacco use related illnesses will decrease, saving the District millions of dollars.

Raising the tobacco tax doesn't just have the support of the public health community, it was included in the recommendations released on January 5, 2024 by the DC Tax Revision Commission. In addition, the State of Maryland just passed an $1.25 increase per pack of cigarettes, and the sales tax on e-cigarettes will rise from 12 to 20 percent, so people will not necessarily head into Maryland to buy these products to avoid the taxes.

Again, thank you for allowing me to speak. We appreciate your taking the steps to protect our children and to address the health needs of our neighbors. But so much still needs to be done. By increasing the tobacco tax and dedicating a portion of the revenue to prevention and cessation programs, we can reduce the rate of tobacco use in the District which will not only save money, but save lives.

American Lung Association.
District of Columbia

April 9, 2024

The Honorable Phil Mendelson
Committee of the Whole
Council of District of Columbia
1350 Pennsylvania Ave NW
Washington, DC 20004

Chair Mendelson and Members of the Council:

We thank you for the opportunity to provide comments on the budget for the District. As part of the budget process, the American Lung Association would encourage the Council to increase the cigarette tax by $1.50 and increase the tax rates on other tobacco products to create parity among tobacco products including electronic smoking devices.

The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease, through research, education and advocacy. The work of the American Lung Association is focused on four strategic imperatives: to defeat lung cancer; to improve the air we breathe; to reduce the burden of lung disease on individuals and their families; and to eliminate tobacco use and tobacco-related diseases.

Tobacco use remains the leading cause of preventable death in the United States, killing an estimated 480,000 Americans and 800 district residents each year.[1]

In data from the 2023 National Tobacco Youth Survey, tobacco use among high school and middle school students continue to show high levels with more than 2.8 million youth using a tobacco product. The American Lung Association is particularly alarmed by the trends of use by middle school students with the CDC report showing a significant increase in tobacco use. The report showed that tobacco use overall for middle school students increased nearly 50% from 4.5% to 6.6%. The report also shows that 2.1 million youth are still vaping, and over 25% are vaping daily which indicates a very high addiction rate. In the district, 10.1% of high school students use an electronic smoking device.

One of the most effective ways to reduce tobacco use is to significantly increase the tax on all tobacco products, including e-cigarettes. Multiple studies have shown that every 10 percent increase in the price of cigarettes reduces consumption by about four percent among adults and about seven percent among youth. The American Lung Association Lung Association believes the Council has an opportunity to impact health in the district and raise $940,000 in annual revenue to support the needs of district residents by increasing the tobacco tax by $1.50 and equalizing the tax on other tobacco products including e-cigarettes. Insignificant or gradual increase in price of tobacco products can be easily counteracted with industry tactics such as coupons and price discounts.

As part of the effort to combat the youth e-cigarette epidemic taxing all tobacco products at a comparable rate to combustible cigarettes (91% of wholesale price) is imperative, as youth smokers are especially price conscious, therefore keeping the price of tobacco products high is one of the most effective steps we can take to prevent youth tobacco use. When the price of cigarettes goes up, youth smoking rates decline. The Lung Association encourages states to look at evidence-based policy measures to address this epidemic, including increasing the price of these products. If there is not an equalized tax rate on all other tobacco products, current users may just switch to lower priced products versus taking the steps to quit.

In the recent release of the American Lung Association's State of Tobacco Control, it was noted that the funding for DC's Tobacco Control and Prevention program at approximatley $2.9 million is (inclusive of approximatley $1 million of federal CDC funds) woefully lower than the Centers for Disease Control and Prevention's (CDC) recommended level of $10.7 million, at 27.4%. The Lung Association strongly supports protecting and increasing this funding especially considering the epidemic levels of youth use of electronic smoking devices and the need to develop educational programs and outreach to prevent youth from initiating tobacco use and encourge current smokers to quit and not switch. We encourage at least 25% of the revenue from any tobacco tax increase to be used to support tobacco control and prevention efforts in the state.

Thank you for your continued commitment to the health and wellbeing of the residents of the district and encourage the Council to increase the cigarette tax rate by $1.50 and create parity among the tax on all tobacco products.

Sincerely,

Aleks Casper
Director of Advocacy
202-719-2810
aleks.casper@lung.org

[1] U.S. Department of Health and Human Services. The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health 2014.

DC CHARTER SCHOOL ALLIANCE

Testimony Before the Council of the District of Columbia
Committee on Health

at the Budget Oversight Hearing on
Department of Health

By Rachel Johnston
Chief of Staff, DC Charter School Alliance
April 10, 2024

Good afternoon, Chairperson Henderson and members of the Committee. My name is Rachel Johnston. I am a proud Ward 5 resident and the Chief of Staff at the DC Charter School Alliance, the local non-profit that advocates on behalf of public charter schools to ensure that every student can choose high-quality public schools that prepare them for lifelong success.

Charter schools are committed to providing safe and healthy learning environments for the nearly half the District's public school students they serve. Their staff have invested time and effort to ensure their students and families have access to the care they need to be healthy and in compliance with No Shots, No School. In fact, of the 125 eligible charter schools for the Children's School Services (CSS) school nursing program, 94 percent have some nursing coverage, either from CSS or privately, are taking steps to get their health suite approved, or are waiting for staffing assignments.[1]

I want to thank the CSS team and its leader, Dr. Andrea Boudreaux, for their ongoing effort to equitably staff charter schools' health suites. I also want to thank Dr. Christina Grant and her team at the Office of the State Superintendent (OSSE) for their leadership and collaboration with our schools on No Shots, No School. OSSE has been particularly helpful this year in creating concise, easy-to-reference one-pagers that LEAs can share with their communities, and they've also helped streamline the student immunization process with standardized deadlines. Finally, I want to thank the Administration for the support they've provided to schools in their efforts to ensure students are immunized. Our schools continue to effectively partner with DC Health to expand vaccination access, including partnering on community health fairs and hosting mobile vaccine clinics on school campuses.

While there is still room to improve immunization rates in DC, we appreciate the citywide effort to ensure students are healthy so they can actively engage in learning. Today, I focus on two areas where DC charter schools are still facing challenges and ways we believe DC Health can support.

School Health Challenges

Before I dive in, I want to share that we're excited to see the recent increase in health suite coverage provided through CSS's new staffing model introduced this year to address the well-known national nursing shortages that are impacting our schools. CSS initially had challenges with staffing the new model, particularly last fall as the school year kicked off. But right now, our data shows nearly nine in ten charter schools with assigned CSS personnel are receiving 40 hours per week of coverage.

While a vast majority of schools in the CSS program now have 40 hours of coverage, the **first** challenge I'd like to highlight is that the same individuals are often not providing that coverage. Consistency is necessary to build strong relationships with students, parents and school staff. Our

[1] Nursing and Administering Medication in DC Charter Schools. DC Charter School Alliance. April 2024. https://drive.google.com/file/d/1rvpAGTnXEFwuR1gVukNeQDNaebGlRwsB/view

schools rely on health suite personnel to support the everyday health needs of students and actively engage in the immunization compliance process. We look forward to working closely with CSS to improve consistency and ensure well-trained health suite staff can provide this support.

Second, we've heard from schools that have applied for health suites that the approval process can be inefficient, complex, and lengthy. Some have reported that it can take several years from application to approval with no clear timeline from the beginning. One primary reason cited is that feedback schools receive from DC Health is inconsistent, which prolongs the approval process. For example, DC Health's first inspection will reveal three problems that need to be addressed, and the school will resolve those issues. Then, a second inspection will highlight different problems not identified in the first inspection. When DC Health doesn't provide enough specific details about their requests, schools end up having to redo tasks they could have fixed properly the first time.

Recommendations for Resolving School Health Challenges

As you consider the FY25 budget, I want to share some recommendations for consideration to resolve these challenges our schools have faced. **First**, to address shortages of providers and ensure consistency of coverage, we recommend:

- The District join the Nurse Licensure Compact (NLC)[2], which would expand the pool of nurses immediately available for hire. Currently, 41 jurisdictions, including neighboring states Virginia and Maryland, are part of the NLC.
- CSS and DC Health partner with adult charter schools that have health certification programs to expand the pool of qualified personnel. Academy of Hope, Carlos Rosario, Briya, and the LAYC Career Academy all have alumni with a variety of medical certifications, who could be good candidates for health suite personnel.
- The Council ensure adequate funding is provided to pay school nurses on par with surrounding jurisdictions, including neighboring Prince George's County. We understand that many tough decisions must be made in this budget cycle. Pay parity is crucial in hiring and retaining health suite staff. Even the smallest pay discrepancy makes a big difference in ensuring consistency in personnel across schools.

Second, some charter schools have expressed interest in Administration of Medication (AOM) training for additional staff to ensure students are adequately cared for when a nurse is not present, during the school day, on field trips, and during after school activities. Currently, 250 school staff are AOM trained across charter schools, with an additional 75 completing the process. This demonstrates a high interest in ensuring many staff are trained to support student medical needs. However, the current training program restricts the number of staff who can

[2] Nurse Licensure Compact. www.nursecompact.com.

participate due to capacity limitations. We recommend DC Health identify additional AOM trainers that schools could voluntarily engage to train more staff and add extra capacity.

Finally, to improve the health suite approval process, we recommend DC Health standardize the approval process cycle and clearly outline the dates schools must submit interest to apply for a health suite for the following school year. We also urge DC Health to re-examine the approval checklist to clarify any gaps. This is critical to ensure schools aren't asked to go through multiple inspections to have their health suites approved and ready to serve students.

Moving Forward

The health and wellness of their students are top priorities for our schools. As always, the DC Charter School Alliance welcomes the opportunity to continue collaborating to ensure all students have their health needs met so they can actively participate in learning.

Thank you for your time and attention, and I welcome your questions.

Statement of Carrie Stoltzfus, Executive Director, Food & Friends, before the DC Council Budget Oversight Hearing: Committee on Health meeting
with the Department of Health
April 10, 2024

Good afternoon Chairperson Henderson and members of the Committee. I am Carrie Stoltzfus, the Executive Director of Food & Friends. Thank you for your support of our mission to improve the lives and health of DC residents living with serious illnesses such as cancer, kidney failure, HIV/AIDS, and others that limit their ability to provide their own nourishment. We are also grateful for our partnership with Dr. Bennett and the staff of DC Health.

I'm here today to request your support for level funding of $1,335,000, which is currently in the Community Health Administration (CHA) budget in the Mayor's FY25 Budget Proposal. Last year we home-delivered over 840,000 medically tailored meals free of charge to nearly 2,500 District residents and their dependents.
These funds will help us keep pace with continued high need for medically tailored meals , using public and private resources to care for the most vulnerable DC residents. The majority of Food & Friends' budget comes from philanthropy and health care partnerships, and for each dollar we receive from the District, we raise about $4.00 from other sources. The support from DC Health and your support from the Council remains key to our ability to carry out this important work.

We know that our work reduces healthcare costs while saving lives. Those living with complex health conditions who receive medically tailored meals and medical nutrition therapy experience 50% fewer inpatient admissions and 70% fewer emergency department visits than those not enrolled in such a program. A recent Tufts study estimates that if all US eligible patients received access to meals with nutrition standards such as ours, in just the first year over **1.5 million hospitalizations could be avoided for a net cost savings of $13.6 billion.**[i] One of the neighbors we are proud to serve, Michael, will tell you first-hand about the difference our services make to him via separate testimony.

Food & Friends will continue to meet the challenges of feeding those who are medically vulnerable. We appreciate the Council's support of our mission and our request to protect our funding in the FY25 Budget Proposal, and we look forward to a continued partnership. Thank you.

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[i] Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. JAMA Netw Open. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898

FOOD & FRIENDS

our work in **washington, d.c.**

WHO WE ARE

Since 1988, we are the only community-based organization in the D.C. region providing home-delivered Medically Tailored Meals and Medical Nutrition Therapy to our neighbors living with serious illnesses that limit their ability to provide nourishment for themselves.

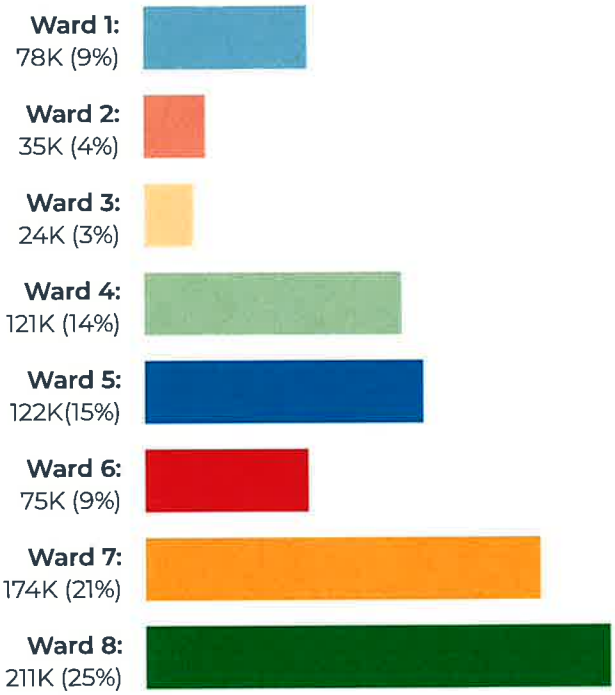
WHAT WE DO

With the help of thousands of volunteers, Food & Friends prepares and delivers nutritionally tailored, delicious meals directly to our neighbors' homes. Our Registered Dietitians and professional chefs work closely to provide individualized services to our clients.

WHO WE SERVE

Food & Friends provides Medically Tailored Meals, groceries, and Medical Nutrition Therapy to people living with life-challenging illnesses. All meals and services are free-of-charge to the client. Recognizing that clients with children often share their food with their kids, Food & Friends also provides services to dependents and caregivers in the household, ensuring the parent can focus on getting well.

TOTAL MEALS DELIVERED



Food & Friends is built on a simple premise: anyone can get sick, and everyone can help.

In FY23, Food & Friends home-delivered 841,736 Medically Tailored Meals to 1,942 primary clients in the District of Columbia. In 2023, our clients had a range of illnesses including cancer, diabetes, renal disease, HIV/AIDS, maternal health concerns, heart disease and other serious illnesses.

841,736
meals delivered to D.C. residents

2,437
total clients live in D.C.

970
nutrition encounters with our registered dietitians

330
volunteers live in D.C.

76%
of all households served have **income less than $1500/month**

CONNECT

Food & Friends
219 Riggs Road NE
Washington, DC 20011
www.foodandfriends.org

Phone: (202) 269-6836
Fax: (202) 635-4265
publicgrants@foodandfriends.org
United Way #8429 CFC #52114

impact in **washington, d.c.**

LOWER COST OF CARE

Proper food and nutrition helps increase absorption of medication, reduces side effects, and helps patients maintain a healthy body weight. As a member of the national Food is Medicine Coalition (FIMC), we adhere to rigorous nationwide nutrition and quality standards and uniquely employ Medical Nutrition Therapy through our Registered Dietitians, personalizing each client's nutrition needs and encouraging lifelong improved nutrition.

According to the District of Columbia Department of Health, serious illnesses such as diabetes cost an estimated $346 million dollars in D.C. each year for the approximately 52,000 residents with diabetes or prediabetes. Research shows that people living with complex health conditions and enrolled in Medically Tailored Meal (MTM) programs experience 50% fewer inpatient admissions and 70% fewer emergency department visits than similar patients not enrolled in an MTM program.[i] Recently published national research shows that if all U.S. eligible patients received access to MTMs with nutrition standards such as ours, in just the first year of service 1,594,000 hospitalizations could be avoided for a net cost savings of $13.6 billion.[ii]

EQUITY

Our Medically Tailored Meals and Medical Nutrition Therapy are free to clients and their families, and we work tirelessly to ensure that no eligible client is turned away. Over 76% of our client households have income of less than $1500 per month—we immediately address inequitable social determinants of health such as healthcare access and food security.

HEALTHIER COMMUNITIES

We believe in the power of compassion and the importance of neighbors helping neighbors, so we create opportunities for impactful and fulfilling volunteer service that helps our sick neighbors and builds a healthier community for all. MTMs have been associated with reduced depressive symptoms and fewer dilemmas between paying for either food, healthcare or prescriptions.[iii] Our Client survey shows that 73% of our clients report improved mental health, 83% report improved quality of life, 81% report they are better able to follow doctors' orders and over 93% of our clients reported that they learned to eat better for their health condition after talking with our dietitians.

"Thank you! Excellent service, friendly staff, delivery always on time. Feeling a lot healthier and haven't been in the hospital since."

— **Food & Friends Client**

NEED FOR INCREASED SUPPORT

Food & Friends saw a 5.3% increase in need in the District in 2023, likely due to pandemic-delayed diagnosis of severe illnesses and due to rampant food insecurity from inflation and a volatile job market. To achieve our mission, we stitch together Federal, State and local public funds, private contributions and reimbursements from partnerships with Medicaid managed care plans. By supporting Food & Friends' services, the District of Columbia engages in a true public-private partnership that benefits the most vulnerable citizens and helps to build a healthier, more economically vibrant community.

i. Seth A. Berkowitz et al, Meal Delivery Programs Reduce the Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries, HEALTH AFFAIRS, (2018).

ii. Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. JAMA Network Open. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898

iii. Tapper EB, Baki J, Nikirk S, Hummel S, Asrani SK, Lok AS. Medically tailored meals for the management of symptomatic ascites: the SALTYFOOD pilot randomized clinical trial. Gastroenterology Report 2020;8(6):453-456. DOI: 10.1093/gastro/goaa059.

FOOD & FRIENDS

Cost savings data from two projects:

Bright Start: *Partnering to Improve Maternal Health*

AmeriHealth Caritas District of Columbia

About

- AmeriHealth Caritas DC members are referred to Food & Friends by their Bright Start (Maternity) Care Manager
- Program Aims:
  - Improve engagement in care and expectant mother's health
  - Promote healthy eating behaviors
  - Reduce nutritional risk factors, including food insecurity
  - Support members in delivering healthy, full-term infants.
- Program components:
  - Medically-tailored meals
  - Groceries
  - Nutrition counseling

Results†

- 79% eat most (>75%) of the food
- 74% better able to follow Tx plan
- 79% report less stress procuring food
- 63% rate postpartum transition easier

	Estimated Total Cost Differential	Estimated % Change in Total Number of Visits
30 Day All Cause Readmissions	($83.59K)	-100 %
Potentially Preventable Admissions	($8.15K)	-100 %
Low-Acuity ED Visits	($37.28K)	-32 %
EMS Visits	($53.03K)	-75 %
Total Cost	($1.91M)	-61 %

Implementation notes

1. Billing via medical claim vs invoice allows for risk adjustment, spend against MLR, and easier tie to encounter data to prove ROI
2. After initial increase in expense, we measured lower overall cost of care, better patient satisfaction, higher engagement with plan and providers
3. As we learn more about the dollars and cents for helping Medicaid enrollees address health related social needs, this work may be a useful model for calculating costs and advocating for reimbursement

†Results from CY 2021, 343 pregnant women and 205 child dependents served. Total cost of care data based on 318 Adult members with sufficient data for 3-year review of claims.

Maryland Pilot

Food & Friends partnered with Maryland Physicians Care in 2020/2021 to conduct a ten-month pilot to deliver medically tailored meals to 43 diabetic members. 18 medically tailored meals per week were delivered to each member for three months.

A pre-/post six-month cohort analysis was conducted by Maryland Physicians Care at the end of the pilot. A control group of forty similar diabetic Maryland Physician Care members who did not receive medically tailored meals was compared.

Results showed members who received medically tailored meals had a decrease in emergency department visits and a net savings of approximately $8,000 per member post six months. Below are the results.

	#	PriorMedRxExp	PostMedRxExp	Difference	Per member
Enrolled with F&F	43	888,461.48	749,425.61	(139,035.87)	(3,233.39)
Not Enrolled with F&F	40	$ 653,837.67	$ 844,130.45	190,292.78	4,757.32

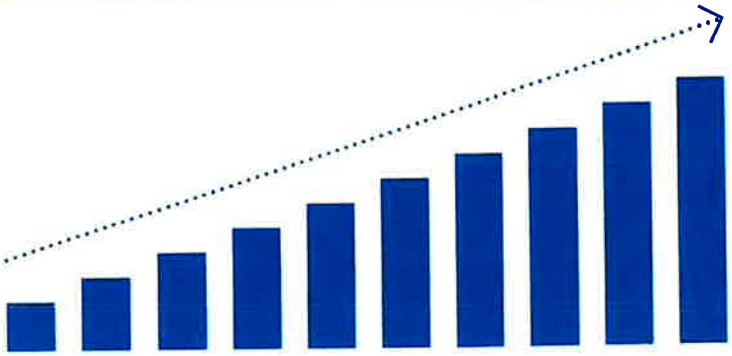
Estimated Impact of National **Medically Tailored Meal Insurance** Coverage on U.S. Hospitalizations and Healthcare Expenditures: **A Cost-Effectiveness Analysis**

Study published in JAMA Open Network by investigators at the Tufts University Friedman School of Science and Policy

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797397

Overview

This NIH funded research modeled the 1- and 10-year impacts of a national MTM program on hospitalizations, healthcare expenditures, and costs for Medicare, Medicaid, and private payers.



Eligible Population

US adults age 18+ covered by Medicare, Medicaid, or private payers, with at least one diet-sensitive condition (diabetes, heart disease, emphysema, stroke, non-melanoma cancer, kidney disease, and HIV) and one or more limitations in instrumental activities of daily living. This represents **6.3 million eligible Americans** nationally, including 2.6 million in Medicare, 0.7 million in Medicaid, 1.6 million dually eligible for Medicare and Medicaid, and 1.4 million covered by private payers.

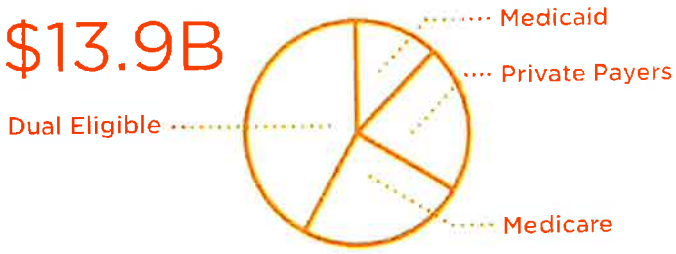
MTM Intervention

Provision of **10 nutritionally tailored meals** per week, for an average of **8 months per year**, in each year of intervention. The average total intervention cost was **$9.20 per meal** (based on 2019 contracts with health systems and payers among 11 MTM organizations).

Study Findings

If all **6.3 million eligible individuals** received MTMs, the intervention cost would be **$24.8 billion** in the first year. In one year, the intervention would prevent an estimated **1,154,000 hospitalizations** and save **$38.7 billion** in healthcare expenditures.

Overall, MTMs would produce a net cost savings of **$13.6 billion** in the first year including **$3.4 billion** in Medicare, **$1.7 billion** in Medicaid, **$5.9 billion** among Dual Eligible, and **$3.0 billion** for private payers.



Over 10 years, the MTM intervention would reduce hospitalizations by **18,257,000** and reduce healthcare expenditures by **$484.5 billion** for a net policy cost savings of **$185.1 billion** (in 2019 USD). This includes net savings of **$30.2 billion** in Medicare, **$22.6 billion** in Medicaid, **$88.0 billion** among Dual Eligible, and **$45.5 billion** for private payers.

MTM Impacts on Health Outcomes: Overview of Recent Research

The potential utility of MTMs in clinical care is now supported by studies observing improved diet quality, food security, and disease management when high-risk patients with diet-sensitive conditions receive MTMs.[1-5] These findings suggest that MTMs may improve health through multiple pathways including improved nutrition, less food insecurity, better financial wellbeing, reduced stress and anxiety, and improved medication adherence and self-management. Studies documenting improvements in health outcomes due to MTM receipt include:

1. In a recent randomized controlled trial, **600 patients** hospitalized with chronic heart failure were assigned to receive either usual hospital meals or medically tailored meal plans, nutritional counseling, and if necessary, supplemental IV nutrition. The tailored nutritional support led to a **56% reduction** in mortality at **30 days**.[6] While the tailored meals in the latter trial were provided in-hospital rather than home-delivered, this research supports the benefits of comprehensive, tailored nutritional support for high-risk patients.

2. Patients with advanced cirrhosis and ascites required **fewer weekly paracenteses** and reported **improved ascites-specific quality of life** after three months of MTMs.[4]

3. Among patients with HIV receiving MTMs, **antiretroviral therapy adherence increased** and among patients with diabetes, **diabetes self-management also improved**.[1,5]

4. MTMs have been associated with **reduced depressive symptoms** and **fewer dilemmas** between paying for either food, healthcare or prescriptions.[1]

5. Among patients with recent heart failure hospitalization, 1 month of MTMs **improved clinical summary scores** on the Kansas City Cardiomyopathy Questionnaire.[3]

1. Palar K, Napoles T, Hufstedler LL, et al. Comprehensive and Medically Appropriate Food Support Is Associated with Improved HIV and Diabetes Health. J Urban Health 2017;94(1):87-99. (In eng). DOI: 10.1007/s11524-016-0129-7
2. Berkowitz SA, Delahanty LM, Terranova J, et al. Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity: a Randomized Cross-over Trial. J Gen Intern Med 2019;34(3):396-404. (In eng). DOI: 10.1007/s11606-018-4716-z
3. Hummel SL, Karmally W, Gillespie BW, et al. Home-Delivered Meals Postdischarge From Heart Failure Hospitalization. Circulation: Heart Failure 2018;11(8):e004886. DOI: doi:10.1161/CIRCHEARTFAILURE.117.004886
4. Tapper EB, Baki J, Nikirk S, Hummel S, Asrani SK, Lok AS. Medically tailored meals for the management of symptomatic ascites: the SALTYFOOD pilot randomized clinical trial. Gastroenterology Report 2020;8(6):453-456. DOI: 10.1093/gastro/goaa059
5. Berkowitz SA, Shahid NN, Terranova J, et al. "I was able to eat what I am supposed to eat"-- patient reflections on a medically-tailored meal intervention: a qualitative analysis. BMC Endocrine Disorders 2020;20(1):10. DOI: 10.1186/s12902-020-0491-z.
6. Hersberger L, Dietz A, Bürgler H, et al. Individualized Nutritional Support for Hospitalized Patients With Chronic Heart Failure. Journal of the American College of Cardiology 2021;77(18):2307-2319. DOI: 10.1016/j.jacc.2021.03.232.

Committee on Health
Performance Oversight Hearing
April 10, 2024

Honorable Chairperson Henderson and Members of the Committee on Health,

Thank you for convening today's hearing regarding the proposed budget for DC Health. My name is Alex Moore and I am here today representing **DC Central Kitchen**. Since 1989, we have targeted the root causes of hunger with innovative programs that lower barriers to employment, create good, living wage jobs for District residents, and bring nutritious, dignified food where it is most needed.

We are proud to be a long-time partner of DC Health's Community Health Administration (CHA) via the award-winning **Healthy Corners** program. In the past 12 years, this partnership has established Washington, DC as a national leader in community-based, community-led solutions to "food deserts," as we have built the capacity of small corner stores to stock and sell fruits and vegetables to DC residents who face inequality in access to nutritious food and household food insecurity. With DC Health's expert guidance, we have integrated high-impact outreach, education, and technical assistance activities that empower store owners to share best practices with one another and maximize the redemption of federal benefits like SNAP and WIC on healthy items at these local retailers.

While fresh produce and fridges are critical to our operation, there is no more essential ingredient to Healthy Corners' winning recipe than trust. For more than a decade, we have established trust with small businesses, residents, local farmers, and the dedicated team at DC Health. In turn, those efforts have made Healthy Corners an integral component of a more equitable and healthy food system in the District, and we thank the Chair and the Committee for their vocal support of this program through the years.

To that end, we recognize the trust that DC Health, Mayor Bowser, and this Committee have placed in DC Central Kitchen and Healthy Corners. The Mayor's proposed budget includes $750,000 in local funding for Healthy Corners, a powerful investment in what we know to be a difficult budget cycle. We applaud this allocation and appreciate what it will mean to our residents and small businesses. Last year, Healthy Corners posted record sales, despite the end of Federal pandemic allotments to the SNAP program. Even though many of our most food insecure households had fewer food dollars to spend, they continued to prioritize Healthy Corners' nutritious offerings and leverage our special SNAP Match benefits to expand their purchasing power at a time of reduced resources. Thanks to the District's participation in the Summer EBT program and efforts to Give SNAP a Raise, Healthy Corners will be able to continue providing a multiplier effect for these essential benefits, simultaneously empowering SNAP customers to make healthy choices while incentivizing small businesses who provide those options.

We respectfully ask the Committee to protect the Mayor's proposed funding level for Healthy Corners as budget discussions continue on behalf of the 15,000 residents and 54 corner stores who count on this program. We are working to add 10 additional SNAP Match locations over the next two years and these funds will lock in the required local matching funds tied to our most recent USDA grant, 100% of which flows directly to SNAP customers in the form of SNAP Match produce incentives.

For all of Healthy Corners' successes, we know that we are just one part of the larger effort to address DC's food access and food security needs—needs that remain persistently high and place significant

burdens on front-line food providers. DC Health works with many of these respected providers, and we encourage the Committee to support DC Health's portfolio of Healthy Food Access partnerships. Food & Friends, Capital Area Food Bank, Martha's Table, FRESHFARM Markets, DC Hunger Solutions, and DC Greens have established robust partnerships with DC Health that are a model for public-private collaboration. In addition to the important funding DC Health offers to these integrated, collective food access solutions, CHA staff provide expert technical assistance, critical perspectives, and holistic guidance that continuously make these programs more efficient, effective, and outcome-driven. Should the Council be able to protect these programs' funding levels in this year's budget, you can be confident in their ability to deliver meaningful returns to residents.

Finally, DC Central Kitchen recognizes the importance of continuing to expand SNAP's reach and funding levels. We encourage the Council and Mayor's office to make yearly participation in Summer EBT a priority, along with raising awareness of this critical boost to food insecure families. We also hope that giving SNAP a raise will remain a priority for our city's leadership in the years to come. As this Committee well knows, SNAP is not simply an "expense." It is a powerful investment in public health, public safety, local economic vitality, and our core values as a city. We recognize that the effort to give SNAP a raise will take years, and we are prepared to be the District's partner in this work for as long as it takes.

We are grateful for DC Health's partnership and believe it is a model for this city and others. I am happy to answer any questions you may have about Healthy Corners, the impact of this proposed funding, and how DC Central Kitchen is doing everything we can to build a healthier, fairer community. Thank you.

Greetings Council Members,

My name is Antoine Harris, and I am a newly hired school-based social worker at Roosevelt Stay Opportunity Academy. I have the pleasure of waking up every day and working with some of the world's most brilliant and innovative educators. However, the work we do at Roosevelt Stay can be physically and emotionally exhausting. Working in one of the District's only alternative education programs has its own set of unique challenges, which include many of our scholars struggling with the lack of basic resources, housing instability, and a lengthy history of traumatic life experiences which have led many students to turn to substances as a mean to escape the hurt and pain associate to their traumatic life experiences. As I write this letter, I can't help but reflect on the second day of the 2023/2024 academic year, when I was called to meet with a student due to staff having suspicion of the student being under the influence. Within five minutes of meeting with the student, they became unresponsive and required CPR. Shortly after DC EMS responded, it was discovered that the student had consumed fentanyl before walking into the building. Thankfully, the student's life was saved thanks to the quick actions taken by staff. However, let me make it very clear that this situation could've led to the student's death if the staff did not act as swiftly as they did.

As someone who has previously worked with individuals experiencing substance use disorders, I have firsthand knowledge that the District of Columbia is currently battling a public health crisis due to the increasing usage of substances such as prescription pain medication, opioids, fentanyl, K2, and many of our youth unknowingly ingesting marijuana that is laced with fentanyl. I find it extremely concerning that Roosevelt Stay Opportunity Academy has been pleading with the District for the past year for the nurse but has been unsuccessful with our attempts despite many government officials knowing the current struggles many of our students face. Having a dedicated nurse assigned to Roosevelt Stay is a vital need for our students, who range from ages 16 –24 years old and come from many communities in the District that are heavily impacted by many social determinates of health such as economic instability, community violence, limited access to healthcare, and limited access to healthy food items. Today, I am pleading for members of the council to address my expressed concerns by providing Roosevelt Stay with a full-time nurse to help service our scholar's medical needs.

Sincerely

Antoine Harris, LICSW

brooklynne payne

Good morning chairman gray and members of the committee on health. Thank you for the opportunity to testify today. My name is brooklynne payne. i am a ward 4 resident and a junior at dunbar highschool. I have been a part of the Young Women's Project (YWP) since October 2023 and now I am a youth advocate working on sexual and mental health issues. YWP is a multicultural organization that builds the leadership and power of DC youth so that they can transform policies and institutions to expand youth rights and opportunities. In addition to providing education in schools, teen organizations, and youth-residential centers, it allows youth to learn about sexual and mental health topics and develops their knowledge on topics that are right for their age.

I am here to talk about the lack of support/teaching about mental/sexual health illnesses for teens. I know this from personal experience as I didn't learn anything about these two topics from within school, but during my time working for YWP. As a teen, growing up is bound to happen, and that comes with needing to know about yourself mentally and physically. I didn't know enough about either of these subjects, and not knowing enough about them has caused situations in my life that I could have prevented if I had been given the right advice from a reliable source.

The issue I'm bringing to the council is the lack of teaching for sexual/mental health, and the lack of funding put into it. As these things are very important and everyone goes through something relating to this topic at least once in their life, people are not taught about it enough in their teen years, the year where people are experimenting the most. And aside from that, the organization representing (YWP) youth advocates play the roles adults are supposed to play, as we do more teaching about topics that should be taught in school with no government funding.

While at school, I've realized not a lot of teens know as much about sexual/mental health as they think. Looking back at the data from the sexual health survey from all schools that YWP made to track students' knowledge, approximately 62.48% of students out of 541 who did the survey stated they got no education on these topics in school which is beyond concerning. Another statistic that came out of the survey was how interested students are in learning more about these things in a school setting. Also the lack of counselors and mental health workers in schools are drastically decreasing. Because there is little financing for them and a shortage of professionals in the field being employed, having a trusted adult to talk to within school is limited to almost non-existent, which has a significant impact on students.

I have a few recommendations that I think will benefit students. First, DCPS and Charter schools should hold mental/sexual health days every year for all highschool students where the focus is on what mental/sexual health is and having it covering different topics related to these issues. I think this can help because it wont take a lot of work as it's only once a month, and for the next 4 years students will get refreshed on the topic to remember what it is they've learned. Second, DCPS and Charter schools should be required to provide a link on their website home pages that takes youth directly to the mental health team and services. Right now most websites do not have a link – which requires youth to search through the staff directory to figure out who they can contact for support. Thirdly, we want to ask the council to set aside money to fund peer educators to continue peer educating, and we're asking for around $300,000. We know that with this type of financing, groups like YWP can continue to educate while also doing things that others do not.

Thank you for your time and allowing me to talk to you today.

Thank you Chairwoman Henderson for the time and opportunity to address the council. I will share a synopsis of our journey to obtain our son's birth certificate and some recommendations on how I feel this process can be better in the future.

On August 9, 2022, just 2 days after his own birthday, my husband Jeff delivered our son in a birthing tub in the comfort of our livingroom. We named him Jeff, just like his dad. He was a tiny little guy with a huge voice and he latched on immediately. My husband and I checked all his vitals and recorded them on a newborn sheet which my husband got notarized.

On November 22, 2022, we visited the Dept of Vital Records(DVR) believing that we had all we needed to obtain a birth certificate. We paid and waited but were told that we had to register his birth before we could obtain a birth certificate. This was news to us so we called the phone number provided to us and reached the Records Management Assistant(RMA), who helped me get the process started.

The RMA gave us a series of documents and forms to complete and return. It took months of phone calls, trips to locations I visited in the past and many emails to obtain documents necessary to prove that our son was born when and where we claimed. Thankfully I did not have a full time job and that Door Dash allows me the flexibility to work when available. I would have been fired from my job had I still been working and trying to locate these documents. I spent 2 weeks trying to track down the location I had a pregnancy test for proof of pregnancy and another 2 weeks to track down the location I had an ultrasound.

In the midst of back and forth emails, I was provided with additional documents from the RMA that she hoped would help but only confused me further. I expressed that I had a home birth and would not be able to produce certain documents.

In February 2023, I was finally able to submit what I believed to be sufficient information to obtain his documents. I reached out to the RMA in April of 2023 because I had not heard from her and wanted to know if we needed to provide more information. The following day, I received a reply with a denial letter dated 2 days prior to my reaching out.

After receiving the denial letter, I inquired about next steps and was directed to the DC Superior Court. When I called, I was directed to the self-help department. I spoke to them and was not really given much assistance. This prompted me to go in person where I was told that there was a few people who came in with similar situations and they didn't know how to assist. I was given a list of lawyers who had not dealt with this sort of case before. I stopped by the Mayors Liason office and a lady who worked there walked with me to the self-help department to see if she could get more information and she even sent an internal encrypted email to the Dept of Health that went unanswered.

About 2 weeks later, I called the Superior Court and spoke with a receptionist. I told them that I didn't want to speak with anyone in the self-help department because they were useless. She asked if I wanted to speak to the supervisor and I told her I believe I had but had never spoken to the person she named. After speaking with the gentleman, I was introduced to Melody Webb with Mother's Outreach Network(MON), who leaped into action with her amazing team and they worked with us diligently to attempt to get a birth certificate without having to go to court.

Mrs. Webb set up a meeting with the two of us, MON's intern, the RMA and her manager. During this meeting on Zoom, which has been recorded with permission, the manager can be heard judging my situation, giving incorrect information and even admitting that the dept was moving cautiously because they were facing litigation and at risk of losing their right to issue birth certificates. Also during this meeting, there were changes that were being made to the website to corroborate what they had been saying. MON's intern was provided a document that I had never laid eyes on while doing research.

At the end of the meeting, I was given the option to either resubmit a request for a birth certificate knowing that if it was denied, I would lose the right to register our son's birth in the district where he was born, or petition the court. I chose the latter simply because I had no trust at all in the DVR. I also felt that if I resubmitted the request, it would have been denied out of spite.

While we were preparing to petition the court, the Washington Post reached out because they wanted to cover our story. We hesitated to respond because we didn't want to be in the limelight but once we learned that other families were dealing with this, we knew we had to tell our story to help other families. This was now bigger than our family of 4. On February 15th, the first article was published online and later printed on the front page. We started receiving phone calls and emails from friends, family and people we didn't know. People were upset when they found out what we were dealing with and some even offered to pay our legal fees. Many people wanted to know if we could just take a DNA test and this be over.

MON worked tirelessly to draft a petition to the court and we were granted a court date of March 5, 2024. On that day, we spoke to Judge Soltys and within 5 minutes, she believed that the information we provided as well as seeing our little boy with us was enough to grant his birth certificate. She told us that she would send a copy to the DVR, I would be able to pick up a copy and hand deliver it as well.

We were very excited because to us, this was finally over. We would finally be able to focus on other areas of our lives that we were working to improve, including spending more time with our babies. A second article was published in celebration and to our surprise, our journey was not over.

The following day, I picked up the court order, I went to the DVR and told them I had a court order to receive my son's birth certificate. The young lady I spoke to turned around and yelled out, "hey can we accept court orders?" About 20 minutes later, I was told by a guy that I can't just walk up in there with a court order and expect to walk out with a birth certificate. Furiously, I reached out to Mrs. Webb because what I was told had not happened and again my time had been wasted. Mrs. Webb reached out to a few people and the following day, I received a phone call from the manager at the DVR saying my son's birth certificate was ready to be picked up. There was a notary involved, the birth certificate looked very different and none of this had been explained to me prior. The same day we picked up the birth certificate, we met another mom and learned she was dealing with a similar but different issue. I told her that I would be witnessing at this hearing and immediately she was on board.

After writing this out, I can only help but feel that it's almost as if we were being punished for not wanted our birth experience to be controlled by people who don't care about the health of me or our child. I felt that it would be safer for me to have our children at home and a midwife in the article agreed with me.

Our birth certificate journey is now over but a new journey is just beginning. Getting a birth certificate should not be this difficult, especially for a home birth. Home births have been around since before hospitals were in existence so this is not a new concept. We would like to see more cohesion when it comes to the staff. On multiple occasions we were given incorrect information and not one staff member said the same thing. There is so much confusion behind the scenes, every staff person should be trained or retrained with correct information. That would be a great start.

Thank you for your time and have a great day.

Before the

District of Columbia Council

Committee on Health

Testimony of

Dean R. Brenner

5044 Macomb Street, NW

Washington DC 20016

Budget Oversight Hearing

DC Health

Wednesday April 10, 2024

Chairwoman Henderson and Committee Members, my name is Dean Brenner. As a volunteer, I chair the board of the Alzheimer's Association's local chapter, I'm the National Treasurer of the Alzheimer's Association, and I was the caregiver for my mom who passed away from Alzheimer's in 2018. She was the first woman in the history of my hometown to serve on that town's council, back in 1965.

Last month, the Alzheimer's Association released new data on the Alzheimer's crisis in DC. As of 2020, over 15,000 people in DC who were age 65 or older had Alzheimer's-- a more than 50% increase from the prior report. So, if DC were a state, we'd have the largest percentage of people with Alzheimer's out of all states. The same holds true among US counties. DC is a national hot spot for Alzheimer's, and women, African Americans, and Hispanics are disproportionately affected.

I'm here today to ask for your help with three important issues concerning the Alzheimer's crisis which I urge this Committee to address in developing the next DC budget.

First, in 2020, the Council passed a law to require dementia training for direct care workers. Thousands of DC residents with dementia and their families depend every day on direct care workers in DC nursing homes, assisted living facilities, and their homes for so many activities of daily living. In many cases, these workers are not given adequate training or any training at all, and the results are harmful, even life threatening. A recent Washington Post article showed that people with dementia under the care of staff without adequate training often wander off, and some even die as a result. So, the Council was right to pass the 2020 law to require DC nursing homes, assisted living facilities, and home health agencies to train their direct care workers on how to care for people with dementia.

For reasons I can't explain, though, DC Health has still not implemented this 2020 law. Four years after its enactment, this important law is just symbolic. The last two budgets included $170,000 to implement the law. In January, DC Health testified that they were finalizing regulations, and completing a procurement for a consultant to develop training materials, which they said would be finished by September 30th. Since then, as far as I know, no regulations have been issued, and the procurement is not done. Yet, the Mayor's budget proposes to cut the $170,000 in funding.

Implementing this 2020 law to ensure quality care for thousands of DC residents with dementia needs to be a high priority. So, please urge DC Health to finish implementing the 2020 training law asap—to issue the regulations very soon and to spend the budgeted funds to create the training materials by September 30th. If DC Health can't commit to spending the $170,000 by September 30th, then please include that sum in the FY 25 budget. This is too important to fall through the cracks.

Second, all 50 states have an Alzheimer's Plan, but as I have explained previously, DC's Plan expired in 2019. For five years now, DC hasn't had an Alzheimer's Plan, while the number of DC residents with Alzheimer's keeps surging. In January, DC Health testified that a new plan would be released by the end of February. Here we are in April, and a new plan hasn't been released.

DC is the worst hot spot in the nation for Alzheimer's, but without a plan, DC Health isn't comprehensively and adequately addressing our Alzheimer's crisis. Please encourage DC Health to issue the new Alzheimer's Plan in the next few weeks. Then, I hope DC Health distributes the plan widely, and we'll work together to implement the plan.

Third, for a few months last year, DC Health rolled out an extensive Alzheimer's awareness advertising campaign. But the ads only ran for a few months, so they didn't reach so many DC residents who need help.

Since then, the Alzheimer's landscape has changed because there's now an FDA-approved drug called Leqembi, which slows the cognitive decline caused by Alzheimer's. It can only be taken by people in a very early stage of Alzheimer's. Reaching as many DC residents as possible to alert them to the signs of Alzheimer's and to urge them to seek a diagnosis is now the difference between qualifying for treatment and not. DC Health has a five-year public health Alzheimer's grant from the CDC, so they have the funds for another public awareness campaign. Please encourage DC Health to start this renewed awareness campaign soon.

Finally, to address the DC Alzheimer's crisis, we need more home health aides, more geriatricians, and more support for people with Alzheimer's and their families. We especially need a Dementia Care Specialist within the DC government to help people with Alzheimer's and their families all over DC find care. The Care Specialist would work with DC Health's Dementia Services Coordinator, a policy specialist, and with the Dementia Navigation program, which provides long term support for families. My fellow volunteers and I will be testifying at other hearings on this need too.

Thank you.

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Testimony Before the District of Columbia Council
Committee on Health
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Public Hearing:
Budget Oversight Hearing
Department of Health

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Introduction

Good morning, Chairperson Henderson, and members of the Committee. My name is Leah Castelaz. I am a Policy Attorney at Children's Law Center and a resident of the District. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today regarding the Mayor's proposed Fiscal Year 2025 (FY2025) budget for the Department of Health (DC Health). We would like to thank the Mayor for maintaining funding for two critical investments in supporting and improving family well-being: home visiting and HealthySteps. Both home visiting and HealthySteps support a full spectrum of perinatal physical and mental health services in the District.[1] These programs play a primary role in the prevention and early intervention space by ensuring that pregnant and postpartum people receive essential screenings and are actually connected to needed health services.[2] Additionally, HealthySteps and home visiting emphasis on the parent-child relationship and

responsive caregiving helps to improve future outcomes for children. For example, both HealthySteps and home visiting have been shown to support a child's school readiness.[3] Ensuring a child is ready for school is linked to academic achievement as well as the development of self-regulation, peer relationships and communication skills which have important implications for children's school and life success.[4] Given the District's focus on chronic absenteeism, it is critical to look at both prevention and intervention.[5] Investment in programs like HealthySteps and home visiting are essential to support better short-term outcomes, like improving perinatal health, and future outcomes, like creating pathways to success in education.[6]

Maintaining these critical supports for child and family well-being requires a sustained workforce. From our own experiences, Children's Law Center's clients often have significant behavioral health needs compounded by trauma, loss, or instability. The ongoing shortage of social workers creates a major barrier to care for these children and their families. The Health Regulation and Licensing Administration (HRLA), who are processing and administering professional licenses, play a significant role in the comprehensive approach to District workforce development that is so desperately needed. HealthySteps Specialists and some home visitors are required to have licenses to practice and any delays in licensure can result in understaffing for these important programs.[7] Ensuring the capacity to process and administer licenses is critical not only to

ensuring a workforce for HealthySteps and home visiting, but the many health-related programs in the District.[8]

To this end, my testimony today will discuss investments in DC Health that are necessary to support the workforce for District programs that in turn have a positive impact on children and families. My testimony will also discuss home visiting and HealthySteps, and why maintaining funding is critical to ensure families can build key skills and navigate the pivotal years of pregnancy through age five to support a strong foundation and future successes. Specifically, I will discuss (1) the proposed budgets increase of FTEs to the HRLA licensing board as an important step to supporting the professional boards' capacity to process and administer health licenses; (2) the potentially changing landscape of home visiting funding in the District and why the levels of funding proposed in FY2025 budget are necessary; and (3) the need to maintain HealthySteps funding as proposed in the FY2025 budget to ensure newer programs have the opportunity to meaningfully expand to children and families in Wards 7 and 8, and beyond.

The Professional Boards Should Maintain Capacity for the Licensing Administration

To begin, we wanted to express our support for the increase of 4.8 FTEs in HRLA for licensing staff.[9] We hope this investment will reduce the time that applicants are held up in the bureaucratic bottleneck. Given the significant delays behavioral health professionals experience in receiving licensure, we ask that this Committee work with

DC Health to dedicate 1-2 of these positions to support the District's behavioral health care professional boards, especially the Board of Social Work, which is ill-equipped to process licensing applications in an acceptable timeframe.[10]

In FY2023, the Council added ten new licensing specialists.[11] This funding, however, did not give permanent support to any of the three behavioral health Boards (Board of Social Work, The Board of Psychology and The Board of Professional Counseling) and instead went to the Board of Nursing, Board of Medicine, a licensing assistant for the processing center, and a supervisory health licensing specialist.[12] HRLA did acknowledge that additional staff for the three Behavioral Health Boards would be beneficial but choose not to allocate staffing to them.[13] Choosing not to provide more staff is hurting HRLA's performance as evidenced in the length of time it takes to process applications for social work licensure: the average number of days for the Board to approve Independent Clinical Social Workers climbed from 18 days in FY2023 to 45 days in FY2024.[14] For Graduate Social Workers, the average was 23 in FY2023 and almost doubled to 42 days in FY2024.[15] These were among the longest times to approval of any reported license type.[16] The Board of Social Work still has just one assigned staff person and Board of Psychology does not even have a full-time staff person.[17]

We urge this Committee to work with DC Health to ensure social work license applications are processed in a timely manner by adding additional staff to process applications. Ensuring the behavioral health workforce is strong and sustainable will

improve the safety and well-being of people with behavioral health needs in our community.[18]

The Home Visiting Funding in the Proposed Budget Must Be Maintained in FY2025 to Ensure Stability of Programs Amongst Changes in Federal Funding

Home visiting programs are voluntary programs that pair families with in-home support workers during children's earliest years.[19] Through the development of meaningful and sustained relationships with families, home visits improve many outcomes for children and families including maternal and child health; prevention of child injuries, child abuse or maltreatment; improvement in school readiness and achievement; reduction in crime or domestic violence; and improvements in family economic self-sufficiency.[20] Home visitors can play an important role in identifying and addressing parents' needs from screening for maternal depression, to providing education about parent-child interaction, to connecting parents to community-based supports that address challenges that might impact their parenting.

Currently, DC Health funds five home visiting programs through a mix of local funds and federal funds.[21] Additionally, DC Health is funding the evaluations of two additional home visiting programs in the District.[22] DC Health representatives have identified home visiting services as a prong in their strategy to improve maternal and child health in the District, citing that home visiting supports early entry into quality prenatal care.[23] Based on reported data, home visiting programs are doing just that – improving perinatal and infant health outcomes.[24] For example, DC Health reported that in FY2023 there was an

overall increase in preterm births, however, home visiting programs reported no infants (among pregnant persons enrolled prenatally before 37 weeks) were born preterm following program enrollment.[25] Overall, home visiting is a critical program in the continuum of care for pregnant and postpartum people in the District.[26]

Given the positive impact of home visiting programs in the District, we are glad that the Mayor's proposed budget maintains the FY2024 funding for DC Health's home visiting programs.[27] We ask that this Committee preserve the funding for DC Health home visiting programs so the funding levels remain the same as they were in FY2024. We are excited by the Home Visiting Medicaid Reimbursement Act of 2023's recent enactment, which will open up Medicaid reimbursement for home visiting in the District.[28] We will testify further on the necessary investments for the legislation at the Department of Health Care Finance's budget oversight hearing.

We would like to note that several of the programs funded through DC Health could be eligible for Medicaid reimbursement including Community of Hope's Parents as Teachers program and Mary's Center's Healthy Families America.[29] DC Health home visiting programs' ability to draw down Medicaid dollars opens up the possibility for more consistent and stable funding, with the federal match, for these vital home visiting programs.[30] The legislation requires a per-member per-month payment for home visiting programs, which would allow programs to consistently budget dependent on the number of enrollees and the reimbursement rate established.[31] This model is well-suited

to cover the work of home visitors and support provided services like breastfeeding education, parenting skills, family planning, nutritional information, case management, referral to services, screening, and health promotion and counseling.[32]

Even with a per-member per-month payment, Medicaid does not pay for the full costs of operating a home visiting program; there will be certain aspects of a program that will not be able to draw down Medicaid reimbursement, including training of home visitors, data management, supervision, and related administrative activities.[33] The aspects of home visiting programs not covered by Medicaid can, however, be covered by sufficient investment of other funding streams, such as local and other federal dollars.[34] Medicaid reimbursement for home visiting provides a path toward greater investment in an underinvested service delivery model, but cannot be the only funding source for home visiting programs in the District. It must be strategically braided with other funding sources like Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and local dollars. DC home visiting programs cannot afford to lose any of their progress. We must build up these programs so they can continue to serve DC children and families in the earliest years of development.

The Funding for HealthySteps in FY2025 Proposed Budget Must be Maintained to Ensure Locally Funded Sites Continue to Increase Reach to Children and Parents

Since 2019, the Children's Law Center has advocated for the expansion of HealthySteps, an evidence-based national program model that provides infants and toddlers with social-emotional and development support by integrating child

development specialists into primary care.[35] Embedding behavioral health professionals in the primary care setting allows for increased integration of care, earlier identification of behavioral health issues for both child and caregiver, and greater connection to community supports and resources.[36]

The first few years of a child's life are typically full of rapid change and development for the child, and stress and uncertainty for the parent or caregiver. Without support, younger children are at risk of experiencing a strained parent-child relationship or some form of maltreatment.[37] HealthySteps helps reduce the risk by ensuring parents and caregivers feel equipped to meet the needs of their children as well as their own needs. In FY2023, across all three HealthySteps providers, Children's National, Unity Healthcare, and Georgetown MedStar, the majority of parents were screened for postpartum depression.[38] Through HealthySteps, children were also screened for behavioral and social emotional concerns. Children who were identified for early intervention were connected typically within 45 days.[39]

DC now has nine HealthySteps sites, six of which are locally funded.[40] All locally-funded HealthySteps sites are located in – and serving residents of – Wards 7 and 8.[41] Most recently, local funding has gone to support Healthy Steps at MedStar Georgetown University Hospital (MGUH) KIDS Mobile Medical Clinic (KMMC) which has the unique capability of providing mobile health services on-site to families in DC neighborhoods.[42] With the consistent support of this Council, HealthySteps has made significant progress

since the passage of the Birth-to-Three for All DC Amendment Act of 20218 (Birth-to-Three).[43]

There are still opportunities to grow HealthySteps in the District including expansion of a site to Ward 5, per Birth-to-Three, as well as a newly identified need in the Upper Cardozo area of Ward 1.[44] As the District continues to explore ways to expand HealthySteps, we were glad to see the Mayor's proposed budget does not make any cuts to HealthySteps funding in FY2025.[45] We, therefore, ask this Committee and the DC Council to ensure the proposed funding levels for HealthySteps are maintained and no cuts are made to the HealthySteps budget in FY2025. The current funding levels minimally ensure that HealthySteps can continue to positively impact District families and provides stability to support any future growth opportunities in the coming years.

Conclusion

Thank you for the opportunity to testify today regarding the proposed FY2025 budget for DC Health. We were happy to see no cuts to HealthySteps and home visiting and in the case of HRLA an increase to the budget. We ask the Council to ensure the proposed level of funding is maintained across HRLA, home visiting programs, and HealthySteps.

We recognize that the Council has a difficult road ahead this budget season. Over the last decade, the District's growing economy has supported significant, progressive investments in housing, behavioral health, child welfare prevention, and educational

supports. Unfortunately, this year the District is considering cuts to the budget at a scale the city has not seen since the Great Recession.[46] Many fear that these impressive advancements will come to a halt. However, Children's Law Center believes the District still has a choice. In a time of economic difficulty, the DC Council can choose to take the long view; it can choose to protect important investments in our community's future health and economic development. As you consider spending to drive business and tourism, recognize that the growth and vitality we want in our city requires multi-dimensional investments inclusive of all parts of our community.

Creating a balanced budget does not always require cuts – the District can and should also consider opportunities to raise revenue. To truly maintain our values and the programs that support economically vulnerable District residents, and ensure a stronger economic future, we encourage the Council to consider revenue-raising proposals. The Council must be mindful that the revenue-raising options are balanced and do not wrongly burden low-income residents. We welcome the opportunity to work with the Council as it navigates a difficult budget season to ensure that revenue raised goes to support children and their families.

Thank you for the opportunity to testify. I welcome any questions the Committee may have.

[1] Department of Health Care Finance, Perinatal Mental Health Task Force – Recommendations to Improve Perinatal Mental Health in the District, 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf. "The District, through Mayor Bowser's leadership and commitment to improving maternal health, is undertaking efforts to improve health outcomes and expand options for families to be successful. Bill 250321 builds an existing program and encourages expanding access to home visiting by leveraging federal Medicaid funding." Director, Byrd, Hearing on Home Visiting Reimbursement Act of 2023, October 4, 2023, available at: https://www.youtube.com/watch?v=K8JH7OoxfJw&t=550s; Doctor Doe, Roundtable: Maternal and Infant Health: Addressing Coverage, Care, and Challenges in the District, December 14, 2023, available at: https://www.youtube.com/watch?v=NsQaTDG7_jc.

[2] ZERO to THREE, HealthySteps, The Evidence Base, *available at*: https://www.healthysteps.org/our-impact/the-evidence-base/; National Home Visiting Center, What is Home Visiting?, *available at*: https://nhvrc.org/what-is-home-visiting/#:~:text=Home%20visiting%20is%20a%20holistic%2C%20two-generation%20approach.%201,Services%20Help%20pregnant%20women%20access%20prenatal%20care%20; Health Resources & Services Administration, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, *available at*: https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program.

[3] HealthySteps, *HealthySteps Impacts Important Precursors for School Readiness,* June 3, 2021, *available at*: https://www.healthysteps.org/resource/healthysteps-impacts-important-precursors-for-school-readiness/; Grace Kelley, et. al., *Impacts of Home Visiting Programs on Young Children's School Readiness,* Encyclopedia on Early Childhood Development, 2nd rev. ed., January 2022, *available at*: https://www.child-encyclopedia.com/home-visiting/according-experts/impacts-home-visiting-programs-young-childrens-school-readiness.

[4] Józsa K, Amukune S, Zentai G, Barrett KC. School Readiness Test and Intelligence in Preschool as Predictors of Middle School Success: Result of an Eight-Year Longitudinal Study. J Intell. 2022 Sep 12;10(3):66. doi: 10.3390/jintelligence10030066. PMID: 36135607; PMCID: PMC9503726; Fink Elian, Browne Wendy, Hughes Claire, Gibson Jenny. Using a child's-eye view of social success to understand the importance of school readiness at the transition to formal schooling. Social Development. 2019;28:186–99. doi: 10.1111/sode.12323.

[5] Sarah Y. Kim, *Chronic Absenteeism Remains Stubbornly High in D.C. Schools,* DCist, November 30, 2023, *available at*: https://dcist.com/story/23/11/30/osse-chronic-absenteeism-remains-high-dc-schools/; Lauren Lumpkin, D.C. faces an attendance crisis. Its leaders are struggling to solve it, Washington Post, December 20, 2023, *available at*: https://www.washingtonpost.com/education/2023/12/20/dc-truancy-chronic-absenteeism/; Lauren Lumpkin, Emily Davies, and Meagan Flynn, *D.C. mayor's bill targets truancy, mandates aggressive prosecution,* Washington Post, April 3, 2024, *available at*: https://www.washingtonpost.com/education/2024/04/03/dc-truancy-youth-violence-bowser-bill/.

[6] District of Columbia's Maternal Mortality Review Committee Annual Report, 2021, published September 2023, available at: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/MMRC2021Annual%20ReportFinal.pdf; District of Columbia's Maternal Mortality Review Committee Annual Report, 2014-2018, published December 2021, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Maternal%20Mortality%20Review%20Committee%20Annual%20Report_Finalv2.pdf; FY2023 DC Health Performance Oversight Responses, response to Q43, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232; Perinatal Needs Assessment, 2023, Georgetown University Center for Child and Human Development, *available at*:

https://gucchd.georgetown.edu/Perinatal.php; Colleen Grablick, Black People Accounted For 90% Of Pregnancy-Related Deaths In D.C., Study Finds, April 28, 2022, DCist, *available at*: https://dcist.com/story/22/04/28/dc-maternal-mortality-study-2022/; Perinatal Needs Assessment, 2023, Georgetown University Center for Child and Human Development, *available at*: https://gucchd.georgetown.edu/Perinatal.php; 2023 March of Dimes Report Card for District of Columbia, *available at*: https://www.marchofdimes.org/peristats/reports/district-of-columbia/report-card; and Donna L. Hoyert, Maternal Mortality Rates in the United States, 2021, Centers for Disease Control and Prevention, March 2023, *available at*: https://www.cdc.gov/nchs/data/hestat/maternalmortality/2021/maternal-mortality-rates-2021.htm#Table.

[7] A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District (December 2021), *available at*: https://childrenslawcenter.org/wpcontent/uploads/2021/12/BHSystemTransformation_Final_121321.pdf. This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition. *See also* Amber Rieke, Internal Letter to Committee on Health, March 4, 2024, on file with the Children's Law Center; Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (January 18, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/01/L.Castelaz_DC-Health-Performance-Oversight-Hearing_1.17.2024_FINAL.pdf; and Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (April 10, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/04/L.-Castelaz_Childrens-Law-Center-Testimony-before-the-DC-Council_Budget_DC-Health_4.10.23.pdf.

[8] Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (January 18, 2024), available at: https://childrenslawcenter.org/wp-content/uploads/2024/01/L.Castelaz_DC-Health-Performance-Oversight-Hearing_1.17.2024_FINAL.pdf.

[9] Mayor's Proposed FY 2022 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-42.

[10] Amber Rieke, Children's Law Center Testimony before the DC Council Committee on Health, (February 28, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/AmberRieke_CLC_PerformanceOversightTestimony_BoardofSW_Feb2023.pdf; Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (April 10, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/04/L.-Castelaz_Childrens-Law-Center-Testimony-before-the-DC-Council_Budget_DC-Health_4.10.23.pdf; Children's Law Center Letter to DC Council Committee on Health, Chairperson Christina Henderson, (March 4, 2024), on file with the Children's Law Center.

[11] "Additional enhancements to the Health Regulation and Licensing Administration division Include $932,131 and 10.0 FTEs to support reviewing and processing professional licenses." *See* FY2023, DC Health Budget, E-55.

[12] FY2022 DC Health Performance Oversight Responses, response to Q109, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

[13] *Id*.

[14] FY2023 DC Health Performance Oversight Responses, response to Q123, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

[15] FY2023 DC Health Performance Oversight Responses, response to Q123, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

[16] *Id.*
[17] FY2023 DC Health Performance Oversight Responses, response to Q123, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.
[18] Children's Law Center Letter to DC Council Committee on Health, Chairperson Christina Henderson, (March 4, 2024), on file with the Children's Law Center.
[19] Under 3 DC, Home Visiting, *available at*: https://under3dc.org/wp-content/uploads/2021/05/U3DC-Home-Visiting-5-11-21.pdf; District of Columbia Home Visiting Council, *available at*: http://www.dchomevisiting.org/.
[20] Health Resources & Services Administration (HRS), Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), *available at*: https://mchb.hrsa.gov/programs-impact/programs/homevisiting/maternal-infant-early-childhood-home-visiting-miechv-program; U.S. Department of Health and Human Services, Home Visiting, Office of Planning, Research, & Evaluation An Office of the Administration for Children and Families, *available at*: https://www.acf.hhs.gov/opre/topic/home-visiting; Under 3 DC Coalition. Home Visiting, *available at*: https://under3dc.org/wpcontent/uploads/2021/05/U3DC-Home-Visiting-5-11-21.pdf.
[21] FY2023 Department of Health Performance Oversight Responses, response to Q45, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.
[22] The programs being elevated are Mamatoto Village and Georgetown. *See* FY2023 Department of Health Performance Oversight Responses, response to Q45, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232. *See also* DC Home Visiting Council, Annual Report FY2023, *available at*: https://wearedcaction.org/wp-content/uploads/2023-Home-Visiting-Council-Annual-Report.pdf.
[23] Doctor Doe, Roundtable: Maternal and Infant Health: Addressing Coverage, Care, and Challenges in the District, December 14, 2023, *available at*: https://www.youtube.com/watch?v=NsQaTDG7_jc.
[24] FY2023 Department of Health Performance Oversight Responses, response to Q45, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.
[25] Mary's Center Data on Nurse Family Partnership, on file with Children's Law Center; FY2023 Department of Health Performance Oversight Responses, responses to Q34 & Q45, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.
[26] Department of Health Care Finance, Perinatal Mental Health Task Force – Recommendations to Improve Perinatal Mental Health in the District, 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf.
[27] Mayor's Proposed FY 2022 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-40.
[28] DC Act 25-0390, Home Visiting Services Reimbursement Act of 2023.
[29] "Eligible home visiting program" means a home visiting program that conforms to a home visitation model that has been in existence for at least 3 years and: knowledge; "(A) Is research-based and grounded in relevant empirically based "(B) Has demonstrated program-determined outcomes; "(C) Is associated with a national organization, institution of higher education, or other organization that has comprehensive home visitation program standards to ensure high quality service delivery and continuous program quality improvement; and "(D) Meets the U.S. Department of Health and Human Services' criteria for evidence of effectiveness as determined by a Home Visiting Evidence of Effectiveness review or meets substantially equivalent criteria for evidence of effectiveness as determined by a credible, independent academic or research organization." DC Act 25-0390, Home Visiting Services

Reimbursement Act of 2023, Sec. 111. Reimbursement for home visiting services. (c)(3)(A)-(D). *See also* Healthy Families America, Find a HFA Site, *available at*: https://www.healthyfamiliesamerica.org/sites/; Parents As Teachers, Find a Location, *available at*: https://parentsasteachers.org/program-locator/; U.S. Department of Health & Human Services, Models eligible for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding, 2024, *available at*: https://homvee.acf.hhs.gov/HRSA-Models-Eligible-MIECHV-Grantees; Nurse-Family Partnership, District of Columbia, *available at*: https://www.nursefamilypartnership.org/locations/district-of-columbia/; The Family Place, HIPPY Home Visiting, *available at*: https://www.thefamilyplacedc.org/hippy-home-visiting.

[30] HRSA, Managing Multiple Funding Sources to Supporting Home Visiting Programs, *available at*: https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/managing-multiple-funding.pdf; Elisabeth Burak and Vikki Wachino, *Promoting the Mental Health of Parents and Children by Strengthening Medicaid Support for Home Visiting,* Think Bigger Do Good, May 9, 2023, *available at*: https://thinkbiggerdogood.org/promoting-the-mental-health-of-parents-and-children-by-strengthening-medicaid-support-for-home-visiting/; and National Academy for State Health Policy, *Medicaid Reimbursement for Home Visiting: Findings from a 50-State Analysis,* May 1, 2023, *available at*: https://nashp.org/state-medicaid-reimbursement-for-home-visiting-findings-from-a-50-state-analysis/.

[31] National Academy for State Health Policy, *Medicaid Reimbursement for Home Visiting: Findings from a 50-State Analysis,* May 1, 2023, *available at*: https://nashp.org/state-medicaid-reimbursement-for-home-visiting-findings-from-a-50-state-analysis/.

[32] At least 19 states cover some form of skill building provided by home visiting, including Maryland. *See* National Academy for State Health Policy, *Medicaid Reimbursement for Home Visiting: Findings from a 50-State Analysis,* May 1, 2023,*available at*: https://nashp.org/state-medicaid-reimbursement-for-home-visiting-findings-from-a-50-state-analysis/.

[33] National Academy for State Health Policy, *Medicaid Reimbursement for Home Visiting: Findings from a 50-State Analysis,* May 1, 2023, *available at*: https://nashp.org/state-medicaid-reimbursement-for-home-visiting-findings-from-a-50-state-analysis/; Elisabeth Wright Burak, *How Are States Using Medicaid to Pay for Home Visiting? New Paper Offers More Clarity,* Georgetown University McCourt School of Public Policy Center for Children and Families, January 24, 2019, *available at*: https://ccf.georgetown.edu/2019/01/24/how-are-states-using-medicaid-to-pay-for-home-visiting-new-paper-offers-more-clarity/.

[34] For example, the administrative aspect of billing Medicaid can at times be burdensome, especially for community-based organizations that do not currently bill for services and may lack the experience or staff to properly bill. Home visiting programs across the District must be able to access funds other than Medicaid to support their administrative capacities. *See* Rachel Herzfeldt-Kamprath, et. al., *Medicaid and Home Visiting Best Practice from States,* CAP 20, January 25, 2017, *available at*: https://www.americanprogress.org/article/medicaid-and-home-visiting/.

[35] Anne Cunningham, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (April 9, 2019), *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/07/DC-Health-FY2020-Budget-Hearing-Childrens-Law-Center-Testimony-FINAL-nj.pdf; Tami Weerasingha-Cote, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 20, 2020), *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/07/FINAL-Childrens-Law-Center-2020-Performance-Oversight-Testimony-for-DC-Health_0.pdf; Sharra E. Greer, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (March 19, 2021), *available at:* https://childrenslawcenter.org/wp-content/uploads/2021/07/SGreer_Childrens-Law-Center-Testimony-for-March-19-2021-DC-Health-

Oversight-Hearing_FINAL-1.pdf; Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (February 23, 2022), *available at:* https://childrenslawcenter.org/wp-content/uploads/2022/02/LCastelaz_Childrens-Law-Center-Testimony-for-Fe.-23-2022-DC-Health-Oversight-Hearing_Final-Exhibit-A.pdf; Leah Castelaz, Children's Law Center, Testimony before the District of Columbia Council Committee on Health, (March 2, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/03/LeahCastelaz_PerformanceOversightTestimony_CommitteeonHealth_DCHealth.pdf. *See also* ZERO to THREE, *HealthySteps, available at:* https://www.healthysteps.org/.

[36] HealthySteps Specialists can deliver clinic-based mental health visits with families to address critical needs in areas such as maternal depression, grief and loss, and child behavior management. Specialists can also answer questions about behavioral health as well as facilitate the development of attachment, self-regulation skills, and family resiliency. Early Childhood Innovation Network, Innovation Spotlight: HealthySteps DC, May 2019, ECIN Newsletter, *available at*: https://www.ecin.org/newsletter-may-2019. Family Service Coordinators provide dedicated case management and care coordination for families through the support of DC residents with lived experience navigating systems. Early Childhood Innovation Network, Innovation Spotlight: HealthySteps DC, May 2019, ECIN Newsletter, *available at*: https://www.ecin.org/newsletter-may-2019.

[37] Nationally, children in the first year of their life are 15% of all victims, and more than a quarter (28%) of child maltreatment victims are no more than 2 years old. *See* National Children's Alliance, National Statistics on Child Abuse, *available at*: https://www.nationalchildrensalliance.org/media-room/national-statistics-on-child-abuse/#:~:text=Children%20in%20the%20first%20year,more%20than%202%20years%20old. In DC, children ages zero to three represent 20 percent (104/496) of all children removed by the Child and Family Services Agency (CFSA). *See* FY2023 Child and Family Services Agency Performance Oversight Responses, response to Q146(a), *available at*: https://lims.dccouncil.gov/Hearings/hearings/253.

[38] FY2023 Department of Health Performance Oversight Responses, response to Q46, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

[39] *Id.*

[40] FY2023 Department of Health Performance Oversight Responses, response to Q46, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

[41] *Id.*

[42] FY2023 Department of Health Performance Oversight Responses, response to Q46, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

[43] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[44] "Healthy Steps grantees have communicated that there is an unmet need for an additional HealthySteps Site in Ward 1, Upper Cardozo, as most of their pediatric population resides in that area." *See* FY2023 Department of Health Performance Oversight Responses, response to Q46, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232. Additionally, there are opportunities for sustained financing for HealthySteps in the District. Several other jurisdictions have pursued this type of financing. In January, California launched new dyadic benefits that are modeled after HealthySteps and provide an opportunity to offer services to children and families during a child's pediatric visits. See California Department of Health Care Services, Medi-Cal Children's Initiatives (2022), *available at*: https://www.dhcs.ca.gov/services/Documents/DHCS-Childrens-Initiatives.pdf; First 5 Center for Children's Policy, New Children's Medi-Cal Behavioral Health Benefits 101: Family Therapy and Dyadic Services, *available at*: https://first5center.org/blog/new-childrens-medi-cal-behavioral-health-benefits-101family-therapy-and-dyadic-services. Additionally, starting in January, Maryland will have Medicaid

enhanced payments for CenteringPregnancy and HealthySteps services. The payments will provide an enhanced $15 rate per well-child and sick visits for all children birth to age 4 at HealthySteps sites in Maryland (and in DC if children with Maryland Medicaid coverage seek care at DC HealthySteps sites). See Maryland Department of Health, Maryland Medical Assistance Program, Deputy Medicaid Director Letter RE: Coverage of CenteringPregnancy and HealthySteps Services (December 16, 2022), *available at*: https://health.maryland.gov/mmcp/Documents/PT%2030-23%20Coverage%20of%20CenteringPregnancy%20and%20HealthySteps%20Services.pdf.

[45] Mayor's Proposed FY 2022 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-40.

[46] Cuneyt Fil, *D.C. got used to big budgets, but deep cuts are back,* AXOIS DC, March 7, 2024, *available at*: https://www.axios.com/local/washington-dc/2024/03/07/budget-cuts-layoffs-tax-hike.

JOINT BUDGET COMMITTEE ON HEALTH
TESTIMONY OF WARD 8 FARMERS MARKET, INC. (a 501(c)(3))
By John Gloster, Chairperson of the Board

April 10, 2024 (12 pm)

Good afternoon, Chairperson and members of the Joint Budget Committee on Health.

I am John Gloster. I am the founder and Board chair of the Ward 8 Farmers Market. The Ward 8 Farmers Market is the creation of Ward 8 residents who banded together after the last supermarket in the Ward closed in 1997. It was a bold, self-empowerment move at a time when the Ward's residents felt disempowered, cast off by business interests, and forgotten and neglected by our government. Today, we live in the eerie déjà vu of an Alabama Avenue Giant with empty shelves, poorly run by management that is so afraid of shoplifters that they seem intent on running the store into the ground.

Back in August of 1998, when the Ward 8 Farmers Market began operation, there were no farmers markets in Ward 8. There were no farm stands. There was not even a converted school bus pulling up with produce. Eventually, other markets would pop up. Established nonprofits from across the River came and raised a flag in Ward 8. Some continue to help bridge gaps in the Ward. Some may have come principally because it had become fashionable to do so and was useful in raising funds. But we have remained an authentic Ward 8 product: created by Ward 8 residents, for Ward 8 residents. We are more than a service; more than a place and time for transactions. We are a community.

Along the way, we have served hundreds of Ward 8 families, providing the substance of many tens of thousands of healthy meals. Many years ago, WE pioneered a program of putting healthy fruits and vegetables in corner stores. We have had innumerable healthy cooking demonstrations, free blood pressure readings, free dental exams, free yoga classes, meditation, massages, line dancing and more. Many of our vendors have traditionally been Ward 8 residents, providing some a means to tryout and grow their entrepreneurial aspirations. For others, it is more about a way to connect with the community.

Perhaps it should not be surprising that we have done this all on a shoestring all these years. We have never quite reached that critical mass where we could attract enough funding to hire a fulltime market manager all-year around, so that we could properly grow the organization. Instead, we have to reinvent ourselves each new season, reminding our customers where we are, and pulling up stakes every few years for lack of a permanent location.

Our problem is not confined to the Ward 8 Farmers Market. Other grassroot nonprofit efforts struggle in the same way to reach that critical mass that would inspire more confidence in grantors and qualify us for another tier of funding.

We would like to make a suggestion and a request. We ask this Committee and the Council to place a requirement on related grants requiring that grantees provide a minimum percentage of their awards in subgrants or subcontracts to local, small nonprofits in the communities they serve (especially in Wards 8 and 7). By small nonprofits, we mean those with annual budgets of less than $250,000. The concept is the nonprofit analog to the CBE requirements placed on construction contracts. In this way, the government, through the Council, can tap the larger nonprofits to help mentor and nurture smaller, grassroots nonprofits toward sustainability. In this way, more of those ideas and energies that come directly from the community can reach their highest expression. We hope that you share and value this

ideal. If you do, please take action in **this** budget cycle. Fund healthy lifestyle transformation, particularly East of the River, and pair it with a mandate to partner with small, local nonprofits. Thank you.

AMERICAN ATHEISTS

April 10, 2024

The Honorable Councilmember Christina Henderson
Chairperson, Committee on Health
The John Wilson Building
1350 Pennsylvania Avenue NW
Washington, DC 20004

Re: Informing the Committee on Health regarding the issue of medical denial of care from health institutions and practitioners, encouraging the Committee to explore this issue further

Dear Chairperson Henderson and Members of the Committee on Health:

My name is Rob Hofmann. I am a Ward 5 resident and have lived in DC for almost five years, but I am here today in my role as the State Policy Manager for American Atheists. American Atheists is a national civil rights organization dedicated to equality for atheists and other nonreligious people. We protect the rights of atheists, advance social inclusion, and empower nonreligious people through advocacy, education, and community building.

I am here today to discuss the issue of nonmedical denial of care by health care institutions, which has a disproportionate impact on LGBTQ individuals and pregnant individuals in the District. Denial of care increases insurance costs and negatively impacts patient outcomes, and therefore the Department of Health, DBH, and the Committee on Health should take steps to mitigate these harms by requiring disclosure and transparency.

Federal and District law allows hospitals and health care facilities to deny various types of care based on nonmedical factors such as the religious beliefs of hospital executives. Because hospitals often fail to publicly disclose nonmedical restrictions on services, patients too often lack vital information necessary to make critical decisions about their health and where to receive care, including care for LGBTQ people, end-of-life care, and reproductive care.

For example, a hospital may deny emergency contraception to a survivor of rape, timely abortion care for a pregnant person whose life is at risk,[1] sterilization procedures for patients seeking them, or gender affirming care for trans patients. There is no requirement that health facilities warn patients that they will be denied care, and too often, patients may not even be informed of all their medical options. This lack of information can result in patients wasting time and money,

[1] A nationally representative survey found that 11% of participants had someone on their plan who was denied reproductive care. Hebert LE, Wingo EE, Hasselbacher L, Schueler KE, Freedman LR, Stulberg DB. (2020). Reproductive healthcare denials among a privately insured population. *Preventive Medicine Reports*. 2021;23:101450.

being prevented from receiving needed care, facing discrimination, and even suffering increased risk in emergency situations.

While some types of denial of care are required under federal law, the District can and should require hospitals and health care facilities to inform patients and the Department of Health about nonmedical restrictions on care. The informed consent process is a well-recognized and critically important factor in health care, but there cannot be informed consent if key information about treatment options is withheld from patients. If care related to pregnancy management or gender affirming care is withheld because of a facility's religious beliefs without a patient's knowledge, the informed consent process has been breached.

Several factors make nonmedical denial of care an increasingly significant problem in DC. Because nearby states have banned or have considered severely limited access to abortion services after the Dobbs decision,[2] the number of patients crossing state lines to access reproductive care in DC has and likely will continue to increase. Similarly, an increased number of people are seeking gender affirming care across state lines as more states consider banning health care services for trans people. Patients visiting DC for medical services need to know where they can access necessary care and where the care they seek may be denied. Requiring disclosure to patients about nonmedical denial of care would help address this.

This issue is especially important in the District, which has one of the largest populations of trans people in the country.[3] The U.S. Conference of Catholic Bishops, which issues guidelines that Catholic hospitals must follow, has recently issued new guidance to limit trans care overall, seemingly in conflict with discrimination laws both in the District and the federal level.[4] As of 2020, one out of five hospital beds in DC are in religious facilities that deny care for nonmedical reasons.[5]

Refusals of care have real consequences for those denied needed services, particularly if they already face barriers to care or discrimination.

- In an assessment of 34 states, one study found that delivering at a Catholic hospital was much more common among Black and Hispanic women than among white women. Black women are especially vulnerable to denial of reproductive health care because they are significantly more likely to die from pregnancy-related causes and more likely to seek

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[2] *Dobbs v. Jackson Women's Health Organization*, 597 US __ (2022).
[3] LGBT Demographic Data Interactive. (January 2019). Los Angeles, CA: The Williams Institute, UCLA School of Law. Retrieved from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=11#about-the-data.
[4] U.S. Conf. of Catholic Bishops, *Doctrinal Note on the Moral Limits to Technological Manipulation of the Human Body* (20 March 2023). Retrieved from https://www.usccb.org/resources/Doctrinal%20Note%202023-03-20.pdf.
[5] Solomon, Uttley, HasBrouck, and Jung. (2020). *Bigger and Bigger: The Growth of Catholic Health Systems. Community Catalyst*. Retrieved from https://communitycatalyst.org/wp-content/uploads/2022/11/2020-Cath-Hosp-Report-2020-31.pdf.

frequently restricted services such as abortion or tubal ligation.[6]

- Nearly one in five LGBTQ people, including 31% of trans people, report that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away.[7]

Notably, denial of care is not restricted to any one type of hospital or health facility. Research has also shown that reproductive and LGBTQ care are frequently denied by both religious and secular institutions.[8]

Pregnant patients should feel comfortable that the hospital they select will provide the lifesaving care they need in the event of a complication, and LGBTQ patients should know where they can receive the care they need without judgment or discrimination. No one should have to spend time and money seeking health care only to be unexpectedly turned away by hospitals that prioritize the beliefs of executives over the health and safety of their patients.

We urge you to consider how the Department of Health, DBH, and the DC Council can address this important issue**.** American Atheists, along with national partners, has worked to address the issue of denial of care in several states, and we would eagerly work with the Departments and Councilmembers to help ensure that denial of care is appropriately disclosed to patients before they receive services. Thank you for your time and consideration.

Sincerely,

Rob Hofmann
State Policy Manager
American Atheists

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[6] Shepherd, K., et al. (2018). *Bearing Faith: The Limits of Catholic Health Care for Women of Color.* Public Rights & Private Conscience Project and Public Health Solutions. Retrieved from https://lawrightsreligion.law.columbia.edu/bearingfaith.

[7] Mirza, S. A., & Rooney, C. (2019, July 19). *Discrimination prevents LGBTQ people from accessing health care*. Center for American Progress. Retrieved from https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care/.

[8] Platt, L., et al. (2021). *The Southern Hospitals Report: Faith, Culture, and Abortion Bans in the U.S. South.* Columbia Law School Law, Rights, and Religion Project. Retrieved from https://lawrightsreligion.law.columbia.edu/content/southern-hospitals-report.

Testimony of Mary Katherine West
Home Visiting Program Manager
Committee on Health
Department of Health
Fiscal Year 2025
Council of the District of Columbia

April 10, 2024

Good afternoon Chairperson Henderson and members of the Committee on Health. Thank you for the opportunity to address the Committee as it conducts this budget oversight hearing for DC Health. Thank you Chairperson Henderson for your ongoing support for families in the District. My name is Mary Katherine West, and I am the Chair of the DC Home Visiting Council and a Program Manager for Early Childhood at DC Action. I am a member of the Under 3 DC Coalition, and a Ward 1 resident.

DC Action uses research, data, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. Our collaborative advocacy initiatives bring the power of young people and all residents to raise their voices to create change. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

In this tight FY25 budget year, we are thankful that the mayor has not cut funding for the DC Health home visiting program. We ask the council to maintain this funding at its $1.5 million budget allocation.

DC Health supports four home visiting programs and two home visiting program evaluations. In FY23, DC Health performance oversight responses report these programs served 885 caregivers and 381 children in the District. To learn more about DC Health home visiting programs, please refer to my performance oversight testimony.

Home visiting is a critical component of DC's early childhood strategy. Home visitors, participants, and advocates have shared for years that the four DC Health home visiting programs have endured stagnant or diminishing grant funding. Failure to align funding levels over the past several years with the cost of the program has caused programs to struggle to support their staff and maintain consistent service delivery for families. While home visiting programs would benefit from increased investment to support these aims,

we ask that minimally the Council maintain the current level of investment this year. Home visitors and participants in these programs cannot afford cuts. We are hopeful that if funded and implemented, the Home Visiting Services Reimbursement Act will be a sustainable funding source that increases investments through the federal match for home visiting programs in the future.

I look forward to testifying in more depth about the impacts of the Home Visiting Services Reimbursement Act at the Department of Health Care Finance Hearing.

Home visiting is a prevention and early intervention service that is free and voluntary for families, and primarily serves low-income Black and brown families living in Wards 4, 5, 7 and 8. Home visiting works to support families in a whole-person, whole-family approach, which results in improved maternal and infant health. In fact, DC Health cited home visiting as an essential component in its strategy to improve maternal and child health in the District.

DC is facing a maternal health crisis, which disproportionately impacts Black and brown mothers and pregnant people. DC Health data show that, over the past six years, severe maternal morbidity, defined as the "outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health," has increased across all demographics. Black women in DC continue to experience severe maternal morbidity at almost double the rate of all other races.

Inadequate access to health care for Black families and racism in health care drive these disparities. For example, in 2022 just over half of District births to Black and Latinx parents involved prenatal care in the first trimester, compared to 81% of births to white parents. Home visitors can help parents initiate prenatal care and support them in getting to all of their appointments.

However, despite committing to supporting and improving the sector and its workers, investment from the District in DC Health's home visiting program grants has consistently declined over the last several years, diminishing programs already limited spending power. Insufficient and unreliable budgets create a stressful work environment for home visitors through inadequate pay, high administrative burden, high stress, and job instability.

Home visitors in the District are highly skilled, educated, and care deeply about the people they work with and the services they provide. They deserve support and stability from their workplace. Through their work they serve as a reliable and personal resource for a family from pregnancy through their child's first years of life. Although all families can use additional support, home visiting in DC serves families that face barriers to resources

and opportunities because of factors such as economic discrimination, racism, and immigration and disability status. With home visiting support, families are able to access resources and learn to advocate for themselves and their children and create a strong foundation for their families.

Budget cuts and lack of support for home visitors will likely cause more home visitors to leave the field, resulting in the breaking of promises and severing of relationships that families can depend on to help them meet their goals. Many parents and families view their home visitor as a central person in their support network. When parents have questions about pregnancy or postpartum experiences, they call their home visitor. When parents complete an educational milestone, land a new job, or get a promotion, they call their home visitor. When parents need to renew their child's insurance, enroll in the child care subsidy program, or apply for rental assistance, they call their home visitor. When a child is sick or takes their first steps, parents call their home visitor. Home visitors are there for families through the most stressful and overwhelming moments of parenthood to offer guidance and support and are there to celebrate the successes and joys raising a child and learning to be the best parent they can.

However, inadequate compensation, high stress, and administrative burden have led to high turnover in the sector for years. Additional cuts will only exacerbate these issues, and families that rely on home visitors as a central part of their support system will be cut off from a critical resource. These families cannot afford to lose this resource and have the promise of this support broken.

We are hopeful that if funded and implemented, the Home Visiting Services Reimbursement Act will be a path for increased and sustained investments for home visiting programs, including several under DC Health's administration.

Home visiting is a proven strategy to improve short and long term outcomes in health, education, and economic self-sufficiency, for both parents and children. As a two-generation solution, home visiting is an investment in the safety and prosperity of DC's residents who are the most vulnerable to the impacts of racism, economic instability, and crime in the District.

Thank you for the opportunity to testify today and I am open to any questions.

Mary Katherine West
Home Visiting Program Manager
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DC APPLESEED

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Testimony of Kristin D. Ewing, Policy Counsel
DC Appleseed Center for Law and Justice

Budget Oversight Hearing:
Department of Health
April 10, 2024

Thank you for the opportunity to provide testimony regarding budget oversight of the Department of Health ("DC Health"). My name is Kristin Ewing, and I am Policy Counsel at the DC Appleseed Center for Law and Justice ("DC Appleseed"). DC Appleseed is a non-profit, non-partisan organization that aims to make the District a better place to live and work through litigation, teamwork, and advocacy. Throughout our history, we have taken on some of the District's most challenging problems, developed proposed solutions to those problems, and then worked to implement our proposed solutions.

Much of my work at DC Appleseed focuses on health equity and working toward a more equitable, just, and thriving city for all District residents. While there are several budget issues related to health equity within the DC Health budget we could address today, my testimony will focus on the critical need for funding to ensure timely reporting of HIV data and the importance of maintaining funding for school-based health centers.

HIV and HAHSTA Data Sharing

The HIV epidemic has long been a focus for DC Appleseed. During its history, DC Appleseed has worked closely with the DC government to address the HIV epidemic in the District.

DC Appleseed continues to ask DC Health and the HIV/AIDS, Hepatitis, STD, and TB Administration ("HAHSTA") to prioritize publishing citywide HIV data more routinely and promptly to ensure providers and advocates can adequately respond and adjust to specific health issues and population trends in real-time. More specifically, DC Appleseed urges the creation of a public dashboard for HIV data that is updated monthly. This request is particularly vital given that, in recent years, it has taken HAHSTA between thirteen and twenty-four months to publish relevant HIV data. HAHSTA's latest Annual Epidemiology & Surveillance Report, which provides data on HIV, Sexually Transmitted Infections, Hepatitis, and Tuberculosis for the District of Columbia, was released on February 22, 2024, but only includes data through December 2022. At the same time, providers must report all suspected or confirmed HIV cases within 48 hours via an online portal.

Given the existing delays in publishing HIV data, we are concerned that the proposed Fiscal Year 2025 budget for DC Health includes the following budget cuts:

- **$175,000 and 2 FTEs are proposed to be cut from HAHSTA's HIV/AIDS Data and Research Activity**, which provides a comprehensive picture of the HIV/AIDS epidemic in the District of Columbia for purposes of ensuring that the needs of people infected with HIV or at risk of infection are met. This activity collaborates with healthcare providers and laboratories to collect and maintain comprehensive HIV/AIDS data confidentially and securely; analyzes, interprets, and distributes epidemiologic information for use in developing public policy, planning, and evaluating prevention intervention and healthcare services.

- **Over half ($4.42M) of the Research Evaluation and Measurement Division's funding is proposed to be cut.** This division plans and coordinates epidemiologic studies and outbreak investigations, defines residents' health status, and assists with tracking health events. It also includes planning, developing, and coordinating appropriate methodologies to collect and process data and monitoring and evaluating health and social issues.

Cuts to these divisions will impede the timely collection and distribution of HIV data to the public. We must fund DC Health and HAHSTA at levels allowing for quick data distribution through an easily accessible medium such as a public dashboard and more timely Annual Epidemiology & Surveillance Reports that contain further context and background. **The District and local health care providers simply cannot adequately respond to HIV when data is outdated**, and we know there are specific populations within the District where HIV is still a continuing or growing concern.

The District's ability to rapidly respond to HIV population trends is a health equity issue. HIV disproportionately impacts our Black, Latine, and LGBTQ+ communities, as well as Wards 7 and 8, where almost 40% of newly diagnosed cases occurred in 2022. DC also struggles to address prevention in youth.

School-Based Health Centers

According to the recently released Annual Epidemiology & Surveillance Report, youth 24 and under account for almost 20% of all newly diagnosed HIV cases in 2022. Given the data on youth and HIV, we are also **concerned to see that School-Based Health Centers within the Community Health Services Division face a $1.5 Million budget cut**. The budget states this is a decrease to reflect savings, so we are hopeful that there will not be a service impact, given how important these centers are to our students. However, if this reduction will impact services, we urge the Committee to provide adequate funding for these health centers.

These centers can serve as the front line for ensuring youth receive care, from sexual and reproductive health surrounding STIs and pregnancy to primary and preventive care for chronic conditions to substance use disorder education and treatment. Providing care on location in the school increases equity and access. Students who may otherwise be unable to afford care or easily access care due to care deserts, school and work schedules, or other obligations and barriers can now easily receive care on-site. We urge you to invest in these centers that provide critical care to our students so they can thrive in school and beyond.

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Please do not hesitate to reach out with any questions regarding my testimony.

Respectfully submitted,

Kristin D. Ewing
Policy Counsel, DC Appleseed Center for Law and Justice
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Good Morning/ Afternoon, Councilmember Henderson and committee members. My name is Deja Williams. I am a Ward 4 DC native and advocate with SPACEs In Action. Today's testimony will focus on supporting the DC Healthy Steps Program and HomeVisiting programs. My Values are family, community, and healthcare. These values matter to me because, as an organizer and advocate for families with babies from birth to three, the health of my community is a top priority to ensure DC families have a healthy start.

The problem I noticed while working with families in DC is financial insecurity and the need for access to healthcare and prevention and early intervention services. These problems are real for all low-income families in the District, evidenced by the increasing rates of food insecurity, inflation, and the cost burden of early childhood education and some health services. Family support services available to DC residents at little or no cost, like Healthy Steps and Home Visiting, can be critical lifelines and an opportunity for families to thrive.

The District has continued to invest in Healthy Steps over the past five years. This Investment has helped to improve the quality of life for families with babies and toddlers. Families can better connect to resources, services, and support to help soothe the stressors of problems that may arise. Through my work with families in DC, mainly in Wards 7 and 8, they have told me great things about Healthy Steps. I have been able to check in with families throughout the months of them being in the program, and we talk about the growth they have seen in their children and themselves as a parents. I have added the personal stories of two Healthy Steps parents and SIA leaders, Candis and Sarah, to my testimony to be added to the written record. Continued funding for this program will ensure that more families can access various physical and behavioral health supports and services through Healthy Steps.

Similarly, Home visiting is a proven effective early childhood service. Home Visiting leads to positive family outcomes and reduces child abuse and neglect. This service allows a holistic and preventive approach to support families, their health, and economic well-being. The problem I have noticed when engaging with various home visitors is the need for investment in the workforce. DC Health has cited home visiting as a critical service in their maternal and child health strategy, but has failed to increase investments over the last several years. Many dedicated home visitors have expressed the need for higher pay. Low wages and a high-stress work environment are causing home visitors to leave their roles for better pay. High turnover disrupts the system and causes inconsistencies with the families they serve. Cuts to home visiting programs would only make these issues worse. Home visitors are crucial to our community's growth and deserve increased investment. In this tight budget year, programs and participants cannot afford cuts to services and must receive maintained funding. Thank you to Mayor Bowser for not proposing any cuts to Home Visiting programs for FY'25, and we hope the Council will maintain funding at its FY24 level of $1.5 million.

The council's following action should be maintaining funding for the Healthy Steps Home Visiting programs at their recent FY 24 levels.. I believe these two services will result in positive outcomes for our families in DC. Thank you, Councilmember Henderson and committee members, for hearing my testimony.

SPACEs in ACTION

Good morning/ Afternoon Councilmember Henderson and committee members.

My name is Candis Hemphill. I am a parent, caregiver, usher at my local church, and leader with SPACE's In Action. My testimony today will focus on support of DC's Healthy Steps Program for a strong, effective, and connected early childhood system in the District. I am a HS Parent Advisory Council member for the Children's National- The Arc, Anacostia, and the National Board. My values include family, community and health. These values matter to me because, as a parent, I ensure my daughter has the care she needs in education and health to thrive in the community. Mental health is essential to me because I need the proper care to raise my daughter.

The problem I faced was I had my daughter prematurely in May 2021. I was not able to go through with my original birthing plan and had to have a C- section, which I did not want. After she was born, I was told I had to find a doctor. I visited Children's National- The Arc. During her first pediatric visit, I was approached by the Family Services Coordinator about the Healthy Steps program. I did a questionnaire about post-partum depression. I joined the Healthy Steps Parent Advisory Council and found support from the other parents. During this whole process, I became a single parent. My grandmother and my father also passed away in 2021. I was a new mom on maternity leave dealing with grief. The isolation from maternity leave made it very hard to function. Before joining this program, I was depressed, drained, fearful, and hurt.

The solution I found was Healthy Steps. Healthy Steps gave me something to look forward to, too. I had a space where my needs and concerns were met, and my feedback was appreciated. I felt seen as a mother. Once a month, during the Parent Advisory Council Meetings, we receive information regarding our children's health. For example, when the Covid-19 vaccine was available for children under 5, the HS PAC meeting gave us all the details on getting vaccinated. We get gift cards for attending some meetings, which has helped provide necessities such as food.Healthy Steps provided me with not only a safe space but resources as well. I received diapers, wipes, and pamphlets on parenting. The topics included post-partum depression, breastfeeding, sleeping habits, etc. Healthy Steps has given me many tools to be a healthy parent and raise a healthy child.

The next action step should be to continue funding the Healthy Steps program. Continued funding for Healthy Steps will ensure more sites can be opened and more families can be served. All parents in DC should have access to these services. If all parents in DC had access to this program, we could guarantee a happy and healthy future for our babies in DC. Thank you, Councilmember Henderson and committee members, for hearing my testimony.

SPACEs in ACTION

Good Morning/ Afternoon, Chairperson Henderson and Members of the Committee. My name is Sarah Venable. I am a proud mom and leader with SPACEs In Action. My values are teaching my daughter Lyric to be responsible and hold everyone accountable for their actions and behaviors and also to learn with her as she grows.

I have lived in Washington, DC, all my life and have had DHS healthcare. They consider themselves helping with cost and care; however, some of my family's and my needs aren't met. I struggle with my care needs not being taken seriously because I'm placed in a group with others that doesn't suffer from all I do. Meaning they are my age, health coverage, etc, to tell me I don't meet their standards to receive care or medication all because of a number group I fall under. That forces me and my care providers to fill out not one, not even two, but three prior authorizations and or take other steps to MAKE me now eligible for certain medications and CARE. If I'm sick, I must do things that qualify me to be healthy under DHS terms. That's not fair, and I think it is judgmental, biased, and racist. Because of studies from people who just see us as numbers said a percentage of black people are more likely, or this age group doesn't qualify, or females are most likely, and or men aren't qualified. We all are different and shouldn't be placed in any bracket to make others' jobs easier when it is making our health worse or neglecting our Health. I am human and struggle with these things every day, and sometimes I am scared to reach out because I know I'll be placed, not helped, or have to go the extra mile just to be seen or heard.

Healthy steps care management takes loads of stress off me when dealing with my daughter because I am a new mom, and my child needs extra support. This gives me the support to keep going and not give up. I suffer from mental illness, and one of my biggest concerns is my depression and PTSD. Healthy Steps care team helps my daughter's daily life be smooth and safe. They use everything in their power and protocol to ensure and increase my daughter's and my health's safety. Healthy Step program helps parents with different care problems to believe again. Healthy steps are and will always be necessary. The council should maintain funding for the Healthy Steps program in DC so that more families can benefit from this excellent service.

Testimony before the
Council of the District of Columbia

Committee on Health

FY25 Budget Oversight Hearing
for the
DC Health

* * *

Presented by
Jacqueline D. Bowens
President & CEO
April 10, 2024

Greetings Chair Henderson and members of the Committee on Health, my name is Jacqueline D. Bowens, and I am the President and CEO of the District of Columbia Hospital Association. I appreciate the opportunity to present testimony on DC Health's FY25 budget.

DCHA has been the unifying voice of the District's hospitals for over 45 years. We are committed to promoting policies and initiatives that strengthen our system of care, preserve access, eliminate disparities and promote better health outcomes for patients and our community. Our driving vision is to achieve an efficient and effective health care delivery system that supports a healthy, equitable and vibrant community.

As we look at DC Health's FY25 budget, ensuring investments are maintained across the vital services the Department provides to the city. Its investments in tackling

chronic diseases, improving maternal and infant health as well as ensuring the health system is adequately prepared for any emergency the city may face are all critical. We urge the Committee to continue infusing funding to target improved outcomes for our moms and infants, which DCHA is proud to partner with the department in these efforts. Specifically, we urge the Committee to fund the Count the Kicks Campaign as part of the work of the Perinatal Quality Collaborative.

As we look at the challenges facing health care, one of the most pressing is the need to continue our work of creating a pipeline of District residents ready to take on all the challenges that health care faces. This will take continued investment in loan repayment as well as the scholarship programs designed to support DC Residents seeking to get credentialed in health occupations most in need.

Another important tool to attract employees to healthcare in the District is a streamlined licensure process. We are grateful for the continued partnership with Dr. Bennett and the Health Regulation & Licensure Administration team. Its continued work to improve the licensure process is very much appreciated and needs to be continued. Investments in IT to make sure the process is easy for applicants is essential.

Over the last two years, the Committee on Health has made a significant investment in licensing specialists that should be preserved in this year's budget. We anticipate an increased number of applications being processed for the foreseeable future, especially with the newly licensed occupations included in the HORA revision. We must ensure an adequate number of licensing specialists are available and able to respond to applicants and process applications quickly. I

would especially like to thank Dr. Teresa Walsh and Antoinette Butler at the Board of Nursing for their partnership in trouble shooting applications.

Additionally, we renew our call to ensure the Department allocates staff to improve customer service by answering calls to reduce the number of complaints received about not being able to talk to someone within health professional licensing.

Continued investment in emergency preparedness is essential as we seek to ensure our health system is resilient in case of emergencies or disasters. This is a new ASPR grant cycle for the Hospital Preparedness Program budget period, and we are committed to providing assistance to DC Health to ensure the new grant period is a success.

Finally, we know the Committee plans to hold a hearing on the Certificate of Need process in the near future and we

believe the CON BSA subtitle should be handled through the normal legislative process.

Thank you for the opportunity to testify and I am happy to answer any questions.

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Christina Henderson, Chair, DC Council Committee on Health
Members of the Committee on Health
From: Patricia Quinn, VP of Policy and Partnerships, DC Primary Care Association
Re: Budget Hearing for DC Department of Health
Date: April 10, 2024

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming care delivery, and advancing racial and health equity. Our strategic focus areas include:

- Value-based reimbursement
- HIT (Health Information Technology) innovation for health centers
- Cross-continuum stakeholder relationships
- Equity-oriented programs and innovations
- Health center infrastructure and operations

Our collaborators in this work include community health centers, serving over 180,000 patients in every ward of the city. Our members serve District residents most impacted by inequity—95% of health center patients are racial or ethnic minority, 88% have incomes below 200% of the federal poverty level, and 37% are best served in a language other than English.[1] Health centers are at the nexus of efforts to rewrite DC's story of health inequity, and we are grateful for the partnership we have forged over decades with the DC Department of Health. We appreciate the opportunity to provide testimony regarding DC Health's FY25 budget.

DCPCA's partnership with DC Health spans multiple bureaus across the Community Health Administration (CHA) and includes work with Health Emergency Preparedness and Response Administration (HEPRA) and the Office of Health Equity (OHE). CHA is particularly critical to our shared work to build and sustain the robust primary health care system DC must have to improve health outcomes and increase health equity. DC Health is an important voice and thought partner for DCPCA and for sister health sector agencies in championing exactly the kind of preventative services primary care is designed to deliver.

National research shows greater primary care spending in each state is associated with fewer emergency department visits and hospitalizations.[2] Medicare research on regular and continuous primary care

[1] https://data.hrsa.gov/tools/data-reporting/program-data/state/DC

[2] Investing in Primary Care, A State-Level Analysis, Patient-Centered Primary Care Collaborative, Robert Graham Center, Data from 2019

shows a $3,000 cost differential yearly per patient.[3] Given the difficult fiscal environment, it is more vital than ever to make sure that cost effective, comprehensive primary care is accessible to all District residents to prevent more expensive tertiary and specialist care from becoming necessary.

Instead, the primary care system in the US has deteriorated – nationally, primary care spending as a percentage of overall health spending remains stagnant. Additionally, the number of primary care physicians has declined, and the burden of chronic disease has risen. The result is that fewer providers are treating patients of greater complexity, accelerating burnout and workforce shortages.

Federal officials are increasingly concerned about the lack of investment in primary care and are seeking remedies. The Center for Medicare and Medicaid (CMS) recently launched two new payment models--*Making Care Primary* (MCP) and *Advancing All-Payer Health Equity Approaches and Development* (AHEAD)--that center primary care and make needed investments in primary care infrastructure. The 10-year testing phase of these primary care innovations will show the connection between early investments and longer-term outcomes. Additionally, CMS is supporting states to integrate social care and community health workers into standards of care.

As DC Health and the Committee on Health work to finalize the FY25 budget, we urge policymakers to maintain and strengthen investments in primary care to ensure that every patient and provider benefits from a primary care system that prioritizes human caring and connection. We seek to better understand the $1.5 million decrease in the Community Health Services division related to School-based Health Centers. School-based health centers are an important source of primary care imbedded in the school community. We urge DC Health to continue to support community health centers and to be a thought leader with sister health agencies to make primary care the center of DC's health ecosystem.

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[3] Sonmez, D., Adelman, D., & Weyer, G. (2023, August 21). *Primary care continuity, frequency, and regularity associated with Medicare savings*. JAMA Network Open. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808555

Hugo Mogollon, FRESHFARM
Testimony for the DC Council Committee on Health
Budget Oversight Hearing on DC Health

Wednesday, April 10, 2024.

Good morning. Thank you, Chairwoman Henderson, for holding this hearing, and thank you, Committee Councilmembers, for allowing me to speak on behalf of the most vulnerable residents of the District of Columbia.

My name is Hugo Mogollon. I am the Executive Director of FRESHFARM. We develop innovative ways to solve critical problems across our regional food system and connect people to their food through hands-on education, farmers markets, and food distribution programs.

I am here today to tell you how grateful we are to see Produce Plus included in the city budget for Fiscal Year 2025 and to advocate for increased city funding.

FRESHFARM is proud to partner with DC Health to manage this strategic investment, which improves resident health and increases equitable access to food among underserved Washingtonians. In 2023, we successfully distributed nearly $900,000 in funds to 7,500 local residents, facilitating access to fresh, locally sourced fruits and vegetables through a network of over 55 food outlets, including farmers markets, mobile markets, and farm stands across the district. Prioritizing support for communities at greater risk of food insecurity and diet-related health issues, the program predominantly benefited Black and Latino households, families with children, and seniors, who overwhelmingly reported that the program helped them to include more fruits and vegetables in their diets and feel healthier.

In 2022, the first year FRESHFARM started managing Produce Plus, it took a week to receive 2,500 enrollment submissions. In 2023, we received 3,000 inquiries in the first 24 hours. We opened enrollment for the 2024 season this past Monday, and we received over 3,000 resident submissions in less than 4 hours. This is a testament to, first, how FRESHFARM invests critical city resources to make incremental improvements in our operations, making it easier for people to participate, and, second, **that the demand for this program is at an all-time high.**

Last year, despite our best efforts, we could not reach everybody who had expressed interest in the program, leaving many people out of this benefit: 3,800 residents remained on the waitlist by the end of the season.

To adequately meet this escalating demand, we are requesting an additional $600,000 from the DC Council, which would increase the total annual budget to $2.1 million. This will allow DC Health and FRESHFARM to address the significant unmet demand for the program by increasing the number of DC residents we serve by 30%, including approximately 5,000 seniors.

Produce Plus is one of the incredibly important City's DC Health food investments, keeping the District a national leader in food access. We enthusiastically support the requests of all DC Health grantees and members of the Fair Food for All DC Coalition, including the Capital Area Food Bank, DC Central Kitchen, Food & Firends, DC Hunger Solutions, and Martha's Table. The collective efforts of our organizations are essential to maintaining DC as a model city for food justice and community wellness.

Thank you for the opportunity to provide this testimony today.

Hugo Mogollon
Executive Director, FRESHFARM

I'm asking the Council to keep the $22.5M in funding for the animal shelter to ensure there is sufficient funding for NYA maintenance, and to restore funding for the new animal care and control contract to $6.5M, this will provide proper care for animals .

DC Health found for the new facility is 4 DC Village Lane SW, which is in Ward 8 and east of the river. Honestly, I offer the new Animal Care and Control Facility (ACCF) should be public transit accessible and more accessible to more communities.Animal control services are public safety. It must be properly funded.

DC Health and the animal care and control contractor are responsible for mitigating the spread of zoonotic diseases in the District, yet diseases at the New York Ave. facility run rampant, in part because of the lack of proper isolation wards.

The poorly maintained facility poses a risk to staff, volunteers, and animals, including with poor temperature control, ceilings prone to collapse, hazardous yards (mud pit for a yard), no lighting, and improper kennel doors.

Timely responses to at-large and injured animals are important and can prevent bites, animal attacks, and more. Proper care for animals leads to heightened behavioral issues, which risk public safety. Dogs spend months in kennels without proper care behaviorally deteriorating, then are adopted into the community with no support. DC must ensure it has the funding for a contractor to properly care for its animals.

Funding animal control services is funding HUMAN services and funding our communities.

The animal care and control facility intakes owner surrenders for people in heartbreaking and desperate situations. It is supposed to provide resources to community members to help make pet ownership accessible, including low-cost vet care which is currently not accessible anywhere east of the river and pet supplies through the pet pantry.

A well-run, community-rooted animal shelter is supposed to bridge that gap and help provide services to make pet ownership accessible for people at all income levels. DC must ensure that its animal care service has the funding to serve in this role.

In neighborhoods east of the river, there are currently no veterinary services. This is a public failure, and it leaves large swaths of the city without access to important, public health services. The new animal care and control facility could help fill this gap.

Animal care and control is an important function of a government’s services. It’s infrastructure, and how well it is operating is an important measure of a city.

I would like to add after my in person testimony of the inhumane treatment of so called dangerous dogs on January 18 , the two dogs I referred to, were euthanized after 4 years and 1 year in kennel captivity,

without exercise within a few weeks, I was fired by HRA as a volunteer as retalitaion of my testimiony. This poor leadership of pratice of HRA not having the staff capable of handling these type of animals however they have a budget as a one of the largest recipients of donors to have this skill set available. Why does baltimore have this capability and DC does not...and Baltimore shelters do not have the donor or funding compared to HRA DC. I also offer the exorbitant salaries and nepotism of contracts of this non profit warrant a government led audit investigation. I also offer outside looking in this organization relies on the lack of government oversight. What I am saying HRA has been able to fudge the numbers, intimidate staff and senior leadership continues to reap the rewards because DC council has not delved into the DC Health contract or I would also add held DC health as well accountable. I ask the next generation of leaders to step up and look into this abuse of funding on so many levels , HRA, DC Health and stop this continuous abuse of these organizations taking advantage of DC government not doing due diligence and investigating over paid blatant mismanagement.

Testimony to the Committee of the Whole
For the Budget Oversight Hearing for DC Health
Yasmina Konate
Youth Advocate, Young Women's Project
April 10, 2024

Hello Chairperson Henderson and council members. I am Yasmina Konate and I am a resident of Ward 4. I am a senior at Jackson-Reed High School. I am a published children's book author as well as a member of the DC Girls Coalition and the Black Swan Academy. In the future I want to work in the STEM field specifically, Engineering. I started working at the Young Women's Project (YWP) in July 2021. YWP develops youth leaders and supports our work to solve community problems. I became a peer educator so that I could squash misinformation and share important sexual health information with my peers. I am testifying today so you are aware of our work and to encourage the restoration of funding to the DOH FY 2024 budget that will support sexual health education and condom distribution in high schools.

At YWP, I am a returning leader in the ***Youth Health Educator Program (YHEP), which engages 40 youth in 17 schools.*** *My peers and I work as* and educators who work to expand reproductive rights, reduce unintended pregnancy, distribute condoms, and connect youth to sexual health services. *During the 8 years of YHEP, we employed 1,475 youth who reached 50,381 of their peers, distributed 659,053 condoms and made 15,208 clinic referrals. YHEP youth work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

- ***Hired and trained more than 75*** **Peer Educators in 17 schools:** *(click here to see the YHEP Team).*
- **Trained 3,125 peers through classroom presentations and training** in 17 schools on anatomy, menstruation, contraception, STIs & HIV, relationships, pregnancy options (including abortion), and how to access services. . Check out some of our youth presentations here.
- **Distributed more than 45,000 male and female condoms** and safer sex materials through one on one distribution, events, and supporting adult distribution (nurses, health teachers, etc). Youth educators work with DOH-HAHSTA to support school-based STI testing.
- **Surveyed 650 public and public charter students from 16 schools** living in all DC wards (with heaviest representation from wards 4 and 7). *Our 2023-24 Youth Sexual Health Survey Results are linked here*
- **Distributed paper and electronic materials** to 3,125 public and public charter students including infographics and slide presentations, hands on worksheets, hot line numbers, and the 2023 Sexual Education Centers that provide sexual health information, resources, and services,.Currently, there is a lack of sexual health education in my school. Students only take one semester of health class which only

covers a portion of sexual health. However, according to our survey, more than 50% of the student population gets no sexual health-wellness instruction. On the other hand, condoms are only accessible in the nurse's office which makes a lot of students feel uncomfortable. Sexual health resources are very important to have in schools, not only to prevent pregnancies, but also to protect the youth from acquiring STIs. These resources lower the risk and encourage youth to practice safer sex.

I am here to talk to you about the lack of sexual health education in my school. The sexual health and wellness of this generation is important to me because many teens never learn the importance of practicing safer sex. The sexual health education I have received has been in high school but the content I learned was vague and left room for misconceptions. This is the case for many Jackson Reed students, seeing as over 70% percent of them have received less than 1 hour of sexual health education this year. Luckily, my school is fortunate enough to have a Health teacher that educates students on matters of sexual health, but it may be hard for students to ask intimate questions to staff and teachers. The inability of students to get answers to their sexual health questions leaves them vulnerable to misinformation. Hence the importance of peer health education. Peer education gives students a sense of community which makes them comfortable enough to ask questions related to sexual health. As a peer health educator, I have learned just how important sexual health education is and how it can affect a student's future.

All DCPS and Charter highschool students should have access to true sexual health information. This is why I am proposing a sexual health clinic for Jackson Reed. This clinic should test for sexually transmitted infections (STIs), pregnancy test, provide students with free advice and information about sexual health as well as an assorted variety of condoms. We are asking that the Committee allocate $300,000 within the DOH budget to the specific purpose of sex education, clinic referrals, and condom distribution in DCPS and Charter high schools with a goal of reaching 25 schools and 10,000 youth. Peer educators should be engaged as part of this work to increase effectiveness (since adults are not as effective in reaching youth through social media or text messages) and should be paid for their work.

Thank you for your time and consideration.

Capital Area Food Bank
Austin Hicks Chikwendu, Deputy Chief of Regional Partnerships
Committee on Health
FY 2025 Budget Oversight of DC Health
Hearing Date 4/10/2024

Chair Henderson and members of the Committee on Health:

My name is Austin Hicks Chikwendu, and I am the Deputy Chief of Regional Partnerships at the Capital Area Food Bank.

The Capital Area Food Bank is the anchor of hunger relief infrastructure in the region. Although we have a presence in Maryland and Virginia – DC is our home and it is, undoubtedly, where we have the deepest roots.

During our last fiscal year, we provided nearly 12 million meals to our clients and neighbors here in the nation's capital, and this pandemic and its ongoing effects have presented the most resource and labor-intensive crisis we have navigated in 43 years of existence.

Unfortunately, while many institutions and government entities have declared the pandemic to be over, we are not seeing any meaningful lessening of the need in our communities. Each year, the Capital Area Food Bank releases a Hunger Report – a comprehensive study that looks at food insecurity across the food bank's service area. In 2023, our report found that 35% of DC residents struggled with food insecurity over the prior year, a decrease of only one percentage point from our findings the year before.

Across our service area, we are now buying more than 5 times as much food as we used to in a typical year and providing more than 36% more meals in the District of Columbia compared to our last full fiscal year prior to the pandemic.

We have much gratitude for the investments from the Mayor and DC Health at the height of the pandemic that helped us support over 100 partner organizations in DC to lessen the burden, and the cost of food, due to inflation and global supply chain issues.

While the proposed FY25 budget clearly includes some difficult trade-offs, we are encouraged to see continued support for many of the anti-hunger programs included in the DC Health budget. As you deliberate and make budget decisions, we encourage the Committee on Health, and all members of the DC Council, to consider the ongoing challenges of food insecurity among our neighbors and prioritize investments that address hunger and its root causes.

As a member of the Fair Food for All Coalition, a group of organizations that work in unison to address food insecurity across multiple levels of the food system, we would also like to express

our support for the requests of all members, including DC Central Kitchen, DC Greens, DC Hunger Solutions, Food & Friends, FRESHFARM, and Martha's Table. Each of these partners does vital work and the programs and efforts supported by these asks will maintain the anti-hunger infrastructure in the District.

Thank you for your time and consideration.

Testimony to the Committee of the Whole
For the Budget Oversight Hearing for DC Health
Brooklynne Payne
Youth Advocate, Young Women's Project
April 10, 2024

Good morning Chairwoman Henderson and members of the Committee on Health. Thank you for the opportunity to testify today. My name is brooklynne payne. i am a ward 4 resident and a junior at dunbar highschool. I have been a part of the Young Women's Project (YWP) since October 2023 and now I am a youth advocate working on sexual and mental health issues. YWP is a multicultural organization that builds the leadership and power of DC youth so that they can transform policies and institutions to expand youth rights and opportunities. In addition to providing education in schools, teen organizations, and youth-residential centers, it allows youth to learn about sexual and mental health topics and develops their knowledge on topics that are right for their age.

I am here to talk about the lack of support/teaching about mental/sexual health illnesses for teens. I know this from personal experience as I didn't learn anything about these two topics from within school, but during my time working for YWP. As a teen, growing up is bound to happen, and that comes with needing to know about yourself mentally and physically. I didn't know enough about either of these subjects, and not knowing enough about them has caused situations in my life that I could have prevented if I had been given the right advice from a reliable source.

At YWP, I am a returning leader in the ***Youth Health Educator Program (YHEP), which engages 40 youth in 17 schools.*** *My peers and I work as and educators who work to expand reproductive rights, reduce unintended pregnancy, distribute condoms, and connect youth to sexual health services. During the 8 years of YHEP, we employed 1,475 youth who reached 50,381 of their peers, distributed 659,053 condoms and made 15,208 clinic referrals. YHEP youth work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

- ***Hired and trained more than 75 Peer Educators in 17 schools:*** *(click here to see the YHEP Team).*
- ***Trained 3,125 peers through classroom presentations and training*** *in 17 schools on anatomy, menstruation, contraception, STIs & HIV, relationships, pregnancy options (including abortion), and how to access services. . Check out some of our youth presentations here.*
- ***Distributed more than 45,000 male and female condoms*** *and safer sex materials through one on one distribution, events, and supporting adult distribution (nurses, health teachers, etc). Youth educators work with DOH-HAHSTA to support school-based STI testing.*
- ***Surveyed 650 public and public charter students from 16 schools*** *living in all DC wards (with heaviest*

representation from wards 4 and 7). Our 2023-24 Youth Sexual Health Survey Results are linked here

- ***Distributed paper and electronic materials** to 3,125 public and public charter students including infographics and slide presentations, hands on worksheets, hot line numbers, and the 2023 Sexua*

The issue I'm bringing to the council is the lack of teaching for sexual/mental health, and the lack of funding put into it. As these things are very important and everyone goes through something relating to this topic at least once in their life, people are not taught about it enough in their teen years, the year where people are experimenting the most. And aside from that, the organization representing (YWP) youth advocates play the roles adults are supposed to play, as we do more teaching about topics that should be taught in school with no government funding.

While at school, I've realized not a lot of teens know as much about sexual/mental health as they think. Looking back at the data from the sexual health survey from all schools that YWP made to track students' knowledge, approximately 62.48% of students out of 541 who did the survey stated they got no education on these topics in school which is beyond concerning. Another statistic that came out of the survey was how interested students are in learning more about these things in a school setting. Also the lack of counselors and mental health workers in schools are drastically decreasing. Because there is little financing for them and a shortage of professionals in the field being employed, having a trusted adult to talk to within school is limited to almost non-existent, which has a significant impact on students.

I have a few recommendations that I think will benefit students. First, DCPS and Charter schools should hold mental/sexual health days every year for all highschool students where the focus is on what mental/sexual health is and having it covering different topics related to these issues. I think this can help because it wont take a lot of work as it's only once a month, and for the next 4 years students will get refreshed on the topic to remember what it is they've learned. Second, DCPS and Charter schools should be required to provide a link on their website home pages that takes youth directly to the mental health team and services. Right now most websites do not have a link – which requires youth to search through the staff directory to figure out who they can contact for support. Thirdly, we want to ask the council to set aside money to fund peer educators to continue peer educating, and we're asking for around $300,000. We know that with this type of financing, groups like YWP can continue to educate while also doing things that others do not.

Thank you for your time and allowing me to talk to you today. Bye.

Testimony to the Committee of the Whole
For the Budget Oversight Hearing for DC Health
Lily Horn
Youth Advocate, Young Women's Project
April 10, 2024

Good afternoon council members. Thank you for the opportunity to testify today. My name is Lily Horn. I am a Ward 6 DC resident and I go to school at BASIS DC. Currently, I am a youth justice advocate for the young women's project and I am captain of my schools Green Club. I have been a peer educator with the Young Women's Project since August 2021 and now I am a Youth Advocate working on sexual health issues. YWP is a multicultural organization that builds the leadership and power of DC youth so that they can transform policies and institutions to expand youth rights and opportunities. I've been working with YWP to educate our peers on important health information and to collect vital information regarding the state of existing sexual education programs.

At YWP, I am a returning leader in the ***Youth Health Educator Program (YHEP), which engages 40 youth in 17 schools.*** *My peers and I work as* and educators who work to expand reproductive rights, reduce unintended pregnancy, distribute condoms, and connect youth to sexual health services. *During the 8 years of YHEP, we employed 1,475 youth who reached 50,381 of their peers, distributed 659,053 condoms and made 15,208 clinic referrals. YHEP youth work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

- ***Hired and trained more than 75*** **Peer Educators in 17 schools:** *(click here to see the YHEP Team).*
- **Trained 3,125 peers through classroom presentations and training** in 17 schools on anatomy, menstruation, contraception, STIs & HIV, relationships, pregnancy options (including abortion), and how to access services. . Check out some of our youth presentations here.
- **Distributed more than 45,000 male and female condoms** and safer sex materials through one on one distribution, events, and supporting adult distribution (nurses, health teachers, etc). Youth educators work with DOH-HAHSTA to support school-based STI testing.
- **Surveyed 650 public and public charter students from 16 schools** living in all DC wards (with heaviest representation from wards 4 and 7). *Our 2023-24 Youth Sexual Health Survey Results are linked here*
- **Distributed paper and electronic materials** to 3,125 public and public charter students including infographics and slide presentations, hands on worksheets, hot line numbers, and the 2023 Sexual Education Centers that provide sexual health information, resources, and services,.Currently, there is a lack of sexual health education in my school.

I am here today to talk about the lack of sexual education support for teens in DC. I know this from personal experience. My school, BASIS DC, provides little to no sexual education. In my 7 years at the school, I have only received a couple of hours of in school sex education. Furthermore, this instruction was very surface level, leaving kids with unanswered questions and no way to ask them. This has affected my peers in significant ways. One of my best friends did not know that her boyfriend was being abusive because she had not learned the rules of consent and boundaries within school. It was not until we had a conversation during lunch that she realized she'd been sexually abused their entire relationship. This is particularly distressing because comprehensive sexual education could have empowered her to recognize the abuse and leave the relationship while also educating him about the abusive nature of his actions.

This situation is reflected in YWP's 2023-24 youth health sex ed survey for BASIS: 63% of BASIS DC student survey takers reported that they receive most of their sexual education information through social media and 77% of them said that they had received 0 hours of sexual education at BASIS.

Furthermore, as part of the Young Womens Project, I pass out condoms to the students in BASIS DC. Condoms are available in the counselor's office, however this is not a widely known fact and it is not heavily advertised. A majority of BASIS students receive condoms from BASIS DC peer health educators like me.

This distribution strategy appears to be effective, as evidenced by the results of the 2023-24 youth health sex ed survey conducted by the YWP. The survey found that 82% of BASIS students believe condom distribution is extremely important, indicating strong support for the initiative among the student body.

I believe that BASIS DC students are very ill equipped with the sex education necessary to participate in safe relationships now and in the future. But we can fix this, it's crucial to ensure that every school provides consistent in-class presentations on sexual education. For instance, this year, YWP has collaborated with BASIS to make significant progress in this area. Recently, myself and other youth justice advocates **have been conducting** presentations covering essential sexual education topics such as pregnancy options, STD prevention, and Healthy Relationships.

Because of the academic rigor of our school, the administration expressed concerns about allocating class time for sexual health education. To address this, we implemented brief 5-minute presentations. This approach allowed students to receive valuable information about their health, that they would not have received otherwise, without compromising the high standards of our rigorous courses at BASIS DC.

This example illustrates the vital importance of implementing presentations. Without them, students would remain severely uninformed. Moreover, it demonstrates that such presentations will not consume excessive class time and can and should be employed at every school.

We are asking that the Committee allocate $300,000 to make grants to 3 organizations who would hire peer educators like me and work together to provide sex education, clinic referrals, and condom distribution in DCPS and Charter high schools with a goal of reaching 25 schools and 15,000 youth. Youth advocates like me should continue to be part of this work as it is effective in reaching the youth and should be compensated for their work.

Thank you for your time and for the opportunity to speak today.

Testimony to the Committee of the Whole
For the Budget Oversight Hearing for DC Health
Clementine Kovacs
Youth Advocate, Young Women's Project
April 10, 2024

Hello Chairperson Henderson and council members. My name is Clementine Kovacs and I am a resident of ward 3. I am a sophomore at School Without Walls High School. I love all sorts of art and I row varsity crew. In the future I want to work in law or something related to economics or business. I started at the Young Women's Project* (YWP) as a youth peer educator in 2023. YWP works with youth leaders and develops solutions to solve community problems. I became a peer educator to make an impact in sexual health services and education. I am testifying today so you are aware of our work and to encourage the funding to the DOH 2025 budget that will support sexual health education and condom distribution in high schools.

Being a sexual health educator taught me how important it is to be informed in regards to my health. With YWP we work to educate students on youth pregnancy options, as well as how important consent is and to get tested for STIs regularly. Currently, I am working on creating presentations on topics such as youth pregnancy as well as contraception and birth control so that they are better equipped to understand these options on their own. I also pass out condoms and answer any questions students may have with complete confidentiality.

Within the Walls community this year, according to the *-23-24 Youth Sexual Health Survey* 88% of students report having 5 hours or less of sexual health instruction so far this year, with 65.78% of Walls students having no hours of instruction at all. The survey also demonstrates how 20.32% of Walls students have been sexually active within the last 6-12 months (compared to 27.7% of all students who participated in the survey). The number of students with little to no sexual health education is remarkably low, and YWP along with other programs are determined to bring that number higher by educating students throughout DC. In the Walls survey, when asked which sexual health services they would like to have at their school, the top two answers were exams and consultations, and short term birth control such as pills, patches, or rings. In the general survey the most requested service was condom distribution to students.

In my school, the distribution of condoms comes from either our health teachers or from the nurse's office, but most students choose not to due to the openness and lack of options provided. We have health class for one semester, which includes our only sexual health education. Sexual health resources are important to have at school for a number of different reasons such as preventing not only pregnancies, but also transmission of STIs among youth. Having these resources helps to lower the risk and elevate the opportunities for students to practice safer sex.

In my opinion the addition of more sexual health clinics for students as well as more information on existing clinics would be greatly beneficial for students. Schools such as Walls and Jackson-Reed don't have any sort of clinic or consultations regarding sexual health that is available for students, even though many Walls students believe that it is one of the most important services we could give. I also believe that greater distribution of condoms to students would be greatly beneficial, especially if there was a more discreet way of obtaining them such as bins in all the bathrooms and some hallways.

We are asking that the Committee allocate $300,000 to make grants to 3 organizations who would hire peer educators like me and work together to provide sex education, clinic referrals, and condom distribution in DCPS and Charter high schools with a goal of reaching 25 schools and 15,000 youth. Youth advocates like me should continue to be part of this work as it is effective in reaching the youth and should be compensated for their work.. Peer educators should be engaged as part of this work to increase effectiveness (since adults are

not as effective in reaching youth through social media or text messages) and should be paid for their work. Thank you for your time and consideration.

** At YWP, I am a returning leader in the **Youth Health Educator Program (YHEP), which engages 40 youth in 17 schools.** My peers and I work as and educators who work to expand reproductive rights, reduce unintended pregnancy, distribute condoms, and connect youth to sexual health services. During the 8 years of YHEP, we employed 1,475 youth who reached 50,381 of their peers, distributed 659,053 condoms and made 15,208 clinic referrals. YHEP youth work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

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- ***Distributed paper and electronic materials*** *to 3,125 public and public charter students including infographics and slide presentations, hands on worksheets, hot line numbers, and the 2023 Sexual Education Centers that provide sexual health information, resources, and services,*

Hello, I'm Peter Wood. I currently serve as Advisory Neighborhood Commissioner in Adams Morgan, in Ward 1. Today, I am testifying before this Committee to advocate for DC to invest in saving lives. Specifically, we need to incorporate safe consumption sites in our response to the ongoing overdose crisis that is killing hundreds of Washingtonians every year.

What we have is insufficient.
The conversations guiding overdose prevention in DC must better address a question that's often dismissed: What does recovery look like when we acknowledge that sobriety alone doesn't work for everyone? DC currently has zero official safe consumption sites. We need two, ideally in Ward 4 and east of the Anacostia River. But, one might ask, isn't there already a center for stabilization and sobriety? Yes, and its services—while helpful for some—are not enough. We can try to force sobriety onto people as long as we want, but the end result is proven to be inadequate.

Losing lives is expensive.
Just like with gun violence, pedestrian and cyclist deaths, suicide, and many other types of loss, overdoses incur costs. That includes social costs of losing people close to us. Emotional costs of seeing loved ones succumb to their condition. Political costs of seeing campaign rhetoric meet the reality of failed social safety nets. Financial costs of endless burial services and drained hospital resources, which is especially important when we need hospital beds for emergencies and none are available. Economic costs of a healthcare workforce that is overworked and burned out.

Safe consumption sites are effective.
When we develop solutions that are practical, rather than idealistic, we tend to see progress. And with safe consumptions sites, we don't have to guess how they work. We have examples, including one close by in New York. At OnPointNYC, people who would otherwise be using in hidden, often dangerous settings, have a place to avoid associated risks like infection. OnPointNYC even works with the surrounding community—including a school—for neighborhood cleanups and education. Washingtonians deserve something similar.

Safe consumption sites are inconspicuous.
An unfortunate mischaracterization of safe consumption sites is that they attract criminal activity and create an unhealthy place for neighbors. What we actually see in safe consumptions sites is that—rather than chaotic—they are kind of mundane. And the consumption component is often a fraction of what happens in the facility. There has also been research specifically directed toward the question of crime rates in areas near safe consumption sites. That research indicates that there's no measurable effect. Conversely, when we don't offer safe consumption sites, that consumption still happens. Except it's done discretely in dangerous settings where holistic medical care is not present.

Wise investments now will prevent even more difficult budget decisions later. Much of the tension over safe consumption sites—in DC and elsewhere—is less about drug use and more about power. Controlling the lives of those who are most vulnerable. I urge this

Committee to lead Council and DC to invest in safe, controlled places for Washingtonians to acquire the medical attention they need but often struggle to find. The alternative, as we have sadly seen, is painful and expensive.

Michael Fauntleroy, Client, Food & Friends
Testimony before the DC Council Budget Oversight Hearing: Committee on Health
April 10, 2024

Hello, I'm Michael Fauntleroy and I live in War 4 in Washington, DC. I am a client of Food & Friends and I'm here in support of the CHA grant to Food & Friends for $1,335,000.

For most of my life, I was accustomed to helping others. I spent years sponsoring local schools, managing job training, and organizing community dinners through the Alliance of Black Telecommunications Employees (ABLE), an employee resource group that I helped lead during my 30 years at AT&T.

But after years of serving my community, and returning to Washington D.C. from Florida to care for my aging mother, the Stage 3 kidney disease that I had been managing for 20 years was showing signs of progressing. Now I was the one needing help.

My kidney disease progressed to Stages 4 and 5, and doctors placed me on dialysis. I was scared to death to actually have needles inserted into my arm and be connected to a machine. The nurses at Washington Hospital Center were a lifeline. They explained to me what dialysis was about and put me in a better place where I could accept what I had to do.

I came to understand that in addition to dialysis, my treatment would require changes to my daily lifestyle and routines. My dietitian at the dialysis center in Columbia Heights referred me to Food & Friends and I immediately engaged with their extensive educational resources. I got on some webinars, I got recipes on how to do certain things, how to use certain foods like the turkey burgers and chicken fillets. I'm just really astounded that the program does as much as it does. I was relieved that even with a newly restricted diet, Food & Friends' meal delivery and nutritional counseling let me heal and still find joy in the food.

Last fall, as I waited for a kidney transplant, I received one of the Thanksgiving feasts that Food & Friends prepares for clients and their families. After spending so many holidays making sure others had a turkey of their own, I was on the receiving end and I was just overwhelmed. A few days after my Food & Friends' Thanksgiving meal with family, I received some good news: my new kidney was ready. On Friday, November 24 I successfully underwent kidney transplant surgery.

Thank you for your continued support of Food & Friends and your care for DC residents like me.

Testimony of Tyria Henry, Ward 8 resident and participant of the Healthy Families America Home Visiting program at Mary's Center.

Participating in the home visiting program has been an incredibly positive experience for me. Initially, I was hesitant about working with a new person, but my home visitor has been nothing short of amazing. My home visitor support has been invaluable, especially during challenging times.

One of the aspects of the program that I appreciate the most is the focus on developmental screenings, such as the ASQ. These screenings have helped me understand my child's growth and development better. My home visitor has also provided me with the tools and knowledge to support my child's development effectively. This, in turn, helped me support his development more effectively. My home visitor provided me with resources to work with him on his delay areas, and we often did activities to address the developmental delays.

Additionally, the resources provided by my home visitor have been incredibly beneficial. They have provided me with information about housing, CPR certification, and continuing education, which have all been crucial in navigating the challenges of being a new mom. Furthermore, my home visitor has been attentive and informative, always ensuring that I have the information I need and keeping track of appointments.

Over time, my relationship with my home visitor has grown significantly. My home visitor's support and guidance have made our relationship very positive. I am incredibly grateful for the support I have received through the home visiting program. It has not only provided me with valuable resources but also with a support system that has helped me navigate the challenges of being a new mom. I would highly recommend the home visiting program to other new moms.

Young Women's Project (YWP) 1609 Connecticut Ave NW, WDC 20009 202.629.1370
youngwomensproject.org

Testimony to the Committee of the Whole
For the Budget Oversight Hearing for DC Health
Chyna Holloway
Youth Advocate, Young Women's Project
April 10, 2024

Good afternoon Chairwoman Henderson and members of the Committee on Health. Thank you for the opportunity to testify today. My name is Chyna Holloway. I am a Ward 1 DC resident and a senior at Jackson Reed High School. Currently, I am a Girl Scout, I occasionally write for my school newspaper, the Beacon, I'm a member of my school's Black Student Union and a member of a Mental Health Council, focused on African American teens. This fall, I will be a freshman marketing or journalism major in college. My goals for the future are to become an entrepreneur, journalist or author, own a restaurant and create a non-profit organization. I have been a peer educator with the Young Women's Project (YWP*) since September 2022 and I am a Youth Advocate working on sexual health issues. YWP is a multicultural organization that builds the leadership and power of DC youth so that they can transform policies and institutions to expand youth rights and opportunities. I'm in the Youth Health Educator Program that focuses on educating peers on Sexual Health & Reproductive Justice.

I am here to discuss the lack of education and support for teens in regards to sexual health. I want to raise awareness on youth sexual health concerns and address the actual needs of youth across the District. Personally, I did not have a complete understanding of sexual health until I started working at YWP.

Sexual Health is important to me because I believe that people, especially youth should be able to approach sexuality and sexual relationships in a positive, healthy and respectful manner. According tto YWP's *2023-24 Youth Sexual Health Survey Results,* students are very eager to learn about sexual health and need more services. Students who took the Jackson-Reed Survey said that they are interested in engaging in more sexual health programs: 90% are interested in youth-led after school workshops, 83% say it is important to have condoms available in schools, and 45% are interested in STI testing and having emergency contraception available at schools. As peer educators, we do a lot of condom distribution. Our Jackson Reed peer educator team distributed 5,200 condoms and safer sex materials at our schools. This same Jackson-Reed team trained 400 youth on anatomy, menstruation tracking, pregnancy options including abortion, contraception, and preventing STIs through classroom presentations and training.

As a sexual health educator, I've learned how important it is to be aware of the sexual resources that I have. The majority of youth do not know their rights. The majority of youth are unaware of accessible clinics or that they could go to without parents' consent. Additionally, STIs testing, clinics focused on reproductive health, and other sexual services should not be limited to the youth. Stigmas surrounding sexual health should be eliminated as it is one of the major causes of why youth are afraid to ask for help. I've had a lot of encounters with my peers asking

me about the basics of reproductive health and how they can better take care of themselves. These instances are strong grounds of the importance of sexual health education and resources and why we should expand it.

We are asking that the Committee allocate $300,000 to make grants to 3 organizations who would hire peer educators like me and work together to provide sex education, clinic referrals, and condom distribution in DCPS and Charter high schools with a goal of reaching 25 schools and 15,000 youth. Youth advocates like me should continue to be part of this work as it is effective in reaching the youth and should be compensated for their work.

Thank you for listening! I appreciate your time and consideration in this matter. Enjoy the rest of your afternoon.

*At YWP, I am a returning leader in the ***Youth Health Educator Program (YHEP), which engages 40 youth in 17 schools.*** *My peers and I work as* and educators who work to expand reproductive rights, reduce unintended pregnancy, distribute condoms, and connect youth to sexual health services. *During the 8 years of YHEP, we employed 1,475 youth who reached 50,381 of their peers, distributed 659,053 condoms and made 15,208 clinic referrals. YHEP youth work 4-6 hours a week and receive more than 75+ hours of training (in stress, toxic stress, resilience building, trauma, brain science, systems change, and other issues). Here are a few things we accomplished:*

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GREATER GREATER WASHINGTON

The Washington, DC region is great » and it can be greater.

April 10, 2024

To Chair Henderson and the Committee on Health,

I'm submitting this testimony on behalf of Greater Greater Washington, where I serve as D.C. policy director. Given the opportunity to provide a statement to the record for the committee's budget hearing for DCHealth, I'm sharing with you a report that GGWash produced in late 2023, "Transportation, Public Health, and Racial Inequities in Washington, D.C."

The report uses air-quality data provided by the George Washington University, publicly available data from opendata.dc.gov, health data publicly available from the Centers for Disease Control and Prevention, asthma data provided by Children's National Hospital, American Community Survey data, and the District Department of Transportation's High-Injury Network map. It assesses that information to demonstrate how a lack of access to safe, convenient, and affordable public transportation creates structural health inequities for District residents.

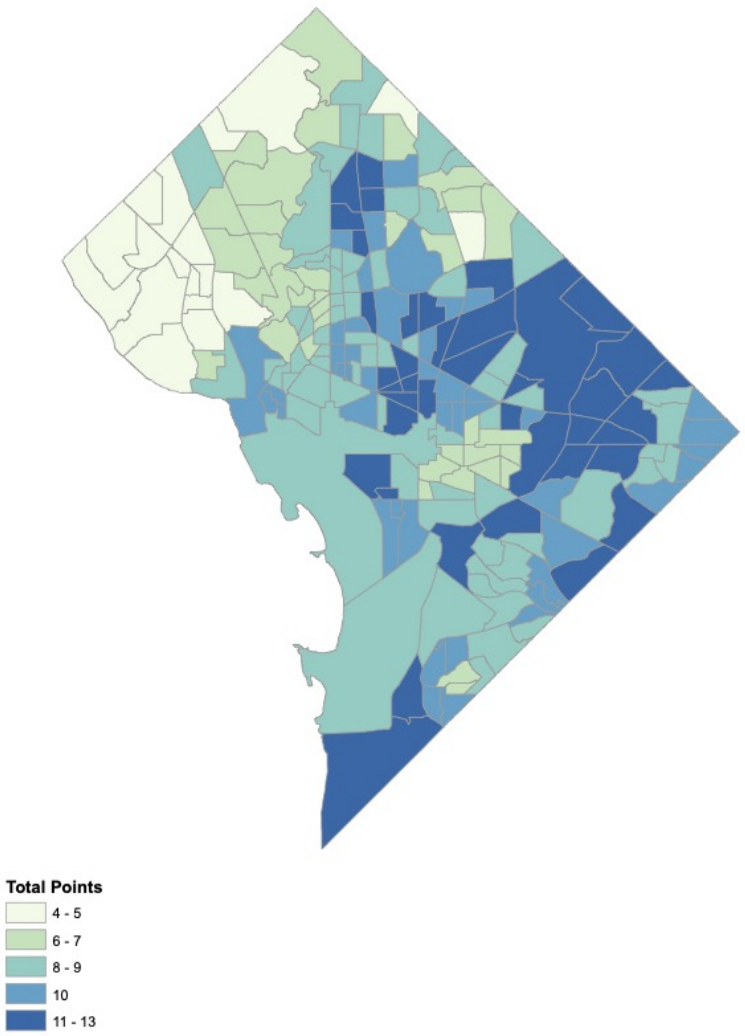
I do not think it will be a surprise to the committee that we found that negative impacts from emissions and vehicular traffic, such as poor air quality and injurious and fatal crashes, are not evenly distributed across the District. Those negative impacts intersect with other disadvantages, such as lower household incomes and poor public-health outcomes, such as higher rates of asthma, coronary heart disease, and mental-health distress.

Here are some takeaways from the report:

- Neighborhoods in Ward 7 and Ward 8, which in comparison to other wards have the least-reliable access to Metrorail and Metrobus, have the highest concentration of zero-car households in the District.
- Ward 2, Ward 7, and Ward 8 have the highest rates of pedestrian and other traffic fatalities in the District.
- The most dangerous roads on the District's High-Injury Network map are in Ward 4, Ward 2, Ward 7, and Ward 8.
- For both children and adults, asthma rates are significantly higher in Ward 7 and Ward 8 than anywhere else in the District.
- Emergency room visits due to asthma are the highest in Ward 7 and Ward 8.

In sum, in addition to more traffic safety violations and fewer public-transit options, if you live in a neighborhood where the median income is below $50,000 and where the majority of residents are Black or Latino, you will experience worse health outcomes, such as asthma, coronary heart disease, and mental health distress. While the report does not causally link these effects,

negative outcomes associated with high-traffic roads (asthma, mental health distress, traffic violence and fatalities, and less access to public transit) are obviously exacerbated by vehicle trips. The below map shows Census tracts rankings for air quality, asthma rates, traffic crashes, and traffic fatalities.



The District provides decent incentives for its residents and visitors to walk, take transit, and bike, and has steadily improved its infrastructure for people using those modes of transportation. Councilmember Henderson's investment in the I-295 reconstruction is one of the more impressive examples of an investment in changes to the District's built environment that do not center drivers. However, making it easier for people to travel by means other than driving will only go so far. At some point, any public-health benefits derived from the modal shift incentivized by infrastructure improvements—better air quality, lower asthma rates for residents, and a lower risk of being hit or killed by a driver—will likely be overridden by the fact that it has not been made harder to drive in the District, especially for residents and visitors who can easily and affordably access alternative modes. Councilmember Henderson's dedication to making the District's traffic-enforcement regime fair, yet consequential, for drivers who break the law is a good start to beginning this paradigm shift.

However, the privilege of driving costs far too little given the public-health impacts it inflicts upon, in particular, Black and Latino residents. GGWash has thusly supported the council in its previous increases of the gas tax and residential parking permit rates. Both should be raised again. Additionally, we ask that the committee take an explicit interest in the potential for implementing a road-pricing program in the District of Columbia by supporting the release and update of a report, suppressed by the Bowser administration, which evaluates how road pricing could improve racial equity here. Because residents of Ward 5, Ward 7, and Ward 8 have longer

commutes to work, and because fewer residents of those wards own cars, they would benefit greatly from road pricing, which raises revenue by reducing vehicular trips and reinvests it—possibly into general-revenue funds, preferably into improving in public transportation, or potentially into a progressive rebate paid back to District residents.

Of course, some District residents and visitors will need to drive—some even for matters of their personal health! However, the public-health impacts of a single-occupancy vehicle trip do not diminish even if one person's need to drive is greater than another's. It is imperative, then, that anyone who does not *need* to drive in the District drives less and less over time. It is essential that the committee and DCHealth center this reality in their work.

Providing alternatives to driving is not enough. Public health in the District is at great risk because too many people drive here, too often; consequently, our public policies must make it harder for residents and visitors to drive. I believe the report is directly relevant to the committee's interests, and I hope that it is helpful in your work.

Thank you,
Alex

Alex Baca
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Council of the District of Columbia

Committee on Health

Councilmember Christina Henderson, Chairperson

Budget Oversight Hearing:

DC Health

April 10, 2024

Testimony of:

Micaela Deming

Policy Director

DC Coalition Against Domestic Violence

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Good afternoon Chairperson Henderson, Members of the Committee, and staff. My name is Micaela Deming and I am the Policy Director for the DC Coalition Against Domestic Violence (DCCADV). DCCADV is the federally-recognized statewide coalition of domestic violence service providers in the District of Columbia and includes domestic violence (DV) specific housing providers, counseling and case management services, legal services, and culturally specific organizations serving: African; Latinx; Asian and Pacific Islander; Immigrant; teens and youth; and survivors who are Deaf and Deaf/Blind. Intimate partner violence continues to be a significant safety and public health concern for DC residents of all ages. These dedicated service providers work tirelessly to address the epidemic of domestic violence across all eight wards of the District.

One in three women and one in four men have experienced domestic violence (DV) in their lifetime[1], which leads to disastrous effects for the victims, their families, and their communities. We also know that 39% of women and 25.5% of men living in DC have experienced sexual violence, physical violence, stalking, or a combination thereof perpetrated by an intimate partner.[2]

Domestic and Sexual Violence in Washington, DC

Domestic and sexual violence are a major public health concern. There is myriad data showing the devastating prevalence and impacts of this violence, especially on the District's youth.

[1] M.C. Black et al., Ctrs. for Disease Control & Prevention, *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 2 (2011), https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.
[2] S.G. Smith, et al., *The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report* 144 (2017), https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf.

Children experiencing domestic violence in the home are more likely to be truant[3]; people who have perpetrated domestic violence with a firearm are more likely to use those firearms in other contexts[4]; domestic violence is a leading cause of homelessness for single women and families in the district[5]. Women in the US are more likely to be murdered during pregnancy or soon after childbirth than to die from the three leading obstetric causes of maternal mortality[6] and Black women specifically are at substantially higher risk of being killed by partners around pregnancy[7].

We know that young women and girls between the ages of 16-24 are at the greatest risk for experiencing dating violence[8] and relationship abuse[9]. Nationally, more than half of cisgender women and men who have been physically or sexually abused or stalked by a dating partner first experienced abuse between the ages of 11-24.[10] According to a recently released CDC report, overall youth wellbeing is experiencing a downward trend at the same time that teen girls are experiencing record high levels of violence. 68% of youth reported experiencing school interference from a dating partner;

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[3] Lisa R. Kiesel, Kristine N. Piescher, and Jeffrey L. Edleson, The Relationship Between Child Maltreatment, Intimate Partner Violence Exposure, and Academic Performance, Journal of Public Child Welfare (2016), available at, https://www.tandfonline.com/doi/full/10.1080/15548732.2016.1209150

[4] Geller, L.B., Booty, M. & Crifasi, C.K. The role of domestic violence in fatal mass shootings in the United States, 2014–2019. Inj. Epidemiol. 8, 38 (2021). https://doi.org/10.1186/s40621-021-00330-0

[5] Community Partnership. DC 2023 Point-In-Time Count. https://community-partnership.org/homelessness-in-dc/#pit-dashboard

[6] Lawn, R and Koenen, K. *Homicide is a leading cause of death for pregnant women in US: Shocking situation linked to lethal combination of intimate partner violence and firearms*. BMJ: first published as 10.1136/bmj.o2499 on 19 October 2022. Downloaded from http://www.bmj.com/ on 26 January 2023 at George Mason University.

[7] Modest AM, Prater LC, Joseph NT. Pregnancy-Associated Homicide and Suicide: An Analysis of the National Violent Death Reporting System, 2008-2019. Obstet Gynecol. 2022 Oct 1;140(4):565-573. doi: 10.1097/AOG.0000000000004932. Epub 2022 Sep 7. PMID: 36075083.

[8] Dating violence is a pattern of abusive and coercive behaviors where a partner exerts power and control over someone they are dating or involved in some type of relationship. The abuse can be physical, emotional and/or sexual.

[9] Violence against young women and girls. Violence Against Young Women and Girls | National Center on Safe Supportive Learning Environments (NCSSLE). (n.d.). Retrieved March 1, 2023, from https://safesupportivelearning.ed.gov/violence-against-young-women-and-girls

[10] Breiding, M.J., Chen J., Black, M.C. (2014). Intimate Partner Violence in the United States 2010. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

this number jumps to 88% for youth who reported a history with teen domestic violence.[11] Reproductive and sexual coercion is a common abuse tactic used to exert power and control over young victims' reproductive choices. The risks of reproductive coercion are exponentially increased by the prevalence of dating violence in the District. A 2019 study revealed that of 550 sexually active high school females, 12% reported recent reproductive coercion and 17% reported physical or sexual adolescent relationship abuse. Reproductive coercion can lead to a host of negative physical and reproductive outcomes including sexually transmitted infections and diseases, and unwanted pregnancy.[12] Teen girls in physically abusive relationships are three and a half times more likely to become pregnant than non-abused girls.[13] To transform our culture and end intimate partner violence, strategies that increase resiliency and reduce risk factors are paramount. We recognize that the work to reduce and prevent violence does not happen overnight. DC Health has made an important commitment by recognizing intimate partner and sexual violence as a public health issue and it must also begin to dedicate funding to primary prevention.

Promising Programs

We have been assisting with the implementation of the Expect Respect curriculum and have provided valuable training to school staff to help them address the forms of teen dating and sexual violence within schools. The Expect Respect curriculum is designed for students ages 12-17 and begins to fill the gap in primary prevention by focusing on educating high school students about safety, social support and skills for healthy relationship building.

[11] Id

[12] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion

[13] https://www.pcadv.org/about-abuse/prevention/parents/the-connection-between-dating-violence-and-pregnancy/

Moving forward, we are completing the development of an age appropriate curriculum for younger students. Acknowledging how much is already asked of teachers during the school day, this material is focused on discussion topics that can be incorporated into lesson plans. In order to implement this curriculum for younger students and expand the use of Expect Respect to ensure these prevention efforts are deployed widely across the District, significant investments and resources must be made to break generational cycles of abuse.

DC Health has also asked DCCADV to develop training for their DC MAP team to help young mothers navigate infancy and newborn care and wellness. I must note here that "women in the US are more likely to be murdered during pregnancy or soon after childbirth than to die from the three leading obstetric causes of maternal mortality.[14] And, that "Black women are at substantially higher risk of being killed by partners around pregnancy."[15] This training partnership would help staff recognize domestic violence in a culturally competent way and offer trauma informed support to hotline callers. This work has yet to be funded - it would only cost around $25,000.

This DC MAP training is a good example of the type of work we could be doing with DC Health with just a small amount of dedicated funding. With adequate funding, we can develop training across all governmental agencies starting with DC Health, to give government staff the support they need to prevent domestic violence in the district.

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[14] Lawn, R and Koenen, K. *Homicide is a leading cause of death for pregnant women in US: Shocking situation linked to lethal combination of intimate partner violence and firearms*. BMJ: first published as 10.1136/bmj.o2499 on 19 October 2022. Downloaded from http://www.bmj.com/ on 26 January 2023 at George Mason University.

[15] Modest AM, Prater LC, Joseph NT. Pregnancy-Associated Homicide and Suicide: An Analysis of the National Violent Death Reporting System, 2008-2019. Obstet Gynecol. 2022 Oct 1;140(4):565-573. doi: 10.1097/AOG.0000000000004932. Epub 2022 Sep 7. PMID: 36075083.

Budget Ask

DCCADV supports the VAN ask for $51.87M in the OVSJG victim services line and the Fair Budget Coalition's full platform. #SafetyIs both well-funded primary prevention and well-resourced services and support for survivors. The significant cuts to family homelessness services, Access to Justice, and the Pay Equity Fund will all have a direct and immediate impact on the health and safety of families. We also support the Fair Budget Coalition's equity-based revenue raising plans, which work to reverse the severity of the impending budget cuts by taxing wealth to raise revenue for essential investments in the community. As we face a budget year that seeks to sweep our social safety net and support systems, we urge this committee to support Washingtonians by rejecting proposals that balance the district budget off the backs of its most marginalized. An underresourced DC is an unsafe and unhealthy DC - Washingtonians deserve better and we look forward to collaborating more with you to make sure they get it.

We are seeking a $355,000 increase in funding for domestic and intimate partner violence prevention education and programming as well as better and deeper collaborations with DC Health. While DC has made significant local investments in responding to community-based violence, we still see a lack of focus on domestic violence and dating violence primary prevention. Given the increase in experiences of dating violence among middle and high school students in the district, as well as the mandates for prevention education for students under the School Safety Act and Sexual Assault Victims' Rights Act, the District must fund and prioritize collaboration with survivors and the service providers to ensure we have a coordinated and sustainable dating and sexual violence prevention programming.

Conclusion

We encourage you, Chairperson Henderson, and your staff to think of us as a resource when developing DC Health's strategy to end community violence and urge this committee to remember that violence in our homespaces and intimate relationships contribute to and exacerbate violence in the streets.

Through a primary prevention lens, we will be able to address the rise in youth and family violence in the District. With the VAN's identified baseline funding in victim services, restoring funding to the social safety net, $355,000 for primary prevention, and greater collaboration with DC Health, we will be able to continue and expand efforts to develop and implement prevention programming and build inter-agency capacity to address domestic and sexual violence. DCCADV believes intimate partner violence is preventable. We will continue to seek sustainable resources to support programming, policy initiatives, and community awareness about IPV prevention in the District of Columbia. We are committed to being DC's leader in efforts to stop violence before it starts. We hope that District leaders, across governmental agencies, will join us. Thank you, Chairperson Henderson, for the opportunity to testify and I'm happy to answer any questions you may have.

Testimony for Nurse at RSTAY

Good morning councilmembers. I am Dylan Craig, a teacher at Roosevelt STAY Opportunity Academy. I am testifying today to raise awareness about our immediate need for a nurse at Roosevelt STAY.

Frist, I want to thank the council so far in their support for the Roosevelt STAY community, especially regarding our move to the Garnet-Patterson building, and our push for safe and appropriate facilities for our students.

However, right now we need to bring attention to how our community is suffering without a nurse on campus. We often serve a vulnerable population at Roosevelt STAY, including many expecting mothers. Without a nurse on campus, we have frequently had to call an ambulance for students facing health concerns that need immediate attention. Waiting for an ambulance is incredibly uncomfortable and scary for our students, especially when there is no healthcare practitioner in the building to respond right away, putting both the student and sometimes an unborn child at risk. It is not hard to imagine the terror an expecting mother feels when they are at school, a seemingly safe city facility, and they begin to feel pain, only to learn there is no nurse on campus to take appropriate measures.

Even beyond this specific population, we just need someone in our building to administer medication, provide basic health supports, and advise if further medical attention is necessary for all of our students. We are leaving our students at risk of not receiving proper treatment when an emergency arises. Even our most well-trained staff do not compare to a licensed nurse when a student's health is at risk, or worse, their life. Knowing our school lacks a nurse on campus is enough to keep some students from coming, pushing them further and further away from earning their diploma.

Our students can spend 40 hours a week with us, and that is too much time to be away from proper health resources. Also, given the older population we serve, many students are aging out of their pediatric providers, and most have not yet developed relationships with adult providers, putting them in even more of a precarious position.

I understand that there is a nationwide nurse shortage, and we are not the only school suffering due to this issue, but it is important that the council understands Roosevelt STAY's particular needs and the urgency of finding a solution now. The risks are too immense to wait and ignore.

Thank you for taking the time listen and for all that you do.

April 10, 2024

Testimony before the Committee on Health
re: DC Health's Significant Delays Implementing New Street Vending Law (B25-68)

My name is Geoff Gilbert and I am the Legal and Technical Assistance Director at Beloved Community Incubator. I organize with street vendors part of Vendors United // Vendedores Unidos.

We ask that the Committee on Health ensure that the Department of Health has all of the resources and support it needs in order to implement the Street Vendor Advancement Amendment Act of 2023 (B25-68), which the Council passed last April, in a way that is fair and accessible for all vendors. We also want to bring to the Committee's attention that DC Health has missed numerous deadlines and is seriously behind in implementing the new street vending law. The impact of DC Health's delays are that most food vendors throughout the city still are not able to even apply for a license under the new law more than six months after it went into effect on October 1, 2023.

We are very concerned that DC Health began last week to issue cease-and-desist orders to food vendors and to threaten food vendors with $1,000 fines for vending without a license - even though these food vendors are not able to obtain a license because DC Health has not implemented two key aspects of the new law. The two key provisions of the new law that DC Health has not yet implemented are the new microenterprise home kitchen permit and the process for vendors and the public to submit food safety designs seeking approval for preparing food and keeping food that is not individually packaged warm on the street - see Sec. 3(c) on pgs. 6-7.

We hope that DC Health is operating in good faith and simply is behind on implementing the new law, though we fear that the Mayor, given numerous recent negative public statements about street vendors, is using executive agencies to obstruct implementation of the new law and to pave a path to re-criminalize street vending.

First delinquent implementation issue - microenterprise home kitchen permit

The new street vending law required that DC Health publish emergency regulations for the new microenterprise home kitchen permit by November 15, 2023 - five months ago as of next week. This new permit will allow street vendors to prepare and sell all pre-packaged cooked foods and whole or pre-packaged cut fruit from home kitchens and street vending carts. The new permit is the first permit in DC history that will allow street vendors to sell foods prepared in their home

kitchens and it is functionally the first permit in DC history that allows small food businesses to get a start out of their home kitchen by offering for sale any type of cooked food. Without the new permit in place, most street vendors in the city cannot yet apply for a license under the new law.

We are deeply concerned that DC Health's inaction is simply a continuation of its regulatory neglect of street vendors. DC Health has long had the authority under DC's Cottage Food Law to inspect and create regulation for the production and sale of food from home kitchens and from street vending carts, yet it has chosen over and over again not to do so. Rather than promoting safe food practices in home kitchens and at street vending carts, DC Health has chosen to narrowly restrict the type of food that can be prepared and sold from home kitchens and street vending carts - the Council mandated through the new street vending law that DC Health end this exercise of regulatory discretion and expand its services to accommodate street vendors to cook from home kitchens. Historically, DC Health's regulatory choices have kept street vendors trapped in the formal economy and subject to thousands of dollars of fines, debt traps that vendors have not been able to escape in order to overcome DC's Clean Hands Law barrier and apply for licenses.[1]

Second delinquent implementation issue - public process for reviewing street vendor food safety plans

DC Health is also required under the new law to have created as of October 1, 2023, the date the law was fully funded and in effect, the process for vendors and the public to submit food safety designs seeking approval for preparing food and keeping food that is not individually packaged warm on the street. This new public process for seeking approval for food safety designs is a huge victory for transparency and public accountability that street vendors won as part of the new law.

Prior to last year's passage of the new street vending law, street vendors have been required for decades to seek approval of the menu of food they are able to sell as part of the license application process before a food vendor is able to begin operations. Historically, DC Health has only allowed street vendors to sell half smokes and hot dogs. DC Health did not publicize the types of food and the methods for preparing food that street vendors could utilize - street vendors could only schedule individual inspections and were informed behind closed doors of the extremely narrow options that DC Health could offer. This new process gives all street vendors the right to submit to DC Health their food safety practices for review. Our hope is that

[1] See "Where the Sidewalk Ends Part II: A Vision for Decriminalizing and Investing in Street Vendors," Beloved Community Incubator (October 2022), https://www.belovedcommunityincubator.org/vending-decrim.

DC Health will engage this new process in good faith and use it to work with street vendors to improve their food safety practices when necessary and to publicize a variety of approved safe food production methods utilizing affordable equipment. Equipment affordability has been a significant barrier to food vendors obtaining licenses in the past.

Language access issues and application process confusion

Additional serious issues are that DC Health has not provided interpreters when engaging with street vendors since the new law went into effect, has written cease-and-desist letters only in English (most vendors's primarily language is not English), has given no explanation for their cease-and-desist orders, and has sought to punish vendors without providing any information about how to be in compliance. The inspectors also claimed that vendors cannot cook from their home kitchens to sell on the street, which is wrong - the only reason vendors cannot do so is because the new microenterprise home kitchen permit is not yet in place. This is frustrating, unhelpful, and threatening behavior from DC Health.

DC Health and the Department of Licensing and Consumer Protection also have not provided clear instructions to vendors about how they can schedule food safety inspections. Earlier this week, four formerly licensed vendors went to the DC Health offices to schedule inspections of their repaired food carts - these vendors have been working to complete their cart repairs since November of last year and are very eager to resume earning income as street vendors. DC Health informed vendors that they must schedule inspections through DLCP. These same vendors had engaged with DLCP in previous weeks and were informed by DLCP that they needed to schedule inspections with DC Health. Vendors deserve clarity on how these essential license application processes work, rather than remaining stuck between referrals from one agency to another.

DC is a culturally vibrant city and food vendors have long sold many different types of food in addition to hot dogs and half smokes, including soul food, Caribbean food and Latin American food from many countries, primarily El Salvador and Mexico. Many vendors also sell fresh cut fruit. This food is deeply desired by the community - food street vendors rely on repeat customers and word-of-mouth marketing in order to make a living.

We are really disappointed that Councilmember Henderson did not have any questions for us or for street vendors at the end of our panel. After street vendors have fought for years to vend free from fear of police harassment and for equitable access to a license, the Department of Health still has not provided a path toward licensure. Most food vendors are mothers with young children; being forced to stop working means no food on the table, no money for rent. The Department of Health's posture should be to follow the law, publish rules for the microenterprise

home kitchen permit and for the public process to submit food safety plans for DC Health review, and conduct outreach in compliance with DC's language access act to make sure vendors know how to access it. It is incredibly important that DC Health reverse its historic practice of placing unfair burdens on street vendors that keep vendors trapped in the informal economy.

We are excited to work with the Committee on Health and DC Health in order to ensure that DC Health develops regulatory practices that are fair and accessible for all vendors.

Sincerely,

Geoffrey Gilbert

Geoff Gilbert
Beloved Community Incubator
Legal and Technical Assistance Director

HOWARD UNIVERSITY

Council of the District of Columbia

Committee on Health

FY2025 Budget Hearing
Department of Health (DC Health)

Testimony of Dr. Hugh Mighty
Principal Investigator
Centers of Excellence
Senior Vice President, Health Affairs
Howard University

DATE: April 10, 2024

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Good afternoon, Chairwoman Henderson and members of the Committee. My name is Dr. Hugh Mighty, and I serve as the Principal Investigator for the Centers of Excellence and SVP of Health Affairs at Howard University. Beginning in Fiscal Year 2021 with a $30.8 million commitment through FY27, the District of Columbia and Howard University formed a partnership to improve access to health care in the District. Through this partnership, Howard University has implemented five Centers of Excellence: 1) Behavioral Health, 2) Oral Health, 3) Sickle Cell Disease, 4) Trauma and Violence Prevention, and 5) Women's Health. We welcome the partnership and the vison of the council and the Mayor to strive for improving health outcomes for the citizens of the District.

While we have been able to launch programs through the COVID cycle, the ability to enhance and strengthen them has been a challenge due in part to the unevenness in funding dollars and the timing of funds. The original MOU with the mayor's office and council funded the program incrementally for 6 years at full funding. Last fiscal year, the total award was adjusted downward to $20.9 million. Through FY 2023, the COEs have spent $9.8 million of the total award. For consecutive years, FY23 and FY24, DC Health has issued COE funds eight and six months into the fiscal year respectively. These funding delays have significantly affected our ability to hire and keep staff and develop, implement, and sustain programs. Further, there is no allocation for the COEs in the Mayor's FY 2025 budget. This will lead to the discontinuation of critical programs already implemented and being launched by the Centers. We respectfully ask that the Council restore FY 2025 funding for the Centers, which is vital , along with the staff who support those programs. Hiring is a real challenge, and retaining quality people is even more

difficult when they realize their source of income can be removed abruptly. For example, the Women's Health Center, which has just secured a new Director , would most noticeably be affected just as it is ready to deploy a community based program. In addition to securing FY 2025 funding, I am also calling on the committee to restore the original commitment of $30.8 million, even if that means increasing the length of funding for the programs, and to decrease any negative impact on the district's budget. It will also allow the Centers to deploy and modify programs over s longer sustainable period.

Through the end of FY23, the Centers of Excellence have engaged 11,199 community members, clinicians, and students through direct health services, outreach and education, and training. Notably, the Centers also provided direct health services to 6,013 patients through the oral, behavioral and sickle cell disease Centers. The COEs have trained 357 clinicians, offered education programs and workshops to promote best practices in healthcare delivery, and awarded small grants to support community projects that are intended to advance health equity.

Moving forward, the Centers will continue to implement critical projects such the Comprehensive Care Sickle Cell Disease program, the Women's Health home visiting service, behavioral health addiction consult, open access and community-based SUD programs, trauma and violence prevention initiatives, and comprehensive oral health programs for District residents including seniors and the differently abled.

Howard University understands that the District of Columbia is facing hard decisions when it comes to the budget for FY 2025 and outer years. However, it is only through the continued support of the District, in line with its original commitment, that the Centers will be able to continue to provide critical services for the community. This support thus far has brought positive health changes to the most at-risk communities in Washington, DC.

Thank you for the opportunity to provide testimony today to uplift the work of the Centers of Excellence. We look forward to your continued support and partnership to serve DC residents. I would also like to thank your staff for their responsiveness to our outreach.

I have enclosed here for your review some of the programs in progress or being cued up for launch. If you have any questions, please contact me.

Enclosures:

1. Summary of COE Programs and Services
2. Response to Budget Hearing Questions (previously transmitted via email).

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Summary of COE Programs and Services

Behavioral Health:

- Addiction consult service - provides withdrawal management, behavioral health evaluations, treatment initiation, and referral to continuing treatment (only such service in District hospitals)
- Open access clinic - addiction treatment
- Community-based SUD program - telepsychiatry, peer support, community outreach and education. There is currently one community-based program at DC Dream Center, and we are about to launch a second site at THEARC
- Training programs for medical students, residents and addiction fellows

Oral Health:

- Increasing access to urgent oral health care through the urgent care clinic - provides emergency oral health services
- Special needs program - focuses on increasing access to oral health care for senior citizens and the disabled community
- Community education and outreach - provides oral health assessments in the community and linkage to the oral health COE clinic
- Collaborates with MCOs to identify high need, underserved patients to refer and link to the clinic for assessment and treatment
- Trains dental students on best practices to manage urgent care patients

Sickle Cell Disease:

- Comprehensive sickle cell disease care for patients to include disease modifying therapy, exchange transfusions, and patient navigation to address social needs. We are in the process of building out the comprehensive care clinic to expand these services.
- Provider education/share best practices across the District to increase knowledge of appropriate care for sickle cell disease patients
- Sickle Cell Disease trait screening
- Research project on the financial impact of sickle cell disease in high utilizing patients in Washington DC to inform policy decisions

Trauma and Violence Prevention:

- Stop-the-Bleed training for community residents and providers - teaches people how to stop life-threatening bleeding in emergency situations
- Education programs – e.g. violence prevention summit
- Launching mobile unit to provide community-based education, outreach, social needs assessments and linkage to services.

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Women's Health:

- New Center Director hired and working to re-launch the home visiting program
- Program being launched in partnership with key community-based partners such as Mary's Center
- Will begin enrolling patients by the end of this month (April 2024)
- Currently providing widespread community education and outreach focused on maternal health such as this week's Black Maternal health week events: Baby Shower at HUH, Vigil at the HU Chapel, maternal health grand rounds, and policy discussion day.

HOWARD UNIVERSITY

Council of the District of Columbia

Committee on Health

FY2025 Budget Hearing
Department of Health (DC Health)

Response to Budget Hearing Questions
Howard University Centers of Excellence

DATE: April 11, 2024

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Thank you, Committee Chairwoman Henderson, for the opportunity to testify about the dire impact removing funding for the Centers of Excellence (COE) from the FY 2025 budget will have on the work of the centers.

As a follow-up to your question during the public witnesses hearing, contrary to what was shared by DC Health, the COE do not have access to $20,000,000. DC Health notified the COE on May 23, 2023, that any unexpended funds would expire if they were not expended before the end of FY 2023. The COE relayed to DC Health that this was not an expectation that could be met given the four-month lead time. Despite our expressed concerns, all funds unexpended as of the end of FY 2023 expired on September 30, 2023.

As of today, the COE is operating on a March 8, 2024, purchase order of $3,844,233.68, although DC Health has indicated it is working to increase the FY 2024 award to $3,954,233.26. Before March 8, 2024, Howard University provided its own funds for continuity of services. Once FY 2024 funds are expended at the end of the fiscal year, without new funds being provided in the FY 2025 budget, the COE will be discontinued as Howard cannot support the programs again.

I have included below a summary of the timeline of the DC government funding of the COE to provide better context on the timing of awards to the COE and when budget notices were received from DC Health.

COE Funding timeline:

- In FY 2021, the COE was awarded $4,199,601. Due to the COVID-19 pandemic, the ransomware attack at Howard, and lack of staffing infrastructure, none of these funds were expended.

- In FY 2022, the total COE award was $4,200,000. FY 2022 expenditures totaled $3,801,778 leaving $398,222 unexpended. The University's continued efforts to fully recover from the FY 2021 ransomware attack and COVID-19, a tight labor market which delayed hiring multiple positions, and late receipt of the Notice of Grant Award (NOGA) on December 28, 2021, resulted in late execution of workplans and budget spending. However, the sponsor indicated that all unexpended funds would be placed in a non-lapsing fund for use in subsequent fiscal years.

- In FY 2023, the COE was initially awarded $3,787,795.45 on 11/15/2022, 45 days after the start of the new fiscal year. The COE was on track to fully expend these funds. On May 23, 2023, eight months after the start of the fiscal year, the COE received an additional award of $8,770,721.35 and was advised via bi-weekly conference call that the total award ($12,558,516.80) was appropriated from ARPA funds and had to be expended by September 30, 2023. Of the total award, COE expended $6,067,008. According to DC Health, all unexpended funds from FY 2021 – FY 2023 expired on September 30, 2023 and are no longer available.

- On August 1, 2023, the COE received notification that the anticipated FY 2024 award would be $4,186,017.84. On October 11, 2023, the COE was advised that COE funding was reduced by $1,600,000 in the Mayor's FY 2024 budget and by an additional $2,000,000 dollars by the DC City Council, leaving $586,017.84 for FY 2024. DC Health mentioned the possibility of allocating funds from their non-lapsing account when their FY23 budget closeout was completed in December 2023. The COE remained unfunded until March 2024.

- On March 8, 2024, DC Health issued the purchase order (PO) for $3,844,233.68 indicating that it will be modified to $3,954,233.26. DC Health is still in the process of correcting the PO.

Thank you for your attention to this matter. I hope the explanation now sets the record straight.

Respectfully submitted,

Hugh E. Mighty MD, MBA
SVP of Health Affairs
Howard University

Testimony of Claudia Schlosberg, J.D.
Chair, Workforce Development Subcommittee
DC Coalition on Long Term Care

Before the
Committee on Health
DC Health Budget
April 10, 2024

Good morning, Chairperson Henderson and members of the Committee on Health. My name is Claudia Schlosberg, and I am submitting this testimony in my capacity as Chair of the DC Coalition on Long Term Care's Workforce Development Subcommittee. The DC Coalition on Long Term Care brings together consumers, advocates, providers and provider associations and organized labor to improve access to high quality care for District seniors and people with disabilities. We know that access to high quality care depends in large part on having a sufficient workforce to provide needed hands-on care and assistance. The Department of Health and particularly the DC Board of Nursing, play vital roles in helping to ensure that there are sufficient, qualified workers at all levels to meet the support and health care needs of DC's growing population of older adults and people with disabilities.

We are therefore pleased that the Mayor's proposed 2025 Fair Shot Budget appears to increase funding by $746,000 and adds 4.8 FTEs to the DOH's Professional Licensing Division. However, given the number of Professional Boards, their expanded responsibilities and the urgent need for significant regulatory reforms, the need to streamline and improve critical business processes, the need to speed up contracting and improve data transparency, we question whether these modest increases will be sufficient.[1]

As you have heard in prior hearings, inadequate staffing within the Department of Health and outdated and poorly designed systems greatly hinders the District's ability to timely process approvals for businesses and those seeking employment in our vital healthcare industry. Inefficient systems also increase health care costs and make the District less attractive as an employment destination for health care workers at all levels.[2] While it is important to

[1] In contrast, we note that the Mayor's proposed Fair Shot Budget contains over $30 million in new investments to streamline business processes, licensing and permitting for various businesses in the development, hospitality and entertainment sectors. For example, $26 million is allocated to streamline business licensing and reduce costs to entrepreneurs; $3 million is allocated to make it easier for organizations to host festivals and special events and to attract arts fairs and GoGo events, and another $1.5 million is allocated to expand the DC Business Portal to streamline various licensing processes for DC business.

[2] It is now firmly established that DC's supply of trained and certified direct care workers falls far short of demand, leaving many seniors and people with disabilities without needed care and placing additional burdens on family members. Data from the Board of Nursing affirms that DC's direct care workforce labor pool is shrinking at

streamline business processes for entrepreneurs, we should not do so at the expense of agencies that do the hard work of serving the healthcare sector and the residents who rely on these essential services.

Below is a partial list of issues that currently contribute to our current workforce crisis. Unfortunately, without additional staff and resources, the Department of Health's capacity to address these issues appears limited.

Streamlining the Renewal and Licensing Processes - While low pay is the main driver of the direct care worker shortage, the DC Coalition's 2024 Workforce Survey found that licensure and renewal issues also have become a barrier to recruitment and retention of workers. Additionally, last Fall, providers reported that **the vast majority of aides could not complete the renewal process without significant help.** Providers expressed fear that some aides would simply let their certifications lapse and find other jobs. **Indeed, during the last renewal cycle, DC experienced a 30 percent drop in the number of certified direct care workers.**[3]

The Coalition carefully documented the issues with the re-certification process and shared them with the Board of Nursing in a six-page letter dated October 16, 2023, a copy of which is attached and incorporated for the record at this hearing). As a result, we did have a meeting with the Board staff and the Board staff committed to examining the need to make some changes in the process. However, without additional staff and funding to revise the on-line portal, it is unlikely that the BON will be able to make needed changes or to make them timely.

Delays in Skills Testing – Training providers have shared with us that their Home Health Aide and Certified Nursing Aid students often must wait weeks after passing the written certification exam to take the required skills test. This is an in-person assessment of the student's competencies that is conducted by Credentia, DOH's testing vendor. The assessment itself must be conducted by a registered nurse licensed in DC. Due to the shortage of DC licensed registered nurses, the wait time to get an assessment date can be so long that some students need a boot camp refresher to ensure a passing grade; others simply abandon the field and find other work. This problem is fixable. For example, the Board could allow employers to conduct and certify a student's competency in the skills needed to be a home health aide or CNA, or the Board might contract with a local nursing school to conduct the assessments. However,

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alarming rates.

[3] During the last direct care worker renewal cycle which ended on October 30, 2023, the number of home health aides went from 8,380 to 6,683, a loss of 1,707 workers or 20.4 percent. The number of certified nursing assistants went from 5,103 to 2,756, an astounding loss of 2,346 workers or 46ti. The number of trained medication aides (TMEs) declined by 30% during the same period, and by 50% since February 2022. Notably, according to the Board of Nursing website, Certified Nursing Assistants, Home Health Aides and TMEs cannot work beyond December 31, 2023, without an active certification.

without additional staffing, it is unclear that DOH has the needed capacity to address this issue as any changes would likely require changes in regulations, policy and contracting.

Delays in standing up new but needed programs -

1. **The High Need Health Careers Scholarship and Healthcare Loan Repayment Program:** The Council passed and funded the High Need Health Careers Scholarship and Healthcare Loan Repayment Program in 2022 to cover the cost of training for new HHA and CNA students. This program is critically needed to attract more students and to help pay the cost of training and certification for those who do not qualify for the limited number of free programs available to DC residents. We were told that this program would be ready to launch at the beginning of fiscal year FY 24. **However, more than six months later, this program has still not been launched.**

2. **Medication Aide Training Program -- Standards for Medication Aide Certification were finalized by the Board of Nursing as part of the Nursing Assistive Personnel regulations in 2019.** Medication Aides are Home Health Aides and Certified Nursing Assistants who have taken advanced training and demonstrated competencies that allow them to administer medications. The BON developed the curriculum for this program but never launched it. In 2021, the Coalition conducted a Survey of Providers and documented that there is high demand for Medication Aides among long-term care providers. Providers reported that being able to upskill their current workforce to be qualified to administer medications would help reduce the workload of nursing staff while advancing the skills and increasing the pay of direct care staff. Providers reported this also would help with recruitment and retention of workers. Based upon the Coalition's survey results, several schools, including UDC, applied to the Board of Nursing to offer this training in 2022. **Two years later, these applications have yet to be processed.** Last summer, we were told that the BON needed to contract with vendor to offer the national exam but that this would be done by October 1, 2023. We were then told the program would be up and running by January 2024. More recently, the BON staff stated that it could not launch the program because they needed to hire a nurse educator, although it is unclear why.

Clearly, without additional staff and resources, DC Health lacks the capacity to launch these new programs timely.

Data Collection and Analysis -

The Biennial Workforce Survey - One of the key roles that the Board of Nursing plays is collecting data to help us better understand workforce needs and trends. Bi-annually, the BON requires all health professionals and certified paraprofessionals to complete a workforce survey as part of the renewal process. However, the survey, as designed, is unlikely to produce useful data regarding direct care workers. As we noted in our October13, 2023, letter to the BON

(attached), among other concerns, questions were poorly worded, and the answer choices were not pertinent to Home Health Aides and Certified Nursing Assistants. We have urged the BON to revise this survey with input from stakeholders but without additional staff and resources, we are unlikely to see a more useful survey tool in the future.

The Workforce Pipeline – To understand workforce trends, we need to track how many trainees are in the pipeline and the number who take and pass the certification exam. It would also be helpful to know how many are hired and remain employed after various intervals. The LTC Coalition has sought this information through a FOIA (originally dated September 19, 2023) and received a partial response showing that (1) we are training only a fraction of the number of aides needed to replace those that have left the field and (2) the number of aides who take and pass the certification exam has declined significantly overtime. However, we are still waiting for data from 2020, 2022 and 2023. The information is readily retrievable since it is available from the testing vendor, Credentia and because Credentia submits these reports regularly to the Board. However, the BON appears to lack capacity to make this information publicly available or to produce it in response to a FOIA request.

Analytic Capacity - Finally, while collecting data is critical, it is useless unless someone is analyzing it and reporting out trends to leadership. It is unclear whether the BON has the capacity to analyze the data it does collect and whether there are any protocols in place to insure that it is reported to those who might act upon it.

Needed Regulatory Reforms – Over the past four years, the Coalition has identified numerous regulatory reforms that could help alleviate the current workforce shortage including creating a universal credential that combines Home Health and CNA certifications, simplifying the endorsement process and making better use of on-the-job training and apprenticeship opportunities. However, DOH will need additional staff to undertake any of these much-needed reforms.

Reciprocity – Given the size of the District's population and the demand for health care workers at all levels, DC will never be able to train enough residents to meet current and future needs. We must rely on workers who do not live here, but it can take months to get a DC license or certification for an out of state practitioner. The Coalition strongly believes that DC must work to resolve objections and enter the Nurse Licensure Compact and establish reciprocity for Maryland and Virginia CNAs. Currently, the BON's budget is funded from licensure and registration fees. Replacing these fees (either with appropriated dollars or otherwise) must be seen as a priority if we are ever going to solve the health worker shortage.

Investing in all Industries and Workers -

We urge the Committee on Health and all members of the Council to support the critical infrastructure at DC Health that is responsible for licensing and credentialling of health professionals to help alleviate the current shortage of workers. Healthcare is a very large driver of our economy, plus it is essential for the well-being of District residents (as well as tourists).

Yet, the current budget invests almost nothing to modernize, streamline and upgrade policies and systems that are vital to growing and maintaining a qualified health care workforce.

Thank you for the opportunity to testify.

Testimony for the Committee on Health's Budget Oversight Hearing: HAHSTA

By: Kowshara Thomas, Executive Director, Joseph's House

Wednesday, April 10, 2024 // 12:00 pm

Good afternoon, Chairperson Henderson and Committee on Health. Thank you for the opportunity to testify before you today. My name is Kowshara Thomas. I am the Executive Director at Joseph's House. Joseph's House provides transitional housing and holistic care for unhoused individuals with HIV/AIDS and those with terminal cancer. We have operated in Adams Morgan for over 33 years and serve some of the district's most vulnerable residents.

First, I would like to thank the Committee for supporting HIV/AIDS programs, particularly for including $550,000 in last year's budget for transitional housing and supportive services. I have personally witnessed the profound impact our organization has had on improving the quality of life for residents across the city. Stable housing benefits extend beyond individual households—they contribute to improved health outcomes and a stronger, more resilient community. By providing stable housing, we are not just helping individuals, but we are also contributing to the overall well-being of the community.

Joseph's House seeks to bridge the wide health disparities in care our residents have received as unhoused individuals and people of color. Our organization has been at the forefront of addressing these challenges through various innovative programs and initiatives. We provide unique, intensive, and personal care unparalleled for our residents. We often say our residents are too well to remain in the hospital but too sick to return to the streets or local shelter. We also provide a higher level of care than most other medical respites.

In FY23, we housed 20 residents and provided 24-hour nursing, medical case management, and personal care services. We also provided seven individuals with end-of-life care. Our Supportive Services program remains unfunded since the loss of Ryan White. We continue to work to diversify revenue to decrease our dependency on government funding. It's only because of the $250,000 earmarked funds from the council and our funding-raising team that we have

continued to provide this service. The team supported 25 former residents with medical coordination and access to benefits and 17 former residents with securing and maintaining housing.

Our services fill gaps in the strained healthcare and social services systems. The lack of stable housing and resources makes it difficult for individuals to adhere to complex medical regimens or treatments. There are many barriers to homelessness, and we are committed to addressing them.

Joseph's House has recently expanded its criteria to accept residents even if they are actively using as long as detox isn't required. We also developed and strengthened the Supportive Services Program by increasing and enriching therapeutic engagement opportunities for residents and former residents and providing them with group and individual therapy. This expansion has allowed our clients to experience their community more deeply, reducing isolation and improving overall mental health and well-being.

In conclusion, I ask you to prioritize $600,000 in funding for Joseph's House in the upcoming budget cycle. Your support will enable us to ensure that every Washington, D.C. resident has a place to call home. Thank you for your attention to this critical issue. I am available to provide any additional information or answer any questions.

Kowshara Thomas

Greetings to all.

My name is Kaitlyn Wilson; I am an educator at one of our Opportunity Academies: Roosevelt STAY. For context, our student population ranges from 16-24, with the average settling around 20 years of age. As an educator completing my 8th year in education, a school nurse is a fixture of equality of which I have previously relied heavily upon in the advocacy of greatness of my students. Our student body welcomes a large population categorized with immigrant-status. Nearly 100% are students of color. This is worth mentioning because of the vulnerable place society places such students. Many being without documentation or citizenship, leaves them a forgotten minority, with little or no access to insurance and subsequently, healthcare, such as general care, vaccines, contraceptives and testing. The same can be said for our students of color: a disregarded, underserved minority. Given the adult nature of our student body, this places many students open to a few more health risks than an elementary- aged student. Additionally, I have observed a gap in medical information and knowledge in our students. A nurse or a medical professional could assist in educating these young people and dispelling misunderstandings and misinformation. Moreover, many of our students are mothers, fathers or live in multi-family households, which also adds yet another layer to the glaring need for a clinic on site. Thirdly, substance abuse is a common topic at our school and there have been instances where a medical professional would have absolutely been preferred in multiple emergency situations. We are fortunate to date that our staff reacts quickly and wisely. However, there would be a peace of mind to have a medical professional on staff. The fact that we have been allowed to exist without access to a nurse or medical professional of some sort gives discriminatory undertones towards the OAs of DCPS and we should be more upset than we are allowed to display here. We strongly urge DCPS to use its power, influence and resources to find Roosevelt STAY means for a clinic and a school nurse.

Thank you.

Kaitlyn Wilson
Roosevelt STAY Opportunity Academy

Testimony for the Committee on Health
4/10/2024
Ana Lemus, Street Vendor (Ward 1)

My name is Ana Lemus, and I've been a street vendor in Columbia Heights since my son was 8 months old - he's 13 now, so more than 12 years. I sell minutas (shaved ice), fruits, snacks, drinks, and pupusas. For years we dealt with harassment and violence from the police - but now, it's the Department of Health that comes to harass us. Last Thursday (4/4/2024), they came to give us papers telling us to shut down our businesses, and this Monday we were threatened with fines if we don't comply. We want them to show us how to follow the law instead.

Last year, we passed a bill that would allow street vendors easier access to a license. But as of today, the law has not been fully implemented in the different agency offices in government. Under the new law, the Department of Health is supposed to give us a permit to make food from our homes and bring it to sell, but they still haven't implemented the law. Instead of shedding some light on the path, they have chosen to threaten and punish us instead.

We are honest people, we like to work with sweat coming down our forehead. We work long hours to feed our children and feed the community. But we haven't felt this hopeless since the police would harass us. And the scars from that are real: my daughter still feels depressed, and still hasn't healed physically from getting beaten by the police.

We are asking you, Councilmember Henderson and the Committee on Health, to force DC Health to make the permits that they're legally required to create. The DC budget should make sure that DOH creates the permits and lets vendors get their licenses like they were promised. We want peace, and we want a just process to get a license - we don't want DC Health to abuse our right to work, and we don't want them to persecute us while they haven't done their job.

Testimony for the Committee on Health
4/10/2024
Reyna Sosa, Street Vendor (Ward 1)

My name is Reyna Sosa. For 12 years, I've sold atol de elote (a warm corn drink from Central America) and Mexican antojitos, or snacks - chicharron and yuca, taquitos, plantain chips, fruits - at the corner of 14th and Irving Streets NW. I want to explain what happened on Thursday, April 4th with the Department of Health. They came in the afternoon to tell us to shut down, without explaining why. We speak only Spanish - they brought no interpreters into Spanish and wrote on their papers in English. I tried to tell them we were still in the process of getting a license - they gave us a cease and desist letter anyway.

But we're not going to move, we're not going to stop, until they give us the license and tell us how to comply with the law. That's what we're asking, CM Henderson, we want you to help us and make the Department of Health release the requirements for the license. When the inspectors came, I asked them to leave and come back when they explain to me how to get a license, every step I need to take, explain the whole process - this is what we want. We want to follow the law, but DOH won't give us a chance.

DOH also started telling me that I need a special cart to begin selling. I know that's not true - I should be able to send in my current designs for approval under the new law. And even the vendors with carts are having a very difficult time getting a license right now. We are all trying to get licenses and DOH stands in the way.

DOH and DLCP have even threatened my children when they're selling on my behalf, telling them that they will come with a truck and take all of my merchandise away. When will this intimidation and abuse end? Why the abuse of authority?

DLCP and DOH contradict themselves - they each tell me I need to go get their license first, go down to their office first. I want them to just give me the information clearly and tell me what to do. After so many years of running from the police just to do my job, I'm so tired. Please, help us get the licenses that we deserve, so we can continue working to put food on the table for our families and pay our rent.

Testimony for the Committee on Health
4/10/2024
Kahssay Ghebrebrhan, Street Vendor (Ward 2)

My name is Kahssay Ghebrebrhan. I am a street vendor, working at 6th St and Indiana Ave. NW for almost 30 years. I sell hot dogs, halfsmokes, chips, cookies, and other snacks. White people like hot dogs, African-Americans like me like halfsmokes because they're spicy! My customers all love me. I sell in cold weather, hot weather; rain, snow, wind; winter, summer; no matter what, I do my job. When the pandemic came, I had to stop working to be safe, the Mayor told everyone to stay home.

I went to the Department of Health on Monday April 8th to schedule an inspection for my hot dog cart. But they were rude to us, and they didn't help us schedule an inspection. Instead, they told me I had to go to DLCP. But DLCP told me I had to go to DOH! So what am I doing?

The Mayor and her agencies should show respect to us - we've been working for decades, feeding the people of this city. They gave me no information in Amharic, they gave us the wrong form to fill out, and then they told us everything was online. I can't go online, I don't know how the forms work and I normally pay for my fees with checks or money orders.

No one wants to hire me - I'm an old man. I'm broke too - I'm a broke, old man, but DC doesn't care about us. Street vending is my job, and it's what I want to do. Life is a struggle here, and all I can do is the job I've known for a very long time. DOH has to help street vendors get their license, that's their job. Let us pay in person with money orders and checks. Let us fill out forms the way we used to. Let us get a license to do the job we've been doing for decades.

Heidi Smith

Hello. I adopted my cat from the New York Avenue shelter several years ago, and feel connection to the facility.

I urge you to keep the $22.5 million allocated. It is desperately needed, as is a full funding of the $6.5 million for the contract year. Thank you!

Comments on DC Health's Proposed Fiscal Year 2025 Budget
For the Committee on Health
April 22, 2024

Community of Hope is a non-profit Federally Qualified Health Center and homeless services provider. We provide medical, dental, and behavioral health services, along with a robust set of maternal and child health care, including evidence-based home visiting and operating the District's only free-standing birth center. We also provide housing and supportive services to individuals and families experiencing homelessness.

Community of Hope has provided primary care which includes perinatal care to DC residents for 31 years. We provide perinatal care for 700 new pregnancies a year with more than 85% of our pregnant patients being Medicaid recipients. Our patients are at higher risk for negative maternal and child health outcomes due to higher incidence of social and medical risk factors and lower incidence of protective factors. Our 30 person Maternal and Child Health team provides comprehensive supports including WIC, home visiting, care coordination, doula support, and group health education.

Home Visiting

Evidence-based Home Visiting programs have a proven record of improving perinatal and birth outcomes, as well as the physical and mental health of new parents and their babies. The proposed $1.5 million budget allocation to DC Health to maintain its current funding for home visiting programs will allow DC Health's partners, including Community of Hope to continue bringing services to our maternal and child health patients, in their homes, where they feel most comfortable.

Community of Hope also supports the funding and implementation of the Home Visiting Reimbursement Act of 2023. The passing of this legislation was an important step to expanding home visiting services that provide stability and direct access to care for some of DC's most vulnerable populations, and we are hopeful that if implemented, the Act will be a sustainable funding source that increases investments for home visiting programs in the future.

Senior Dental Services Grant

Community of Hope is pleased to see the Mayor's proposed budget again seeks to fund the Senior Dental Grant at $550,000. We have had very positive results since first being awarded the

grant in FY19, providing care to seniors who truly needed quality dental care, many of whom would otherwise be unable to receive such care. Dental care is not covered by Medicare, which leaves the Senior Dental Services Grant as the only option for many patients without additional insurance. Community of Hope is using these grant dollars to ensure that there are no costs associated with dental care for our seniors.

The grant provides dental services for uninsured and lower income District residents aged 65 and older. We serve a high percentage of patients from Wards 8 and 4 (49% total), and (24%) of our Senior Dental patients live in zip code 20032, where our Conway Health and Resource Center is located. There continues to be a great demand for dental services, and Community of Hope continues to make investments that allow our talented dentists, dental hygienists, and dental assistants to provide high quality care to our seniors. Additionally, the grant allows us to partner with oral surgeons and other specialty care which seniors require and unaffordable. Recently, Community of Hope has made capital investments with Senior Dental funding to provide a special dental chair that is accessible for patients who use wheelchairs, as well as digital scanners to reduce some of the digital fabrication visits. We are well-positioned to ensure that seniors continue to receive the dental care necessary to support their overall health.

Now more than ever, it is critical to invest in removing barriers to accessing healthcare, especially in Wards with the highest rates of chronic conditions, combined with a lack of access to quality providers close by. The Mayor's proposed FY25 budget makes important investments toward increasing healthcare equity and removing barriers to access to healthcare. Community of Hope appreciates its ongoing partnership with DC Health, and we look forward to working together in the future to continue providing services that address the healthcare needs of DC's residents.

We appreciate the opportunity to provide these comments to the Committee. If there are any additional questions from the Chair or members of the Committee, please do not hesitate to reach out to our Director of Policy and Advocacy, Cydnea Shearlds.

WRITTEN TESTIMONY SUBMITTED FOR
THE 2024-25 BUDGET HEARINGS
FOR THE DISTRICT OF COLUMBIA
April 24, 2024

Dear DC Council Members:

I am writing as a DC property owner, taxpayer, and animal parent. For too many years the concerns and priorities of DC pet owners, their pets, and the abandoned pets and un-owned, stray, or outdoor animals in our midst have been neglected, ignored, turned away, and denied a second chance — often by DC Government's own Animal Care and Control Contractor.

Because of this, I strongly and respectfully urge the Council to remedy the terrible deficiencies of the past. While I am very much aware of the heavy workload and the obligations you have for the welfare of the human beings who reside in the District, many of them are attached to pets who are part of their families and who contribute to their mental and emotional well-being, safety and overall quality of life. Animal Care and Control has a direct impact on their lives.

The allocation of $22.5 million for the construction of a new Animal Care and Control Facility (ACCF) is most welcome. Given the current pressing needs however, and the likelihood that the results of the Covid pandemic have set a new "normal" of frequent overflow, I urge the Council to consider increasing that funding to **$30 million,** and to ensure the new facility is easily accessible to all DC residents and centrally located.

The Department of Health is juggling many balls, but the ball it has repeatedly dropped is its advocacy for a fair and realistic Animal Care and Control contract. The contract's budget has been reduced over the years to the point where the animals and the staff and volunteers caring for them are suffering from lack of space, poor sanitation, haphazard care, and little time or money to give these animals some training and behavioral programs for a second chance at life. These animals didn't choose to be abandoned or abused or thrown away like garbage, and ending up in the ACCF should not be their punishment.

Again, I strongly and respectfully urge the Council to return the ACC contract to at a minimum its previous $6.5 million funding, but more realistically, **to a $7.5 million** amount. And as an immediate need, funding for urgent repairs, replacement, and regular cleaning should be allocated in the $300,000 range.

Believe me, I would never argue that human needs are less important than animals' needs, but the human-pet animal bond is a traditionally strong one. More so than a man

and his car, or a woman and her tennis bracelet (am I dating myself?), more so than a child and a favorite toy. A pet teaches us all about responsibility, compassion, understanding another species, second chances, and the power of love.

How would these monies be spent?

For the new ACCF — which should be in a central location with a parking lot and easily accessible by Metro and at least two major Metrobus routes — the funding would include: the physical structure itself, fitting out specific rooms/areas for surgery (3), wellness exams, x-ray and infrared equipment, isolation of animals with contagious diseases, quiet spaces for stressed-out or volatile animals, behavioral training, continuing education for pet owners, staff, and volunteers alike, offices and meetings, laundry, storage/refrigeration, restrooms and lockers, outdoor runs and playtime, etc.

The funding for a new ACCF and an improved ACC contract should also include competitive salaries and benefits for **at least FOUR (4)** veterinarians with high-volume-high-quality spay/neuter experience, who can run a clean low-cost spay/neuter program for the general public — along with the appropriate veterinary technician (12) and veterinary assistant (8) staffing — while also handling spay/neuter services for resident ACCF/shelter animals. Low-cost spay/neuter services, so crucial to humane animal population management, is something D.C, residents have not had access to since September 2019, well before Covid.

There should be funding for certified behavioral specialists to provide assessments and treatment/training programs for dogs and cats. A pro-active ACC contract would provide for regular **and frequent** low-cost vaccine clinics, public education programs about responsible pet ownership, training, caring for your pet through all stages of life, etc. — again, something DC residents have gone without over the years — and in-service training for employees. And of course there must be funding for Animal Control Officers, Dispatchers and Investigators and their equipment.

Keeping DC pets healthy and safe, their families knowledgeable about how to care for them, and taking in all unowned but found or surrendered animals who need a second chance at life, keeps our city on the right side of everything: public health, safety, compassion, and strengthening the bonds between humans and animals.

Thank you for reading my testimony. DC residents have had to put up long enough with a lax ACC contract, a deteriorating ACCF facility, a negligent Contractor, and a weak Contract Administrator. Please make this right!

Sincerely,
Emi Lynn Yamauchi

Testimony for the Committee on Health
4/10/2024
Medhin Ayele, Street Vendor (Ward 1)

I'm Medhin Ayele, I'm a street vendor in Columbia Heights selling hot dogs and halfsmokes from my vending cart since 1994. Since the pandemic started, I have been out of a job because I could not pay the taxes for my license. Thanks to God, the Council passed a law last year to help me forgive my debts and go back to work. But now, DOH is in my way.

I went down to see them on Monday, April 8th, to request an inspection. They made me fill out the wrong form, and then they told me that I couldn't get an inspection until I have a business license! But DLCP told me I can't get a business license until I get an inspection! They said everything is online, I can only pay by card, but I can't do this. I need help. They had no one to speak in Amharic to me. They had no papers, forms, or explanations in Amharic. They told me that if I tried to do my job they would give me a $1000 fine every day I work. They gave me no respect in that office.

For the many years I was working, it was easy to get a license renewal. I could visit the office, request an inspection, and pay all my fees by money order. Now it's all different. I am older, English is my fourth language, and technology is very difficult for me. I don't have someone who can help me.

I am desperate to go back to work. I have tried to find other jobs to at least let me feed myself - I tried to apply for a cleaning job at George Washington Hospital, for example, and they asked me for a high school diploma or a college degree! For older people, they're not going to hire us. This is the struggle I'm in. Street vending allows me to work when everyone else ignores me. I am ready to work. I want DC Health to put their forms on paper, in Amharic, and help street vendors have an easy path to getting a license.

Nia Bodrick

Budget Oversight Hearing: Committee on Health

April 10, 2024

Nia Imani Bodrick, MD, MPH, FAAP

Regarding HealthySteps

Good Afternoon Council member Henderson and Members of the Committee,

My name is Dr. Nia Imani Bodrick and I am a Pediatrician and President of the DC Chapter of the American Academy of Pediatrics (DCAAP). I also serve as a Director for the Early Childhood Innovation Network (ECIN), a role in which I provide oversight for the HealthySteps program at Children's National. Finally, I am a member of Under 3 DC, a coalition which is committed to securing a strong start in life for every infant and toddler in DC. I am speaking today on behalf of DCAAP and Under 3 DC. My testimony will focus on the importance of the HealthySteps program for a strong, effective, and connected early childhood system in the District.

The HealthySteps program provides early childhood development support to families in the pediatric primary care home. HealthySteps incorporates a strength based, family centered model of care that promotes the development of healthy parent-child relationships, and integrated behavioral health care and care coordination in the primary care setting. I am testifying in support of the HealthySteps program because I have personally seen how important these resources are to our community.

The HealthySteps program is designed to meet families where they are; almost all families bring their children to see their pediatric primary care provider. In the first three years of life, there are at least 12 opportunities for a family to receive family centered care from the HealthySteps team. I rely on this team (which includes a licensed mental health specialist with expertise in early childhood and maternal mental health) and a family services coordinator to provide family centered wrap around services for the families I serve. They work with pediatricians to provide screening, consultations and care coordination for maternal mental health disorders including postpartum depression and anxiety, screening and connection to services for early intervention and connection to concrete supports such as safe sleep, food resources and peer support.

Since I began working in DC in 2014, I have seen the HealthySteps program expand from two sites to a total of 9 funded sites, of which six are locally funded. This has been an amazing success and I would like to thank you for your continued support of these programs.

The Healthy Steps model requires staffing resources, services and training that are not currently covered by Medicaid. Currently, several of the funded sites are not fully staffed. It is important that these sites continue to be funded, but I also would like to highlight the need for additional investment to provide support for the behavioral and mental health workforce, which are the key players in the implementation of the HealthySteps program. Funding is critical for more pediatric practices to commit to and sustain this model that has a track record of a positive return of investment for children and families. Although previous funding has focused on historically under-resourced communities in Wards 5, 7, and 8, access to this level of care is important for all children in the District. Therefore, I am asking you to sustain this investment, so we can continue to provide staffing for those in this field when the opportunities arise. Thank you, again, to the DC Council for your continued support of the HealthySteps program. Investment in this program is beneficial for the DC community as a whole and your consideration of this matter is greatly appreciated.

Budget Hearing – Public Testimony

Thank you for the opportunity to provide public input on the DC Budget. I am a DC resident and was recently a volunteer at the Humane Rescue Alliance (HRA), DC's animal control contract. From 2018-2023, I spent most of my weekends walking dogs at the DC-owned New York Avenue animal shelter (NYA).

New DC Shelter

I applaud the DC Government for addressing the urgent need for a new DC-owned animal shelter and dedicating $22.5 million for this purpose. The current structure (NYA) must be demolished and rebuilt – central heating and air conditioning systems do not work; rats and other pests run rampant; the ceiling in one building is prone to collapse, etc. This poorly maintained facility poses a safety hazard to staff, animals, volunteers, and members of the public. Understanding that a new animal shelter will take time to build, I ask the Council to set aside funds for NYA maintenance so it is safe for humans and animals alike.

Accessibility for Residents East of the River

If the location on New York Ave will not be the future shelter location, I urge the DC Government to consider selecting a central location easily accessible for most District residents, and especially for those East of the River. The Anacostia clinic, blocks away from the new DC Health building, is without a certified veterinarian. Despite promises to open a medical facility by February 1, 2024 (in a location also just blocks from the new DC Health offices), HRA still has not opened or staffed such a facility.

Anacostia residents have virtually no access to animal healthcare services; a public health failure and an injustice to Ward 8 citizens. Several studies demonstrate that disparities in how people of different races access vet care disappear once socioeconomic factors like distance and cost are addressed.[1] Simply put, this is a racial and socioeconomic justice issue. The DC Government must provide accessible animal healthcare that is equitable and just for all of DC – not just wealthy, white NW residents.

Contract Oversight

I urge the DC Government to improve its oversight of taxpayer money funding the DC animal control contract – DC Government must ensure that DC residents receive the public health services they pay for and that DC animals receive humane care. The current contract with HRA is vague, lacks effective oversight and enforcement measures, and contains no humane animal care standards.[2] HRA has failed, for months at a time, to meet several obligations outlined in the contract and yet is still paid for unfulfilled/deficient services.[3] The DC Government must take over or separate out vital services that HRA refuses to offer. The DC Government must open the animal control contract for competition at $6.5

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[1] Race and ethnicity are not primary determinants in utilizing veterinary services in underserved communities in the United States: Journal of Applied Animal Welfare Science: Vol 21 , No 2 - Get Access (tandfonline.com); Promoting social justice through spay/neuter | HumanePro by The Humane Society of the United States.

[2] The current contract cites the DC Health Standard Operating Procedures (SOPs) for animal care standards. Based on the results of my FOIA request for all SOPs in the contract, no SOP for animal care standards exists.

[3] For example, DC Health and HRA both insist that HRA is not responsible for low-cost spay and neuter services, a fundamental basic for any community that is available in nearby cities (Baltimore, Philadelphia, Richmond, etc.). However, the contract mentions that the animal contract will enforce the Mayor's duties to provide this and other services outlined in DC Code – if HRA isn't providing this service, then exactly who is supposed to do that? It's shocking that DC residents have no access to this.

million and stop giving HRA sole-source contracts. More competent organizations will want to serve DC with a new animal shelter, a clear contract, and appropriate funding.

This budget and upcoming contract cycle is an opportunity for DC – to provide residents with the services they deserve (and pay for). With a new shelter, the District could attract world-class animal care contractors and services for our community. As our nation's capital, DC should have the best animal welfare programs in the country.

Katie Lee

Katherine Binney

I am submitting this testimony with regards to budget items related to DC Animal Care and Control. I began volunteering with the Humane Rescue Alliance in June of 2023 while living in Eckington near DC's Animal Care and Control Facility on New York Avenue. In October, I joined a group of volunteers raising concerns around animal services provided by HRA. Since then, I have spent significant time researching animal services and animal shelter operations, including reviewing services publicly provided and funded in nearby jurisdictions (Alexandria, Arlington, Baltimore, Fairfax) and online resources provided by the ASPCA, Association of Shelter Veterinarians, Best Friends, and Maddie's Fund - established and well respected national organizations in animal welfare. My comments result from my experience with HRA, volunteering in other shelters, and my research. It is important to note that since raising concerns in January's performance oversight hearing, I have been removed from my volunteer position with HRA. I am no longer permitted to work with the organization as of March - no reason was given, nor warnings of organizational policies I violated. I thus do not have direct insight into the physical shelter conditions in the last month and a half.

Animal Shelter

I am thrilled to see the budget includes funding for a new animal shelter. This funding is key to a critically needed service for DC residents. The current New York Avenue animal care facility needs significant maintenance and does not contain facilities, such as high quality surgical suites, at least some office space, and divided space to house different species, that are critical to high quality animal care and control services. Please ensure this line item is maintained.

However, I was disappointed to hear of DC's planned location for the new shelter, in the far corner of DC. In order to ensure equitable access for DC Residents, it is critical for the new shelter to be easily accessible via public transit. While I support having the shelter east of the river, the proposed location is difficult to reach even for residents living east of the river already. DC Council previously gave the Humane Rescue Alliance (HRA) $5M to buy land on M St in Navy Yard to build a new animal shelter. While HRA has failed the community, holding onto the land since 2015 with no forward progress on a new shelter, the Council did well in supporting the location of that proposed shelter. In restarting this project, the Council needs to ensure an equally accessible location is chosen for the government-built shelter.

Animal Services

While I have concerns with HRA's performance as DC's animal care and control contractor, the Council should still consider allocating increased funding to animal care and control. In particular, the District needs to ensure the availability of low cost spay-neuter for residents, and effective community cat program management. The council should ensure there is funding to support staffing for these programs, at minimum. I'd also ask the council to consider funding additional animal caretaker and behaviorist positions given a rise in animal intake over the last year. I was extremely frustrated to hear Director Bennett testify that she did not need additional

funding for animal services when asked, despite a current lack of funding for at least 3 months of animal care services (ie current contract is unfunded for an open 3 month option period), and no clear plan from DC Health on how to ensure residents can access the low cost spay-neuter services outlined in DC Code.

Oversight

While I am supportive of funding for a new shelter and for animal care and control services, I also believe there needs to be significant oversight of externally contracted animal control services given the underperformance of the current contractor. HRA has continually overpromised and under-delivered. Not only have they failed to build the promised new shelter after a $5M grant from DC, more recently, they've failed to actually open a well-publicized new vet clinic in ward 8. At the January Performance Oversight hearing, HRA's CEO testified that HRA would be opening a new vet clinic at the old Whitman Walker center on February 1st. Months later, the clinic remains unopened. I was extremely disappointed in Director Bennett's testimony responses related to the animal care and control contract. In particular, the "unannounced inspections" at the New York Avenue have all been within 24 hours (mostly less) of inspections at the Oglethorpe facility - with many residents raising concerns specifically about the New York Avenue publicly owned facility, this ordering makes no sense, as the New York Avenue inspections can clearly be anticipated. Director Bennett also seemed not to take seriously residents' concerns and requests for increased oversight and a tighter contract. Additional budget for animal control services needs to be paired with increased oversight. Maybe that should include funding a DC Health internal position specifically focused on animal care and control services, emphasizing oversight of HRA or any future contractors.

Finally, I would like to thank Councilmember Henderson for her continued engagement on these issues.

Kyle Holstine

Dear Committee on Health,

I am testifying as an animal lover, a volunteer at Human Rescue Alliance (HRA) and a resident of Ward 4. Please consider my sincere comments as you consider your budget priorities for the upcoming fiscal year. I have a few concerns I would like to mention.

> As a volunteer dog walker I have sometimes witnessed the poor conditions at the HRA kennels. A poorly maintained facility poses a risk to staff, volunteers, and animals, including with poor temperature control, ceilings prone to collapse, hazardous yards (mud pit for a yard), no lighting, poor overflow conditions, and improper kennel doors.

Additionally, the improper care for animals leads to heightened behavioral issues, which risk public safety. Dogs spend months in kennels without proper care behaviorally deteriorating, then are adopted into the community with no support. DC must ensure it has the funding for a contractor to properly care for its animals. I have personnally witnessed this costing the lilves of multiple sweet dogs. If they would have received the proper care and management I am sure they would be alive today.

Thank you for considering my testimony.

Kyle Holstine

Dear Council Member Henderson and members of the Committee of Health,

My name is Taylor Smith, I am a Family Support Worker of Mary's Center, and I am advocating on behalf of home visiting programs in the District. As a family support worker, I conduct home visits to provide health and social services to families in a setting that is both comfortable and accessible for them. The education, materials, resources, and support given as well as the relationships formed between home visitors and community members promote better birth and maternal health outcomes in areas where this improvement is most needed.

Supporting and encouraging families to be proactive about their health and wellbeing has been one of the most important aspects of my job- many participants come to me in varied stages of pregnancy without yet having a prenatal care provider. For one participant, who enrolled in her second trimester after not having received prenatal care for 13 weeks (about 3 months), this meant finding a space for her at a Mary's Center clinic where she could receive consistent care for her high-risk pregnancy. This participant gave birth to a healthy baby and now she and her baby both use Mary's Center for primary care, something that would not have occurred had she not enrolled in a home visiting program. Another participant I work with was able to have a vaginal birth after a previous cesarean section, a goal that may not have been met if home visiting had not empowered her to advocate for herself.

A day in the life of a home visitor is one with many responsibilities. The morning may be spent outreaching to new families we are looking to bring into the program and then stopping by a clinic to pick up diapers, postpartum kits, cribettes, formula, and other supplies. Then, we go to visit a participant in her home to talk about breastfeeding her coming baby. However, after checking in about her questions and concerns, we learn that she has not yet created a birth plan with her doula and is feeling apprehensive about this. Instead of the presentation we had planned, we pivot to meet her needs and help her to create a birth plan that she can bring with her to the hospital when she goes into labor. Our promise to be participant-centered requires great flexibility, but it is important and necessary to form close relationships with participants and support their well-being. After the visit we spend a large amount of time documenting our conversation on several different platforms. We then meet up with a participant who we are supporting through a domestic dispute and drop off supplies for her and her baby while they stay at a family shelter we assisted her in getting access to. After arriving back home, the rest of our day might be spent sending texts to a participant to see how she is recovering after birth, or facilitating a two-way call with another participant to set up an appointment with a program that supports community members in applying for insurance and public benefits. All of this requires a delicate balance of a large caseload and many shifts of focus, but that is a part of the versatility that makes the home visiting field so beneficial for the community.

One of the biggest challenges I face in my role as a home visitor is helping my participants navigate through the services and systems in DC that are most often confusing and counterintuitive. Thus, it is no surprise that many participants do not know what their next steps are for things like housing support, postpartum care, or legal proceedings, considering that many state officials and even system employees are unsure of how to navigate these

services themselves. Support in navigating these processes is what home visitors take on. Our focus may be on health, but health must be viewed holistically or else progress will be isolated and limited. We take it upon ourselves to ask the questions that participants do not know how to ask, and to become experts in traversing social services. This is not in the job description or even the pay grade, and yet someone must do it. That someone is the home visitor.

It is disappointing enough that our pay has remained stagnant despite the cost-of-living crisis and inflation, but hearing that we are susceptible to further budget cuts is even more frightening. This would mean a promise broken to a participant who joined home visiting to improve their wellbeing. This would mean leaving participants to fend for themselves when navigating a system that is not set up for them to succeed. This would mean people in the community going without the support they deserve, because the home visiting team who serves them was downsized or even eliminated. I love my job, but I am incredibly lucky to be able to hold my job because I live with my family and do not have to pay rent. This is not a job that everyone can handle emotionally in the first place, and the low salary reduces the chances for even more people to become a home visitor, including those who share the same love for the community that I do. Because of these problems, I ask that at a minimum DC should avoid further cuts to programs and pursue meaningful improvements to their processes, procedures, administration, and funding.

Kirsten Stade

Thank you for this opportunity to offer testimony on the Mayor's Budget for DC Health. As a former volunteer with DC Health's Animal Care and Control contractor the Humane Rescue Alliance, and having volunteered at the New York Avenue animal shelter facility since 2011 and until being relieved of my volunteer dutites in March after raising concerns about shelter conditions, I have several points regarding the budget for this contract and related facilities.

New Animal Shelter

First off, I am pleased to see that the Mayor's current budget proposal draft includes $22.5M for a new animal shelter to replace the current shelter on New York Avenue NE. The current shelter on New York Avenue is in serious need of maintenance and in its current state, poses serious risks to animals, staff, and volunteers. The facility offers inadequate temperature controls and poor outdoor lighting, making it difficult and dangerous for staff and volunteers to walk dogs during the crucial evening hours during the winter months. The kennel doors are not properly constructed to allow for safe leashing or handling of dogs, and the ceilings are prone to collapse. There are no facilities for proper isolation of animals, with the result that disease has run rampant in recent years.

I understand that DC plans to use the $22.5M for a new shelter at 4 DC Village Lane SW, which is nearly in Maryland and not easily accessible to most residents of the city. Companion animals are family members, and their role in providing comfort and stability may be particularly significant for vulnerable populations such as low-income minority populations of DC. Having the animal care and control facility centrally located and easily accessible by public transit is vital for the well-being of these populations. I would urge the department to keep at least the $22.5 million figure for a new shelter in the budget, but to either use it to rebuild the New York avenue facility and retain it for animal care and control, or construct a new shelter in a more central location that is easily accessible by public transit to most DC residents.

Animal Care and Control Contract and Services

In addition to funding for a new city-owned animal shelter facility, the budget needs to include sufficient funding for the animal control contract and services to be performed by the contractor. Adequate funding to the tune of at least $6.5 M is essential not just for animal welfare, but for justice and equity for all DC residents. The animal control contract should be fully funded to allow for full staffing of the animal control facility and full provision of animal control services including:

- Full open access animal intakes, ensuring that DC residents have a safe avenue for relinquishment of animals they cannot care for;
- At least two veterinarian positions to care for the health needs of shelter animals and companion animals belonging to DC residents;
- Low-cost spay/neuter services available to DC residents, at a rate of at least 300 appointments per month. This is a vital service that ensures both the health of companion animals and population management of DC animals;
- Provision of low-cost pet vaccine and microchipping clinics for at least ten hours per week;
- Adequate animal care staffing to ensure proper exercise and behavioral care for shelter animals. This is vital for public safety as it ensures that animals adopted out or placed in foster care have been rehabilitated from prior trauma, given the chance to learn basic obedience and impulse control skills, and set up for success for life in a home. The contract should provide clear standards for in-shelter animal care, including at least 30 minutes of exercise outside of kennels per day for all dogs including Dangerous and Potentially Dangerous Dogs.

This budget is an opportunity for DC to invest in underserved communities in a city characterized by extremely high levels of income inequality. Providing reliable, low-cost services to DC residents allows equal access to pet

ownership to underserved communities, as studies have shown that disparities in how people of different races use veterinary care disappear once barriers like distance and cost are minimized.

Ryen Hanna

My name is Ryen Hanna, and I am a Ward 1 resident and member of Volunteers for HRA Reform. I am writing today to communicate the importance of competent animal services for our communities and ask the council to sufficiently fund the animal care and control contract and a new government-owned animal shelter in FY2025.

With these budget decisions and the consideration of animal care and control services, the DC Council has choices to make: invest in the community or neglect residents' needs. DC has a choice to fund crucial infrastructure or allow it to continue to crumble. As your constituent, I am asking you to make community and infrastructure your priorities and properly fund animal care and control.

Animal services have been neglected for years in DC, from the current sole-source, inadequate contract with no enforceable provisions to the completely run down Animal Care and Control Facility (ACCF) on New York Avenue NE. Every day, DC residents bear the consequences of these failures, from non-existent affordable spay/neuter services to lacking intake services as the current contractor frequently turns desperate constituents away. These failures, which impact both the animals and residents of DC, cannot continue to go unscrutinized and unresolved.

The DC Council has the opportunity to begin to address these systemic issues this budget cycle, and it is time that DC residents receive this investment in human and animal services, public safety, and equity. Starting in October, DC residents deserve a stronger, more robust animal care and control contract with specific provisions and definitions, including medical services like public vaccines and low-cost spay/neuter, mandated intakes for potentially abandoned friendly cats, and specific protocols for when animals are "saveable" and when euthanasia is allowable.

Making these changes will strengthen DC communities and support DC families in every ward, but they require proper financial investment first. A better contract with more provisions will be more expensive and likely require additional staffing, which in practice would mean funding the upcoming contract to at least $6.5M for the 9-month period which could cover the salaries of one additional vet, additional vet techs, and additional certified behavior staff. It would mean preserving the proposed $22.5M to build the new ACCF and ensuring that the new proposal is equitably and accessibly located to reach underserved residents, increase access to services across the board, and make pet ownership and animal welfare accessible for all.

These investments will benefit DC residents, providing lifesaving services that can keep families together, and promote public health and safety. They will improve future animal services and attract talent and resources to the District, potentially including other animal care organizations who might be willing to bid on a contract in the future. They could once again make it a national leader in the animal care field, instead of the notorious disaster it is today.

I look forward to seeing the Council invest in its constituents this budget season and sufficiently fund animal care and control services, including by funding the building of the new ACCF. Thank you.

April 23, 2024

DC Council's Committee on Health Budget Hearing for DC Health FY25 (April 10, 2024)
Written Testimony of Lenore Boulet
(member of Volunteers for HRA Reform)

Thank you, Chairperson Christina Henderson and Councilmembers Brianne Nadeau, Zachary Parker, Charles Allen, and Vince Gray, for giving me the opportunity to provide this written testimony. My name is Lenore Boulet, and I was a 15-year volunteer (resigned 11/30/23) at Humane Rescue Alliance (HRA) and its predecessor organization, Washington Animal Rescue League.

I care deeply about animal welfare in the DC area, both for the humane treatment and help for the animals, and for the safety and health of the DC public. To that end, I am writing to request the Council's consideration in two areas of budgetary concern, namely, the new animal shelter, and funding for the current animal control contract.

1. New Animal Shelter

I am so pleased to see that $22.5 million has been budgeted to fund a new Animal Care and Control Facility (ACCF) in DC. This is long overdue and is essential for the health and safety of DC's animals and people. I strongly encourage the Council to keep the proposed $22.5 million in funding for this new shelter. I am heartened that DC will be in charge of building this, and not HRA, given HRA's stunning failure to build the long-promised shelter on land that DC granted them. I urge the Council to determine a location able to readily serve as many of the DC public as possible, and ideally metro accessible.

2. Funding for NYA Facility, and Animal Control Contract

Given that the NYA facility will need to remain in use until the new shelter is built, I urge the Council to provide adequate funding to keep it a safe, clean, humane place to shelter animals, and for the humans working there too. I also ask that the Council restore funding for a new robust animal care and control contract to $6.5 million, to make sure there are sufficient resources to provide for: proper care for all animals and full open access intakes; at least two veterinarian positions; and low-cost spay/neuter services and other important services the animal care and control contractor provides.

I thank the Council for considering this testimony when making budget decisions in this area.

Lenore Boulet

FY 2025 Budget Oversight Hearing

Written Testimony of Dr. Chiping Nieh, PhD, CPH
(Member of Volunteers for HRA Reform)

Councilmember Henderson and other members of the Council and Council staff, thank you for the opportunity to submit this testimony. My name is Chiping Nieh. I am an epidemiologist and a Ward 5 resident. I am a former volunteer with the Humane Rescue Alliance, supporting the organization for an average of 10 hours per week from 2016 until 2023, mainly at the Animal Care and Control Facility (ACCF) at New York Ave (NYA) location.

I am submitting this written testimony urging the Council to allocate more funds to support animal care and control services in DC. Specifically, I have two asks:

(1) sufficiently fund a robust animal care and control contract, and
(2) ensure adequate funding for maintaining the ACCF at NYA.

Allocating more funds for animal care and control as well as maintenance of ACCF at NYA is not just an investment in public health and human services, but also a testament to DC's commitment to community support. It is a step towards ensuring the safety and well-being of the animals, staff, volunteers, and public. With a well-funded animal care and control contract and a properly maintained ACCF at NYA, we can guarantee that:

(1) DC residents will have access to essential services such as low-cost spay/neuter and vet care, animal care and control field services, and pet pantry program. These services are instrumental in helping families keep their pets, thereby reducing shelter surrenders and strays,
(2) animals in care receive proper in-shelter care and enrichments which reduce potential injuries due to adopting out highly stressed animals or having prospective adopters meeting highly stressed animals at NYA. Managing the stress levels of the animals can also reduce wear and tear on ACCF due to kennel frustration-related activities,
(3) the ACCF receives immediate repairs, proper preventive maintenance, and regular sanitation to prevent the spread of communicable diseases and ensure safe and healthful conditions for the animals, staff, volunteers, and community members who visit the ACCF.

Currently, the low-cost spay/neuter services are not consistently available to the DC public, potentially contributing to the overcrowding situation observed in local shelters. Additionally, low-cost vet care is unavailable anywhere east of the river. The lack of affordable animal-related services often increases owner surrenders due to economic hardship or financial difficulty. DC

Health and the DC Council must ensure these services are provided to DC residents by allocating more funds to support this much-needed provision to the animal care and control contract.

The ACCF at NYA is regularly having issues related to bugs/mites/rodents, failed HVAC, rust/mold and poor drainage. Kennels are in various states of disrepair. The adjacent parking lots where staff and volunteers walk dogs are full of broken glass, razor blades, and overflowing containers of pet waste that haven't been emptied for months. Getting a dog from a kennel to a play yard is an obstacle course of potential safety hazards for both humans and dogs. On days when there has been rain, the main play yard is a dangerous pit of mud and feces, posing serious fall and health hazards. I believe most DC residents would be horrified by the conditions DC's homeless animals are living in. The Council must ensure there is proper funding to fix these issues.

I urge the Council to look into this as a matter of urgency. This is an opportunity for DC to position itself as a national leader in providing high-quality care for DC animals. Animal care and control is an important function of a government's services. Its infrastructure and how well it operates is a crucial measure of a city. Even locally, other major cities are doing it significantly more competently than DC is by providing spay/neuter services, which are vital to controlling overpopulation and the well-being of pets, people, and communities. It is not acceptable that as the capital city of the U.S., DC is lacking such crucial services. I urge the DC Council to allocate more funds for the animal care and control contract to provide the communities the services they deserve and help the nation's capital regain its reputation as a national leader in animal welfare.

Thank you for your time and consideration.

Dr. Chiping Nieh

Planned Parenthood
Care. No matter what.
Planned Parenthood of Metropolitan Washington, DC

TESTIMONY OF PLANNED PARENTHOOD OF METROPOLITAN WASHINGTON, DC REGARDING THE CHANGES OF THE CERTIFICATE OF NEED PROCESS IN THE FISCAL YEAR 2025 BUDGET SUPPORT ACT OF 2024

DC Council Committee on Health
Public Hearing: Budget Oversight Hearing on Department of Health
Written Testimony April 24, 2024

Thank you Chairperson Henderson and members of the Committee for the opportunity to provide written testimony for the Budget Oversight Hearing on the Department of Health. Planned Parenthood of Metropolitan Washington, DC (PPMW) submits this written testimony to support the changes in the Certificate of Need requirements for small facilities that provide important conventional health care in the Fiscal Year 2025 Budget Support Act of 2024. Our interest in this matter arises from our plan to operate a mobile unit in Washington, DC, primarily in Wards 7 and 8. The unit will bring reproductive health care, along with other primary care, to individuals in DC who are otherwise unable to obtain preventive care. We have already received the funding to purchase and outfit the unit, but the purchase must be delayed because the State Health Planning and Development Agency (SHPDA) requires us to obtain a Certificate of Need (CON).

Who We Are

PPMW has been providing sexual and reproductive health care services in Washington, DC since 1937. At our health center in northeast DC (Union Market) we provide a range of services including family planning and contraception, cancer screenings, STI screening and treatment, gender-affirming care, medication abortion and procedural abortion. In the past few years we initiated primary care services, both to complement the services received by existing patients, but also to address the health care needs of a wider group of individuals who already associate us with high-quality care. A majority of our patients are women of child-bearing age, but a significant number of patients are LGBTQIA+, or are older, and come to us for cancer screening, primary care and gender affirming care.

Plans for a Mobile Unit

PPMW's planned mobile unit focuses on two unmet areas. First, the mobile unit will partner with social service organizations to help address the reproductive and preventive health needs of their constituents, many of whom are among the most vulnerable populations. These individuals may be homeless, have mental health issues or a history of substance abuse problems. They are youths, victims of domestic abuse or recently released from incarceration. Or they may be people who have so many other responsibilities that they do not believe they have the time to seek health care where they reside or elsewhere in the city. The mobile unit will bring health care to them. PPMW's services, focusing on reproductive health care, and other preventive health care, will not duplicate services already provided in these neighborhoods; it will be filling a gap that exists and persists.

Second,PPMW hopes to use the mobile unit to bring essential reproductive health care to youths at their schools, specifically charter high schools and high schools that do not otherwise provide reproductive health care services. Right now, many, but not all, DC high schools provide health care services; we hope to use the mobile unit to fill this gap.

The patients we intend to help will likely not have any form of health insurance, or they will be covered by Medicaid.

The mobile unit will have 3-6 employees.

Proposed Certificate of Need Changes

We agree that a proposal to omit a CON requirement for smaller medical practices that provide conventional office services in the Health Services Planning Program Amendment Act of 2024 is appropriate. The proposed exception for facilities with fewer than 10 employees is a start. A better exception, is to have a limitation on the number of physicians, but allow the physicians to staff the office as necessary.

The need to amend the CON process is well illustrated by SHPDA's onerous requirements of PPMW. It is beyond dispute that the aims of the mobile unit align exactly with the values set forth in the DC Health Systems Plan and SHPDA Implementation Plan each of which emphasizes primary care engagement, including access to care that is "effective, convenient, and affordable." *See e.g.,* D.C. Health Systems Plan at pp. 56-61, 99-101. Implementing a mobile unit addresses each of the priorities set forth in the SHPDA 2021 Implementation Plan because a mobile unit is first and foremost aimed at removing barriers to care. The Department of Health and SHPDA recognize that a sizable portion of individuals on Medicaid do not see a primary care provider and that this problem is more acute for women. By focusing on individuals who do not or cannot access other primary care, the proposed project will contribute to the SHPDA's goal of addressing existing barriers to primary care and accruing the benefits of patients accessing preventive health care services.

Yet, despite this obvious alignment of purpose, under current interpretations of the law, PPMW is required to submit a detailed, often cumbersome application to SHPDA AND pay a whopping $16,000 application fee.

We respectfully suggest that rather than instituting a new registration process, that will be costly to implement, and will result in delays, that SHPDA utilize its current waiver process for small facilities.

Reform of the CON process is needed, and the changes that appear in the Budget show a promising and practical start. Thank you again for this opportunity to submit written testimony, and we are open to questions on this issue from the Committee.

Council of the District of Columbia
Health – Budget Oversight Hearing
Testimony: Luis Chavez - The Family Place
April 10, 2024

Good day esteemed members of the Council,

My name is Luis Chavez and I'm the Director of Operations and Outreach at The Family Place and a former Home Visitor for 5 years. The Family Place is an organization located in Ward 1 serving low-income immigrant families across the District of Columbia. I stand before you today to advocate for the importance of maintaining funding for home visiting programs. These programs are critical in supporting families during their most vulnerable and crucial years, ensuring that infants and children reach their developmental milestones on time and without delays.

Home visiting programs utilize evidence-based methods to promote parent-child bonding and provide essential material support to expectant parents and families with young children. The impact of these programs on the overall well-being of families cannot be understated. They create a safe and stable environment, help families reach their parenting goals, and ultimately contribute to the healthy development of children which gives them an advantage once they reach school age.

Budget cuts to home visiting programs not only destabilize these vital services but also disrupt family continuity and support systems. The loss of a home visitor creates instability and a gap in access to critical resources for families in need. It places additional stress on staff members who are already working tirelessly to support these families.

Furthermore, the populations served by home visiting programs are often neglected by mainstream systems of social services. These underserved families rely on the consistent and reliable support provided by home visitors to navigate the challenges they face. Maintaining stability in home visiting programs is essential to ensuring that these families receive the support they need.

I urge you to consider the long-term impact of reducing funding for home visiting programs. The benefits of these programs extend far beyond individual families and have a positive ripple effect on communities as a whole. Investing in home visiting is an investment in the future of our children and our society. I implore you to prioritize the well-being of families and children by protecting the funding for these invaluable programs.

Thank you for your time.

Luis Chavez
Director of Operations and Community Engagement

Mercedes Huffman, Ward 6

Councilmembers, Committee on Health staff, I am grateful for the opportunity to provide testimony. My name is Mercedes, and I am a Ward 6 resident, a former volunteer with the Humane Rescue Alliance (HRA), and a member of Volunteers for HRA Reform. I am submitting this testimony to urge the DC Council to prioritize community infrastructure and sufficiently fund animal care and control in FY25.

Animal care and control is an important function of a government's services. It is infrastructure with key public health and public safety components, and how well animal services operate is an important measure of a city. While currently DC is lagging behind neighboring local jurisdictions and other comparable cities when it comes to the quality and quantity of public animal services, the DC Council has a unique opportunity this budget season to reinvest in DC residents and to set DC on a path for future success.

One area that DC is an unfortunate outlier in is its lack of provision of low-cost spay/neuter. Despite the DC code requiring their provision, low-cost spay/neuter services officially closed in September 2019. Five years later, the program remains shuttered, and DC residents lack options. In the upcoming contract renewal, the DC government must provide funding and oversight to reopen public spay/neuter, which will likely require at least one more contract-funded veterinary position. The current contract only allocates one veterinarian, which is not enough to provide services to the public's animals as well as all-shelter animals. Therefore, in order to provide low-cost spay/neuter and improve animal control services, the Council must increase funding for the animal care and control contract, and based on our estimates, this will require at least $6.5M. There is a great need for a better, more specific contract, and allocating the same funding amount as is allocated to the weak contract will not set DC up for success.

Another area where DC has been lacking is in its upkeep of its New York Ave. (NYA) facility, which currently serves as the Animal Care and Control Facility (ACCF). NYA has a notorious reputation — animal welfare groups from across the country have heard of the disintegrating conditions at NYA and the lack of maintenance. When I was a volunteer with HRA before I was fired shortly after submitting testimony to this committee during the January oversight hearings, I mostly volunteered at the ACCF, and I can attest that the reputation is true. I was grateful to see the $22.5M in the budget proposal, and I urge the Council to preserve that money in their budget discussions.

However, I am worried that, with the currently planned location at 4 District Village Lane SW which is in the outskirts of DC and practically at the Maryland border, the DC government has not learned its lesson about the importance of investing in animal care. The weak and unenforceable contract, the notoriously rundown NYA — all of these are consequences of the DC government not properly investing in animal control services. When spending $22.5M on a project, DC must ensure that its investment is accessible to as many DC residents as possible, which the current proposed location is not. I respectfully ask the Council and DC Health to find another location for the shelter that is transit accessible and more readily available to most DC residents.

DC residents deserve proper investment in animal care and control, and it is past time for the DC Council to provide it and meet community needs. The DC Council has an opportunity this budget cycle to correct mistakes of the past and provide funding for a robust animal control contract, an accessible new shelter, and maintenance for the current ACCF. As your constituent, I am asking you to take it and make the investment in DC communities.

Carolyn Babendreir

DC Health Budget Hearing Testimony 2024

Good Afternoon Council member Henderson and the Committee for DC Health. My name is Carolyn and I serve as a Supervisor to a team at Mary's Center. I'm happy to be here today to share with you about one of your best impactful and most effective investments that you've offered the community through Home Visiting.

You have heard today from several witnesses advocating for Home Visiting across the city. Throughout each testimony its clear how essential funding and sustaining these programs are.

Home Visitors have access to struggling families in the district in a way that almost no other social service or public agency has. We often have public school workers, children's teachers, pediatricians, and prenatal care providers etc. reaching out to our home visitors to reach these families when no one else can.

In theory our programs should primarily be focused on curriculum based education and activities centered around individual health and child development, in actuality our Home Visitor do so much more.

While home visiting does not generate immediate front end revenue for the district the true impact is immeasurable. In my program alone we have numerous stories of families who were able to access career development support, and family goal planning which allowed them to gain economic stability that they were not able to achieve without the support and resource access from their Home Visitor. Some of these parents went on to become medical assistants another parent was able to complete a nursing school program during her time in home visiting. This impact on individual families economic stability is not shown the data that we collect to try to demonstrate why we deserved funding.

This speaks a larger impact of home visitor which is how they act as the bridge to a network of resources that council already funds. An essential lifeline to immediate necessary resources. Home visiting gives insight to the day to day families challenges and struggles more than any other service that the district provides. Issues such as Domestic violence, mental health challenges or even perinatal high risk conditions. Identifying these issues early allows families to access help and support that they may have never sought out on their own. Often times a home visitor is the only lifeline a parent trusts to seek help and support. Our families in home visiting often experience such a heavy burden trying to maintain their children's health and happiness while dealing with the challenges of physical and mental ailments, economic instability and

housing crises to name a few. Through home visiting we offer them a respite from carrying that burden alone if only for an hour a week.

This is not without significant challenges for the home visitor. Administrative burden that accompanies funding reduces the capacity of home visitors to seek their families where they are. Year after year home visitors face some of the most intense challenges and experiences that the most struggling DC families experiences and while the burden on hVs increases the investment has not. As a supervisor an issue near and dear to me is how undervalued our Home visitors are. While Home visitors are not direct employees of DC Health, DC health and you the committee determine year after year whether or not they deserve a livable wage. Our home visitors deserve stability so that they can concentrate on supporting your constituents in achieving stability for their families.

Home visiting is an evidence-based strategy that supports families during their most critical years of life. Home visitors support expectant parents and families with young children to create a safe and stable environment and reach their parenting goals. **While home visiting programs could effectively use an increase in funding, at a minimum DC should avoid further cuts to programs and pursue meaningful improvements to their processes, procedures and administration. Councilmember Henderson I heard you earlier acknowledge the positive impact of Home Visiting on the city and then acknowledged for another DC service that not upkeeping funding with inflation is effectively a funding cut to a program. I firmly agree and I ask that you consider why if the council is aware of the importance and the impact of Home Visiting why is this not reflected year to year in investments into our programs. Some of our programs have remained stagnant or faced cuts several times over the years, which puts these essential services in jeopardy. So to close I ask the committee: If you have any doubts about what we do, how we do it, and how we support the Families in the district** I ask you please come to a home visit, meet our families, your constituents in home visiting, and we are certain that you will see the value in our programs by the end.

Jennifer Pallotta

I am a District Resident (Ward 4) and am writing to ask that DC Health increase its funding relating to animal care and control services and rebuilding the current animal care and control facility, as this will benefit the entire community.

Specific things I would like to see are:

#1. Funding for a new animal care and control contract that includes more social services. I would also hope that the new animal care and control contract requires living wages for any and all covered workers.

#2. The current animal care and contro facility (located at NY Avenue) needs repair and maintenance.

#3. It is my understanding that the proposed budget includes $22.5 million for a new shetler!! This is amazing! Regarding the new shelter my hopes are:

a.) My understanding is the current proposal is to use a non-HRA (Humane Rescue Alliance) property for the new shelter. I very much agree with and encourage this as this will facilitate a competitive bidding process for the animal care and control contract.

b.) My understanding is the current proposal identified a property in Ward 8 near the border with Maryland. I think it would be great if the new animal care and control facility were accessible by public transportation.

c.) Assuming that renovation and construction of a new animal care and control facility will take time, I hope that repairs to the current facility and New York Avenue are completed.

d.) If possible, it would be great if the new facility had some type of clinic for low cost spay and neuter services. When I was in my vet's office in Washington, DC, I overheard the vet tell another client it would cost $700 or $800 to spay/neuter their dog (I do not know whether the dog was male or female). This is obviously beyond reach to many people. I was stunned.

Animal care and control services benefit everyone, including community residents that do not own pets. When I walk my dog around my neighborhood, I am constantly amazed by the variety of people who talk to me about their dogs. A new animal care and control facility and a more robust animal care and control contract would be great ways for DC Health to invest in community wellbeing.

In closing, I really hope DC Health builds a new animal care and contol facility and that new location is a model of what an animal shelter can be, providing safe harbor to animals in need and services to residents who love their pets but may need some extra help in caring for them.

DC Councilmembers, committee staff, my name is Maxine Collins, and I am a Ward 1 resident, a former Humane Rescue Alliance (HRA) volunteer, and a current member of Volunteers for HRA Reform. I appreciate the opportunity to share my priorities as your constituent on the FY 2025 budget.

I am urging the Council to fully fund animal care and control services to improve racial equity and access in the District. This must include $6.5M for the upcoming animal care and control contract to allow for specific, well-defined provisions and robust public services, preservation of the proposed $22.5M for a new ACCF which must be built in an accessible location, and sufficient funding for maintenance of the current NYA facility.

When fulfilling its purpose, animal care and control services are supposed to bridge gaps and make pet ownership more accessible at all income levels. But with the current state of DC's animal services, as well as rising costs of vet care, food, and supplies, pet ownership is becoming less accessible in DC. And the effects of this are not being felt evenly.

In the District, Black households are disproportionately likely to be living below the federal poverty level, according to the Council Office on Racial Equity. 75% of households earning under $100,000 per year are Black, even though Black households only make up about 40% of the population. When DC does not sufficiently provide its residents with these public services, Black families disproportionately bear the burden of that failure.

For example, low-cost spay/neuter has not been provided in DC since 2019, which has given residents only two options for getting their pets this important procedure: pay upwards of $500 at a private vet or drive long distances (oftentimes over one hour one way) to a clinic in a different state where the prices are cheaper. For low-income residents, neither of these two options are often feasible, which is unjust. And studies back up the importance of providing low-cost services for all: research shows that disparities in how people of different races access vet care disappear once socioeconomic factors like distance and cost

are addressed. Low cost spay/neuter services promote public health and economic justice, and DC Health must ensure it is complying with DC code and providing these services to DC residents. The DC Council must provide DC Health with the funding needed to do so.

Where these services are being offered also determines their impact and who can access them, which is why the location of the new Animal Care and Control Facility (ACCF) must be chosen intentionally. Currently, there are no veterinary services East of the River, which leaves a huge need gap the new ACCF could help address. However, while I encourage the District to prioritize properties East of the River to promote racial equity, I have serious concerns about the 4 District Village Lane SW property that DC Health has found. The location is pushed to the very edge of DC and is not feasibly walkable from the nearest metro station which is almost three miles away. Essentially, the new facility would require a car to get to, which is not accessible for many DC residents, including the roughly 35% of DC households who do not have a car. DC Health must reevaluate and find a more accessible location for the ACCF to ensure that its equity-fulfilling services can be used by all who need them.

Animal control services are community services, and DC residents are direly in need of DC government's investment in them this year to promote racial equity and make pet ownership accessible for all. I urge Councilmembers to use the opportunity we have this budget season to sufficiently and intentionally fund the upcoming contract and a new, accessible ACCF, strengthening DC families and communities.

Thank you for your attention to this issue,

Best regards,
Maxine Collins
Ward 1

Good morning, Chairperson Henderson and esteemed members of the Committee. Thank you for the opportunity to address the Council today. My name is Chassis Hawkins-Younger, I am one of the home visitors within a program at Mary's Center, and I am testifying about home visiting programs within our area.

Home visiting is defined simply as maternal and overall family health support provided directly to the neighborhoods where it's needed. As home visitors, we meet families exactly where they are, where they are most comfortable, to provide support and connection to resources already within their community that holistically benefit them. I've had participants share with me that they weren't aware of certain resources for maternal and paternal support and mental health support prior to us having discussed their various challenges. I've also had a participant share with me the importance of having a direct line to assistance and support for perinatal education as a new mom in the area without any family or friends to rely on.

As a home visitor, my day includes enrollment calls, home visits, constant communication outside of home visits, and documentation. Visits to the clinic and community resources are also included. Maintaining flexibility is also a huge part of my day. Flexibility could be shifting the purpose of the visit to focus on what a family is currently facing or rearranging my schedule to support a participant based on their current needs. One of my participants who felt unheard by her provider went in for a routine prenatal appointment, so I accompanied her virtually for support. Our phone visit transformed from virtual support during her appointment, to me holding space for her, asking questions with her, and encouraging self-advocacy when the appointment turned into her being admitted into labor and delivery. Home visitors are there for their families, and with supporting families with diverse scenarios, having the ability to pivot and adapt to challenges is not always that simple.

In my role as a home visitor, one of the challenges that I face is supporting families that are displaced due to issues with housing insecurities. Supporting families who are waiting to become permanently housed can be difficult due to the families, including the children, being negatively impacted. Visits with families are tailored to what the family is currently navigating and what their needs are. The families that we support have a variety of needs, however, it's hard to address those needs when their most important one is unstable. Two other challenges home visitors face are decreased supplies and lower salaries. Budget cuts to home visiting programs impact our ability to effectively carry out our roles as home visitors because with the lack of supplies comes the inability to accompany the already-used resources funded by the community, such as mental health support, tangible items such as baby supplies, pregnancy and postpartum items, food and formula, and other socio-economic resources. Working with lower salaries makes it harder for home visitors to stay in our roles

because while we are passionate about the work that we do, we also have ourselves and/or our own families to take care of as well.

When I think about the future of Home Visiting and my role, I like to imagine increased funding so that home visiting programs can fund the resources and curriculum of the programs, provide continuous growth in training for home visitors that supports the population served, and livable wages that fit the work that we provide. I believe that it's important for DC Council to work towards and invest in the work that home visitors do because we serve your constituents. Some home visiting programs serve only wards 5, 7, and 8, which have been known to have significantly worse health outcomes than other wards in DC. These families are your constituents, too.

Studies show that home visiting positively impacts families during their most critical years of life. When families enroll into home visiting programs, these programs commit to these families for a certain period of time. When these programs go unfunded, promises are not kept, families are not given all of the support that they signed up for and need, and we ultimately fail. The programs fail, the home visitors fail, and DC fails its families. While home visiting programs could effectively use an increase in funding, at a minimum DC should avoid further cuts to programs.

Camila Perez

DC Health Budget Hearing Testimony 2024

Good afternoon, Council Member Henderson and esteemed members of DC Health. Thank you for allowing me the opportunity to address the Council today. My name is Camila Perez, and I serve as a Family Support Worker at Mary's Center. I am here to testify about the importance of Home Visiting programs.

In my capacity as a Home Visitor at Mary's Center, I have witnessed firsthand the positive impact these programs can have on our community. It is critical that the DC council continues to invest in Home Visiting to ensure that our workforce can continue making a positive difference in the lives of our neighbors and families throughout DC. Today I would like to spend my time sharing a few examples of the positive impacts I have been proud to support in home visiting:

- I've witnessed families gaining self-assurance and becoming proactive participants in their healthcare, a crucial step towards empowering them to make impactful changes and improve their overall health outcomes.

- Recently, my participant shared her gratitude towards our home visiting program. My participant felt equipped to advocate for herself during her baby's birth, which lead her to have the birthing experience she desired. She credited our home visits and educational sessions, during which she gained the confidence to communicate effectively with her healthcare providers, there for feeling more in control during childbirth.

- One mom chose to seek support and solace in our program during a profoundly difficult time with the loss of her young infant. Throughout our home visits I was able to provide support as they looked for answers to their questions with the hopes of finding some kind of closure in their loss. This family shared with me how they felt overlooked and unheard during their time at the hospitals even at their most vulnerable. But through our home visiting program, they found the support they needed to navigate their grief.

A fundamental principle of home visiting is being participant centered. Being participant-centered as a home visitor means focusing on their individual needs. There have been times during home visits where my planned activities and educational sessions are thrown out the window because my participant had needs that demanded immediate attention.

Participants are not going to be fully engaged during our home visit if they are worried about housing, where their next meals is coming from, childcare, the list goes on.

Unfortunately, there have also been times when I've been unable to address my participants' needs due to limited resources, which can be incredibly frustrating. When this happens, I do my best with my limited time to have additional home visits and follow-ups in the hopes of finding the necessary support elsewhere.

As a Home Visitor each day presents unique challenges that we must adapt too. For me personally this mean assisting non-English speaking participants in navigating DC's social services and public agencies. For example, I've encountered difficulties when calling DC Medicaid with Spanish-speaking participants, as English-speaking representatives would answer even though we selected Spanish. This requires my intervention to ensure they are connected with the right individuals to provide services in their native language. I invest my already limited time in these situations because at times the public agencies wouldn't take the additional time to explain the reason why their application was rejected or the next steps.

Home visiting programs play a crucial role in establishing meaningful connections and providing essential support to vulnerable populations. They help bridge gaps in access to healthcare and education, ultimately improving the well-being of our communities. While home visiting programs may not generate revenue for DC, they represent a vital investment in your residents.

I thank the mayor for not making cuts to the DC Health home visiting budget. While home visiting programs could effectively use an increase in funding, I ask the council to maintain this funding and avoid further cuts to programs.

Thank you for the opportunity to testify, and I welcome any questions.

Testifier: Makalia Jones
Title: Program Participant
Organization: Mary's Center
Testifying on behalf of: Home Visiting

I really enjoy the convenience of home visiting and being able to have someone come directly to me and supply me with all the supplies that I do not have readily accessible. My home visiting experience has been smooth sailing and convenient, and it is always a pleasant time being able to talk to someone face-to-face and know who I am talking to. I have been in the house for quite some time now after having my baby, so it feels good to see other people and the home visits are very helpful for this. I think home visiting has really helped me be able to interact with people as well as get things I need right to my door. For someone considering joining the program, I would say go for it! Home visiting has been a good experience, it's very informative and it works well. It's disappointing and upsetting to hear that the government is considering cutting home visiting funding. I really do not agree with it at all. It works for people to have family support workers come out to the homes, because there are some people going through things they are not going to talk about. It helps to have someone who is aware of what those signs look like to come check on you and ask you if you are okay, because sometimes you don't even know if you are okay. Home visits are very beneficial for this.

DC Councilmembers, thank you for the opportunity to testify on the FY25 budget. My name is Regina Tosca, and I am a Ward 4 resident with a background in social work and a member of Volunteers for HRA Reform.

I am testifying to urge the Council to invest in DC communities this budget cycle by funding animal services, including:
1) at least $6.5M for the upcoming animal care and control contract's October 2024-June 2025 period,
2) $1.1M to address the current gap in funding for the current contract through September 30,
3) sufficient funding for maintenance of the current New York Avenue (NYA) facility, and
4) $22.5M as proposed for a new Animal Care and Control Facility (ACCF).

Animal care and control services are human services and community resources, and DC residents are relying on the Council's investment in animal care and control as much as DC animals are.

DC's FY25 budget must prioritize and fund services that benefit DC families, and accessible animal care and control services are a key part of that. A recent survey by the Pew Research Center found that 97% of pet owners consider their animals to be part of their family. When run well, animal control agencies keep families together through proactive lost pet reunification, low-cost medical services including spay/neuter and preventative vaccination, and resource programs that make pet ownership more accessible, especially as cost-of-living and vet care prices continue to skyrocket. Under the current contract and the $4.78M it provides, DC's service offerings are pitifully lacking in several of these areas. Low-cost spay/neuter has not been offered since August 2019 despite being mandated through DC code, and the current contractor has a policy that prevents even potentially lost adult cats from entering the shelter system at all — not even for a microchip scan — which makes lost cat reunification challenging. In FY25, DC Health and the Council have an opportunity to provide better services for DC families with a robust, specific, and enforceable new animal care and control contract. To make the needed changes will likely require additional contract funding. According to our calculations, $6.5M for the October 2024 through June 2025 contract period would be more sufficient and could, among other necessary improvements, allow for another direly needed veterinarian position to make low-cost public health services feasible.

Another key function of a competent animal care and control agency is public safety. Not every pet is a good fit for every home and occasionally changing life circumstances make caring for a pet infeasible. The owner surrender programs of well-running animal care and control organizations are extremely important, both for the humans who need to make the heartbreaking decision to give up their pet and for the general public who often have to bear the consequences of lacking intake policies when desperate humans are turned away from services and have no option other than to set their animals loose into the community. DC residents deserve a well-funded contract that has specific requirements for intake, and we need the new ACCF to be built in an accessible location to ensure programs and public services can be accessed by all who need them.

Finally, I would be remiss if I did not mention the very real human effect of lacking investment in animal services for the frontline workers who are employed through the ACCF. The current ACCF at NYA is practically in disrepair, and staff regularly face safety concerns that jeopardize their health. Spending all day working at a facility with HVAC issues, insufficient amenities, and a roof that is at risk of falling in is a labor rights issue, and DC Health must step up to ensure NYA receives proper maintenance to avoid workplace injuries. The DC Council must provideDC Health with sufficient funding to maintain the current facility at NYA and improve working environments for frontline staff.

Oftentimes, especially in challenging budget years like this one, discussion about animal control becomes a debate of “animals versus humans.” However, that is not accurate. Animal services are human services, and investing in animal care and control means investing in community. We are relying on you to fully fund animal care and control services in FY25. Thank you!

Councilmembers and Committee on Health staff, I appreciate the opportunity to submit testimony today in support of fully funding animal care and control services in the District. My name is Kate Finman, and I am a Ward 6 resident, member of Volunteers for HRA Reform, and a former Humane Rescue Alliance (HRA) volunteer, specifically at the government-owned Animal Care and Control Facility on New York Avenue (NYA).

In this testimony, I will share my experiences and observations from the NYA facility, where I spent over 100 hours during my 8 months as an HRA volunteer. Unfortunately, I was fired after speaking at the Council's agency oversight hearing in January. To put it simply, the current Animal Care and Control Facility (ACCF) is severely run-down and ill-equipped for its purpose, both of which create public safety and health issues every day for animals, staff, volunteers, and the public. In the long term, the District must build a new ACCF with the proposed $22.5M and ensure the new shelter is built in an accessible location with the amenities NYA lacks. In the short term, the DC government must ensure the current NYA facility receives proper maintenance and that ongoing safety issues are addressed for the humans and animals who will visit NYA while the new facility is being developed.

NYA lacks basic infrastructure, including lighting which is inadequate in all outdoor areas but most significantly in the main yard. Currently, the main yard has no lighting, which is especially problematic during the fall and winter when the sun sets before 5 PM. I cannot count the number of times I felt unsafe at the facility, trying to keep track of a dog in the dark yard while also watching what was in front of me and trying to monitor the dog's body language. This past summer, when it rained, the yards and eventually some of the main walkways of the facility became mud pits for months without intervention, making the situation even more hazardous especially without proper lighting. Many volunteers slipped in the mud and fell while trying to exit the yard with an on-leash dog pulling them, which could have easily turned into a worse situation if a dog, startled by the fall, had redirected their fear onto the person. Because of limited space and complicating factors, volunteers feel compelled to continue to use the main yard despite safety risks, because if they didn't, fewer dogs would get out of kennel time, leading to increased consequences for the animals and the people who care for them. DC Health must properly maintain NYA yards and add additional lighting in FY2025 to prevent future injury and to allow the dogs and volunteers a safe place to exercise and play.

The kennel doors at the NYA facility are also a hazard, as they are outdated and often jam, requiring people to stick their hands into kennels to fight with the latch mechanism. On at least one occasion, a staff member was bitten by a stressed out dog after she had to stick her hand into the kennel to unlock a stuck door. Additionally, the current kennel doors do not allow for strategic leashing of dogs. Often volunteers and staff must either let the dog run loose or grab it by its collar to put on a leash, both of which are unsafe practices and do not allow for proper control of a dog should the dog redirect its energy onto a person or other animal. DC Health should replace the kennel doors at NYA in FY2025 to prevent future animal bites and ensure humans and animals remain safe. The DC Council must ensure the agency has the funding needed to do so.

In addition to these public safety issues, there are myriad public health risks that the flawed layout and inadequate maintenance at the current ACCF pose for DC. Because there are no true isolation wards, upper respiratory infections (URIs) spread rapidly at NYA, and many dogs who come in healthy will become sick at the facility. All of the dogs share the same yards, pass by each other regularly, and live in kennels without proper barrier separations, all of which contribute to the spread of diseases. In addition to the ubiquitous spread of URIs, there are often more severe exposures and outbreaks at the facility. In 2023, there was an over four-month long canine influenza outbreak, and in February of this year, there were concurrent strep zoo (a highly contagious and severe zoonotic respiratory infection) and parvovirus

(a severe and highly contagious illness often fatal to vulnerable young and senior dogs) exposures. As dogs regularly come in and out of the facility, the diseases they pick up at the ACCF put DC residents' animals and public health in general at risk. Additionally, because there is no properly equipped medical facility at NYA and no on-site veterinarian, sick or injured dogs in need of medical support are transported to the contractor's Oglethorpe location, spreading diseases further and exposing more animals and people to public health risks. DC Health must ensure the animal care and control agency has the proper resources and protocols to limit the spread of disease in both the planned new ACCF and the current one, and the DC Council must allocate adequate funding to ensure their successful implementation.

Building a new ACCF is a long overdue and sorely needed project for DC that will bring a lot of opportunities to the District and DC residents if done right. I am extremely grateful for the proposed $22.5M and urge the Council to include that provision in their budget as well. However, given that the new shelter will not be operational for at least two years, DC must not forget about the ACCF it has — NYA — or jeopardize the wellness of the people and animals who will visit or inhabit the facility in the meantime. Funding animal control and care services is funding public health and safety, and I look forward to seeing the Council and DC Health make these investments for DC residents.

Name: Miah Heiskell-Bryan
Title: Program Participant
Organization: Mary's Center
Testifying on behalf of: Home Visiting

My experience with home visiting has been very positive. My favorite part has been seeing my family support worker, it is a positive experience having her come around. I've had help with problem solving between me and the father of my child, finding resources, staying on top of things, and with transportation to appointments which has been very helpful. Home visiting has supported me through bringing supplies like formula, diapers, and toys. The supplies have helped a lot and helped me save money. Home visiting has supported me to reach the goal of saving as much money as possible when it comes to the expenses of having a baby. It also helped me come to an understanding with the father of my child. Our relationship has gotten better since coming together for home visits. The government cutting funding for home visiting would be terrible, it is something that is incredibly helpful and would positively benefit other mothers like myself. My home visiting program is amazing and I am so grateful to be connected to them. I was not in a home visiting program with my last child and if I had been connected it would have been so much better.

Testifier: Jocelyn Venable
Title: Program Participant
Organization: Mary's Center
Testifying on behalf of: Home Visiting

My experience with home visiting has been better than any other program I have been in when it comes to casework and working with me and my baby. My favorite part has been truly being heard by my home visitor and having a person to have a conversation with over my concerns about my health. I feel as though it has been a lot easier to have home visits than having to go to an office for things I need help with- as far as resources and supplies, they're coming to my doorstep instead of me having to figure it out alone. I have seen changes in myself because I am able to talk about certain things and I have somebody to talk with about topics like breastfeeding, how to put up the bassinet, and resources about my birth certificate and my ID. I would recommend others join home visiting because it has been one of the better programs than most that claim they can help expectant mothers or people with kids. I have been through a couple programs since I have been pregnant and home visiting has been the only one that has stuck. I do not understand why the government would not protect funding for home visiting. There are a lot of moms and parents in general, especially low income parents, who need programs like this to help them get resources because not everyone has the direction for help.

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UNITY HEALTH CARE
Healthier You. Healthier Communities.

Testimony Before the Council of the District of Columbia
Committee on Health
Christina Henderson, Chair

Fiscal Year 2025 Budget Oversight Public Hearing
Department of Health
April 10, 2024

Ryan Buchholz, MD
Acting Chief Medical Officer
Unity Health Care, Inc.

Introduction

Good Afternoon, Chairperson Henderson and Members of the Committee on Health. My name is Dr. Ryan Buchholz, acting Chief Medical Officer at Unity Health Care ("Unity"), the largest network of community health centers in the District, serving 1 in 8 residents. I'm also a practicing pediatrician and internal medicine physician at Unity's Upper Cardozo Health Center, in Ward 1, and I am deeply committed to serving our City's under-resourced communities. I am very pleased to be here today presenting testimony on behalf of Unity.

Thank you for holding today's Fiscal Year 2025 Budget Oversight Hearing on the Department of Health. I would like to begin my testimony by offering a sincere message of gratitude to the District's Department of Health and its excellent team of professionals, led by Dr. Ayanna Bennett.

I want to thank Mayor Bowser for her commitment to – and investments in – the health and well-being of District residents. As many of us have anticipated, the Mayor's proposed Fiscal Year 2025 budget for the Department of Health exposes the financial realities of our city. During these challenging times, we are all leveraging the resources we have to improve the lives of the individuals whom we serve.

For our part, Unity is the largest community health provider of primary and specialty care in the District, serving nearly 90,000 patients and providing over 300,000 patient visits annually. We primarily serve persons of color with incomes below the federal poverty level; nearly 70% of our patients participate in the District's Medicaid and Alliance programs. We currently operate more than 27 delivery sites across the District, at low-barrier homeless shelters, and in schools.

Despite the prevailing challenges, Unity remains resolutely focused on our core mission, serving as an indispensable component of the District's safety net. From supporting individuals experiencing homelessness to pioneering the integration of primary and behavioral health care services, we have consistently championed initiatives aimed at advancing health equity and fostering community well-being. Furthermore, our partnerships with the Department of Health have been instrumental in driving forward critical initiatives, ranging from medical respite care to maternal and child health programs.

In highlighting a few of our efforts, we hope to garner increased understanding and financial support to ensure the continued viability of Unity's high-quality, comprehensive services:

Supporting those experiencing homelessness

Unity continues to provide vital healthcare services to individuals experiencing homelessness across the District. Leveraging our extensive network of delivery sites, including low-barrier homeless shelters, we offer comprehensive medical care, mental health support, and substance abuse treatment to those in need. Our commitment to serving this vulnerable population underscores our dedication to promoting health equity and addressing the underlying social determinants of health that contribute to homelessness. Additionally, Unity proudly provides culturally competent healthcare services at the District's first LGBTQ+ shelter, offering inclusive care tailored to the unique needs of LGBTQ+ individuals experiencing homelessness. Our aim is to create a

supportive environment that reduces health disparities and promotes equity within the LGBTQ+ community.

Unity recognizes the importance of medical respite care in facilitating the recovery and rehabilitation of individuals experiencing homelessness who require acute medical attention. Through our collaboration with the Department of Human Services, we provide short-term medical care for patients discharged from hospitals but unable to return to traditional shelter settings due to medical needs. By offering a supportive environment where patients can receive ongoing medical supervision and assistance with activities of daily living, we strive to prevent unnecessary hospital readmissions and promote continuity of care for this vulnerable population. We applaud the Mayor's FY25 Budget for allocating $130 million for New or Renovated Shelters, including $64 million to create additional permanent supportive housing and congregate shelter space on the site with the existing Federal City Shelter (CCNV). As a provider of high-quality, comprehensive healthcare at CCNV, Unity urges that no cuts be made to this crucial funding and advocate for increased support for essential social services like CCNV, which have become an integral part of addressing homelessness in the District.

Caring for newly arrived migrants

Through our culturally competent care model and partnerships with community organizations and advocacy groups, we offer comprehensive medical screenings, immunizations, and primary care services to newly arrived migrants in the District. Our mobile van plays a crucial role in reaching underserved communities, and we actively refer individuals to our health centers for ongoing care. As a safety net provider, we

recognize the financial implications and bear the cost of healthcare for those who may be temporarily residing in the District or require assistance connecting to health insurance resources. Despite potential obstacles such as residency requirements or limited access to traditional addresses, we remain committed to addressing the unique healthcare needs of this population, facilitating their integration into the local healthcare system, and contributing to the overall well-being and resilience of our diverse community.

Advancing the integration of primary and behavioral health care services

Unity has implemented innovative care models that seamlessly integrate mental health screenings, counseling, and psychiatric services into primary care settings. By offering holistic, patient-centered care that addresses both physical and behavioral health needs, we aim to improve health outcomes, reduce stigma surrounding mental illness, and promote overall wellness in our community.

Advancing health equity in Maternal and Child Health

Unity is committed to advancing health equity in maternal and child health by addressing disparities in access to care, health outcomes, and social determinants of health. Through our comprehensive prenatal care programs, maternal health education initiatives, and strategic partnerships with the DOH, we strive to ensure that all pregnant individuals and children receive high-quality, culturally competent care. Our collaborations with DOH include utilizing Title V funding to enhance access to preventative health services for reproductive-age women, implementing the Preterm Birth Reduction Initiative to decrease preterm birth rates and health disparities, and leveraging WIC funding to provide essential resources to pregnant and postpartum

women and their young children. Additionally, through the Healthy Steps program, we advance pediatric care by addressing developmental and behavioral concerns in infants and toddlers. We advocate for sustained and strengthened support for these vital programs, which are integral to providing holistic maternal and child care to our city's under-resourced communities.

Even in these times of financial constraints, Unity underscores the importance of investing in high-quality, comprehensive, and compassionate healthcare. Our efforts assist tens of thousands of District residents in living healthier lives, making it possible for them to support themselves and their families. In addition, our focus on preventative care and chronic care management contributes to significant cost savings for our healthcare system. According to the National Association of Community Health Centers, on average, the range of services provided by health centers like Unity generates a savings of $2,300 per Medicaid patient and $24 billion in annual cost savings across the national healthcare delivery system. These savings not only benefit the healthcare system but also result in slower-rising costs for patients.

Investing in primary care is crucial for long-term savings. Take, for instance, the ASCEND clinical trial initiated by the NIH nine years ago, targeting Hepatitis C (HCV) infection. HCV carries significant healthcare costs, with treatment averaging $100,000 per person, excluding expenses like liver transplants. Given HCV's prevalence among lower-income individuals, shouldered largely by publicly funded health insurance programs, the impact on the District's Medicaid and Alliance programs is substantial. Through the ASCEND study, Unity treated over 500 participants, resulting in annual savings for the District over the past seven years.

Community Health Centers (CHCs) like Unity Health Care are pivotal in saving public funding and advancing health equity. Through a focus on preventative care and early intervention, our CHCs not only reduce long-term healthcare costs but also address health disparities and provide inclusive access to healthcare services for under-resourced populations.

Conclusion

Unity remains committed to providing comprehensive health services to under-resourced communities, lowering costs for the District through preventive and robust offerings, and advancing health equity. We respectfully request increased financial support to sustain and expand these vital services as we remain dedicated to continuing our work in improving the overall well-being of all residents of the District. I invite Council members to tour one of our centers to witness firsthand the impactful work being done to support our community's health. Your support and engagement are crucial as we strive to build healthier, more equitable communities for all residents. Thank you for your attention, and I welcome any questions or follow-ups you may have.

If you have any questions or require further information, please do not hesitate to reach out to our policy lead, Fiona Mesfun, at fmesfun@unityhealthcare.org.

Casey Welch

Honorable members of the DC Council,

I am testifying to urge the Council to allocate sufficient funding for Animal Care and Control services in the FY2025 budget oversight. Animal welfare services are not just about caring for animals; they are about investing in our communities and addressing racial justice issues.

Firstly, funding animal control services is an investment in human services and our communities. The animal care and control facility serves individuals and families facing heartbreaking and desperate situations, providing resources such as low-cost veterinary care and pet supplies through the pet pantry. These services make pet ownership accessible, particularly in underserved communities where such resources are scarce.

Secondly, this is a racial justice issue, especially in communities East of the River, where animal services are severely lacking. With a significant portion of Black households living below the federal poverty level, the rising costs of pet ownership further exacerbate financial burdens. By adequately funding animal care services, the DC Government can bridge this gap and ensure equitable access to pet ownership for all residents, regardless of income.

Furthermore, the absence of veterinary services in neighborhoods East of the River represents a public health failure, leaving large segments of the city without essential healthcare services for their pets. Investing in the new animal care and control facility not only addresses this disparity but also aligns with studies showing that equitable access to veterinary care can mitigate racial disparities in pet ownership.

Therefore, I urge the Council to vote to approve the $22.5M funding for the animal shelter, ensure sufficient funding for NYA maintenance, and restore funding for the new animal care and control contract to $6.5M. This funding will enable the provision of proper care for animals, full open access intakes, funding for veterinarian positions, low-cost spay/neuter services, and other vital community-centered initiatives.

Thank you for considering these crucial matters in the FY2025 budget oversight.

Sincerely,

Casey Welch

Councilmember Henderson, members and staff on the Committee on Health, thank you for this opportunity to submit testimony on the FY2025 budget, specifically regarding animal care and control provisions.

We are writing on behalf of Volunteers for HRA Reform, a grassroots organization of over 75 current and former Humane Rescue Alliance (HRA) volunteers, staff, and community members advocating for humane conditions for animals and robust animal services for DC residents. This semi-anonymous testimony, while untraditional, is not attached to any one individual's name because many of our members did not feel comfortable participating publicly in this hearing, after 11 volunteers who participated in the January agency oversight hearings were subsequently dismissed from their volunteer positions.

Based on our many years of experience and collective thousands of volunteer hours spent at HRA, our recommendations are summarized below:

- **Increased Funding for the Animal Care and Control Contract:** The current budget proposal includes $4.79M for the upcoming animal care and control contract, the same amount as last year's weak contract. In FY2025, DC needs a stronger contract with specifically required services, including low-cost spay/neuter which is mandated by DC Code yet currently is not provided in the District. If executed in the way DC residents need, the new contract will require more funding, including for a second veterinarian position to meet in-shelter and public health demands. A summary of additional suggestions for services the new contract must provide is attached.

  Because of the importance of animal care and control infrastructure for a healthy city and the current deficit, we are advocating for the FY2025 budget to include at least $6.5M for the new animal care and control contract's 9-month period.

- **Sufficient Funding for the Maintenance of the Current Facility:** The current ACCF, located at 1201 New York Ave. NE (NYA), is in dire need of proper maintenance, and the current contract delegates that responsibility to the city. DC has severely neglected the NYA facility over the almost 60 years the facility has been in operation, which has created health and safety hazards for the animals, staff, volunteers, and public. From infrastructure concerns like a faulty HVAC system and worrisome roof to a lack of lighting, the current state of the NYA facility is a public safety, labor rights, and community issue, not to mention a lawsuit waiting to happen.

  There will not be a new ACCF until at least 2027, which is over two years away, and in that time, people and animals will continue to face unacceptable safety hazards at NYA unless the city steps up to properly fund and maintain its NYA facility.

- **Preserving the $22.5M for the new ACCF in a central location:** The current budget proposal includes $22.5M to replace NYA, which is an important infrastructure investment that DC

desperately needs. We are grateful for this allocation and request that the Council keep this provision in their final budget.

However, the location DC Health chose for the new shelter, located at 4 District Village Lane SW, is inconvenient and inaccessible for most DC residents, especially for those without access to a car. DC Health's proposed site is almost on the Maryland border, not public transit accessible, and unreachable for most of the city, including for many neighborhoods East of the River. Successful, vibrant cities have robust animal care and control services, and pushing the only ACCF to the very edge of the city is not offering DC residents the access they deserve. DC must find a more central location for the new shelter to ensure ease of access to services and the promotion of animal welfare.

DC has an opportunity here to invest in its residents, to provide communities with much needed support, and to regain its status as a national leader in animal welfare. We look forward to seeing the Council take this issue seriously, and we are available to answer any questions or provide any resources through this process. Thank you.

An Outline of Animal Care and Control Services for the Upcoming Contract

The following services are critical to ensuring high quality animal services for District residents. In order to provide these services effectively, the Council must sufficiently fund the animal control contract and staffing to provide these services, which will require an increase in resources from previously funded contracts. **DC residents would benefit from funding for an additional vet & vet techs, additional behaviorists and animal caretakers, and a community cat coordinator**. These positions will ensure the availability of low cost spay/neuter for DC residents' pets, appropriate and humane in-shelter care, and effective management of DC's outdoor cats.

Key services:

A. Intakes: The animal care and control agency must provide animal control services to all non-human animals in need of human support and must provide housing at the shelter to all stray dogs; cats who are injured, ill, or suspected of having been abandoned; small companion animals; and exotic species, as well as farm animals and wildlife in need of rehabilitation before transferring them to a certified rehab or rescue.

   In addition, the agency should accept owner surrenders of all animals within 2 weeks of the initial request, to avoid the abandonment of pets when owners have no other options. The agency should permit "virtual intake," in which an animal is directly placed in a foster home rather than forcing people to physically come to the shelter to relinquish animals.

B. Outcomes: The animal care and control agency should promote positive outcomes for animals in its care. This should include proactive marketing of adoptable animals, especially hard-to-place animals, and should include a thoughtful adoption matching process. The

agency should adopt a "return to field" program for spayed or neutered cats who would have a better quality of life living outdoors in a managed community setting.

C. Operation of the animal shelter: The animal care and control agency should operate a high quality animal shelter following best practices in animal sheltering. In particular, the shelter should be a clean environment that emphasizes and enhances the physical and behavioral well-being of housed animals. The Association of Shelter Veterinarians provides a comprehensive and widely-accepted set of helpful guidelines for the operation of an animal shelter that should be followed.

D. Foster program: The agency should operate a foster program that houses, nurtures, and socializes animals in volunteers' homes while awaiting adoption. The foster program should place particular emphasis on placing shelter animals who are struggling in the shelter environment, or who have been in the shelter for longer than ~2 weeks.

E. Lost and Found: The animal care and control agency should operate a lost and found program. The program should be robust in attempting to match impounded animals against lost reports and double checking for matches prior to adoption. The program should include accepting and publicly posting lost and found reports, including reports of found animals not housed at the shelter.

F. Community cats: The agency should humanely manage the outdoor cat population in DC through a proactive TNR (trap, neuter, release) program, administrative tracking of cat colonies, and public education and support for community cat caregivers.

G. Euthanasia Standards:

The agency should promptly use euthanasia to relieve irremediable pain and suffering and minimize its use in all other cases. Euthanasia policies should be publicly available, and decision-making processes should be well documented and transparent.

The agency should work to prevent the development of behavior issues and work to manage those that do arise, including with medication, appropriate changes in environment, and specific treatment plans developed and executed by certified behavior staff with at least a CPDT-KA. If animals begin to deteriorate and/or the animal care and control organization does not have the resources to properly intervene on an animal's behalf, the agency should notify prior owners, fosters, the general public, and other humane organizations/rescue groups.

In most cases, adoption to a fully informed, capable party should be allowed. Behavioral euthanasia should only be used in cases where other avenues for management have been exhausted, the quality of the life of the animal is poor, and the animal poses an unmanageable risk to public safety.

H. Disease Prevention and Control: The agency should ensure in-shelter sanitation and intake procedures follow best practices to avoid the spread of disease in the animal shelter, which includes establishing proper isolation wards and performing intake exams, tests, and providing preventive vaccines, if merited.

I. Medical Services: The agency should regularly offer low cost vaccinations, low cost

microchipping, and low cost spay-neuter to District residents. To be specific, “regularly” should mean at least 10 hours of low cost vaccinations and microchipping to public animals per week, and at least 300 low cost spay/neuter appointments per month for the general public’s animals. These services should be widely publicized via websites, traditional and social media, mailing lists, flyers in public places, with links for easy registration and appointment requests. In addition, the agency should ensure impounded animals are vaccinated, sterilized, and microchipped prior to adoption or transfer.

J. Education and outreach: To ensure accessibility across the District, the agency should offer events in each ward of the city, including yearly veterinary wellness clinics and vaccine clinics in each ward at a minimum. The agency should also run programs designed to decrease the number of animals entering the shelter, including low-cost dog training classes, classes covering animal care through all phases of life, and an animal behavior hotline.

K. Dangerous Dogs: The District should ensure that owners of accused “Dangerous Dogs” (per DC code) are provided with a case manager to help them navigate proceedings. In addition, the District should act promptly to close Dangerous Dog cases, ideally within 2 months of cases being opened, to promote public safety and avoid dogs held in “limbo” for indefinite periods. Dogs impounded at the shelter during a dangerous dog case must be treated humanely with multiple opportunities for dedicated human interaction each day. They should be provided with daily “out of kennel” time, unless it is too dangerous to allow this. However, most dogs should be able to be safely managed. For example, in Baltimore, in 10 years, only 2-3 dogs have been deemed too dangerous to be walked by shelter staff during dangerous dog proceedings, and those dogs had previously killed a human.

L. Database and record keeping: The agency should have a database that tracks animals served in the shelter accurately and completely.

M. Reporting: The animal care and control agency should provide regular and complete reports about services to ensure residents have transparency into agency performance.

We would be happy to provide more detailed information and references to DC Health, DC Council, and other government agencies on best practices for the above services and the concerns residents have about current services.

Councilmember Henderson and other members of the Council and Council staff, thank you for the opportunity to submit this testimony. My name is Peggy Cusack. I am a 20+ year resident of DC, residing in Ward 6 on Capitol Hill. I am taking this opportunity to provide testimony regarding the FY2025 budget, and more specifically the provisions related to animal care and control.

I am also a former volunteer of the Humane Rescue Alliance and a member of the Volunteers for HRA Reform group. I am not here to talk about HRA, other than to say that after all of the concerns that have been raised and all of the issues with their performance under the current contract I am very concerned and disappointed to hear that DC may be sole-sourcing this contract to them again in FY2025 and worse, that there may be no changes to the existing contract despite the fact that everyone involved has acknowledged the lack of clarity about the current scope of work.

But today I'm submitting this testimony to talk about the budget.

Nine years ago, DC granted $5M to the Humane Rescue Alliance to purchase land in DC. This was with the understanding that HRA would use this land to design and build a much-needed new animal shelter facility for the District. Nine years later, and despite HRA actively soliciting donations throughout that time to support a capital campaign for this imminent new facility, that piece of prime property in the Navy Yard still sits largely vacant.

Meanwhile, the existing animal control facility on New York Avenue continues to house both dogs and people in horrible conditions. This NYA facility is the location where I volunteered with HRA for many years. As I noted in previous testimony in January, this location:

> "*is regularly plagued with issues related to bugs/mites/rodents, failed HVAC, rust/mold and poor drainage. The staff regularly talk about recurring infectious diseases and illnesses caused by environmental contaminants that they have not been able to eradicate from the premises. Kennels are in various states of disrepair. The adjacent parking lots where we are instructed to walk dogs are a maze of broken glass, razor blades, bottles of urine, and overflowing containers of pet waste that haven't been emptied for months. Getting a dog from a kennel to a play yard is an obstacle course of potential safety hazards for both human and dog, and on days when there has been rain the main play yard*

is a dangerous pit of mud and feces so deep that on occasions my shoes have been pulled right off my feet. I think most people in DC would be horrified to see where DC's homeless animals are living.

I am restating all of this here because as far as I know, nothing has changed – these problems still exist – and many more as well.

These are animal issues, but they are also people issues. People work at this facility. People volunteer there. People visit this facility to adopt animals. People visit this facility to surrender their pets and bring in stray animals. Navigating the animal spaces at NYA it is almost inevitable that you leave with a new cut or scratch, a new bruise, a pair of shoes or a piece of clothing that is no longer wearable because of something you encountered in the environment. You are generally always covered with bug bites – even in the winter months. I have strained muscles trying to walk in the mud or slipping on non-tractable surfaces that are always wet. I have scars on my hands and arms from encounters with fences that are falling apart, rusty nails and screws protruding from various structures, and dog doors with sharp edges. When I volunteered I carried a small tool kit with me for my shifts that had zip ties, pliers, tape – anything I could come up with to "fix" the issues I encountered while I was there.

Making sure that the NYA facility is a safe place for animals and people should not be the responsibility of volunteers. The Humane Rescue Alliance is doing nothing about these issues. They have publicly abdicated this responsibility to the City, and they have been very vocal with volunteers on many occasions that it is the City who is responsible for the disrepair and neglect of this facility, and ultimately for the impact that these conditions have on the wellbeing of the animals and people that are there every day.

In another recent budget hearing, Department of Health staff noted that ONCE AGAIN, there has been no funding set aside in the FY2025 budget for repairs or ongoing maintenance at the NYA facility. The $5M grant indicates to me that it's been AT LEAST NINE YEARS since DC officials recognized that the NYA facility needed to be replaced. As an animal lover and DC taxpayer, it is unacceptable to me that we're going to allow the conditions that exist at this facility to stretch into a 10th year without taking any steps at all to address them. Funding must be added to the budget to address repair and ongoing maintenance issues at NYA until a new facility is ready.

I was hoping that funding for this purpose would be included in the budget line item for the animal care and control services contract in FY2025. I was saddened to learn it was not. I was even more shocked to see that the amount allocated for next year's animal care and control contract is the exact same amount allocated for this year. As many of us noted earlier this year during the public oversight hearing, the scope of work in the contract already falls short in many ways when it comes to services that the City has long ago decided must be provided for DC residents and DC animals. Has the Committee already conceded that these services will be left out of the contract again in FY2025? Even setting aside challenges with the current scope of work, wouldn't this number need to increase next fiscal year simply to account for inflation? Shouldn't the City anticipate that operating expenses related to animal care and control will increase in the next contract cycle, the same way they do annually for almost all businesses in DC?

I am asking this Committee to look at this question more closely during the budget process and not simply rely on vague assurances from DOH that all is well and no changes are needed. All is not well. As a sidebar, I also request that DOH invest the time and effort required to improve the current contract in terms of the specificity of requirements as well as the monitoring and oversight of contractor performance. This needs to happen before the next contract for animal care and control is executed. Recent testimony indicates that DOH might be planning to wait to rework the contract until the new facility is ready in 2026 or 2027. To me, that's just throwing good (and very hard to come by) money after bad.

The Volunteers for HRA Reform group has been out there since the January public oversight hearing talking to other cities, experts, rescues, and organizations about how this can all be done better and about current-day best practices that are not being deployed at DC's shelter. Information on these subjects is readily available online and there are many independent organizations and individuals that are happy to assist. As a DC resident, I think DOH has a responsibility to spend the time now to fix this contract instead of throwing millions of dollars for multiple more years into a contract we all acknowledge is riddled with problems. They also have an obligation to draft a contract that addresses what DC residents need – not what their contractor wishes to provide. Pardon the pun, but the tail should not be walking the dog here.

I am relieved to see that some funding has been allocated in FY2025 for a new shelter facility. I know it is a tough budget year, I am grateful for the effort to find this desperately needed funding, and I hope you will fight to keep it in. I also again

urge you to consult independent outside consultants/individuals/organizations regarding the design and build of this new facility and not go back down the path of trusting HRA with this very important task. Fool you once, shame on HRA. Fool you twice, shame on DC. HRA now appears to be walking away with property that has doubled in value over the last nine years, that they have neglected to pay taxes on, and with no penalties for their failure to deliver the long-promised new DC animal facility. Meanwhile, DC is struggling to identify even more new funding to start this process all over again, nine years later.

Going back to HRA and allowing them to maintain their monopoly on animal care services in DC does a huge disservice to our City. We have to get out of the cycle we're currently stuck in where HRA is the only entity in the region with the facilities and assets necessary to provide animal care and control support in DC.

In my view, giving them the new facility only prolongs our problems. We can't wait ten more years for a new facility, and we can't let HRA dictate the design and purpose of this new facility based on their own internal goals and objectives. We need to be clear about what DC needs, we need to design and build a facility that meets those needs, and DC needs to maintain control of the new facility and make smart decisions about who will manage it. And while we're at it, it's high time that DC catches up with the rest of the country on best practices in animal sheltering and basic standards of humane care for animals. Introducing new partners into the equation can only help us.

I will close by thanking Councilmember Henderson and the rest of the Committee for giving us the opportunity to provide testimony, for identifying funding for these very necessary public services and for taking necessary steps to improve animal care and control in DC.

Testimony of Mary Katherine West
Home Visiting Program Manager
Committee on Facilities and Family Services
Child and Family Services Agency
Fiscal Year 2025
Council of the District of Columbia

April 25, 2024

Good morning Chairperson Lewis George and members of the Committee on Facilities and Family Services. Thank you for the opportunity to address the Committee as it conducts this budget hearing for the Child and Family Services Agency (CFSA) . My name is Mary Katherine West, and I am the Chair of the DC Home Visiting Council and Program Manager for Early Childhood at DC Action. I am a member of the Under 3 DC Coalition and a Ward 1 resident.

The DC Home Visiting Council is a body of home visiting providers, local government agency representatives, early childhood advocates, managed care organizations, and other partners that works to strengthen the understanding, implementation, and sustainability of home visiting as a strategy to support positive child and family outcomes in the District of Columbia.

DC Action uses research, data, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. Our collaborative advocacy initiatives bring the power of young people and all residents to raise their voices to create change. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

Home visiting services are critical to support the District's families, and must be preserved in the FY25 Budget. CFSA directly funds three home visiting programs: the Parent Support and Home Visitation program at Community Family Life Services (CFLS), Mary's Center's Father-Child Attachment Program, and the Family Place's HIPPY Home Visiting Program, which served a combined total of 209 families in FY23. In addition, CFSA provides funding to DC Health to support evidence-based home visiting services to 192 caregivers and 241 children through Healthy Families America and Parents as

Teachers, and administers the federal Community Based Child Abuse and Prevention Grant to the HIPPY Home Visiting Program through Creative Soultions for Communities.

To learn more about how these programs function and support families through evidence based practices and culturally responsive home-grown practices, please refer to my recent performance oversight testimony.

Home visiting programs are centered on creating strong and lasting connections, and home visiting programs need funding that reflects this model. While programs support families with tangible resources like diapers and formula, they also provide education and intangible support to help parents meet their goals in parenting confidence, mental health, and economic security. A home visitor may help a parent get a higher paying job, reach an educational milestone, reconnect with or gain visitation or custody of their child, or apply for social services like SNAP, ERAP, or Medicaid.

In FY25, we ask the Council to maintain or restore home visiting funding to FY24 levels at $770,471.

Thank you Councilmember Lewis George for your investment of $300K in home visiting in FY24. This investment followed a one-time increase to CFSA home visiting in FY23 of $70,500.

We appreciate your continuous commitment to DC families through home visiting services. We know you intended the FY24 dollars to be a recurring, long-term investment to support home visiting programs and their workers and the families they serve.

However, at the CFSA Budget Engagement Forum, CFSA shared that the $300K recurring increase was not in the FY25 budget. This reduction, along with a loss of $70K, would set home visiting programs back to FY22 funding levels. If set back to FY22 funding levels, CFLS and the Father Child Attachment program both would face budget reductions of approximately 40%.

The home visiting programs under CFSA predominantly rely on local funding and some federal funding, and these changes have the potential to result in staff cuts and reductions in services.

Home visiting programs spend the vast majority of their budgets on the salaries of their workers who provide these services. Cuts to home visiting programs result in job insecurity, instability, or even job loss for current workers. In the District, the majority of home visitors are Black and brown women who have high levels of education and skill. These workers deserve to be recognized and well compensated for their critical work.

Losing a home visitor creates instability in a family's support system and a potential gap in access to critical resources. It also causes additional stress on other program staff. Either families are removed from programs, or other home visitors and managers have to take on the additional families while a new home visitor is hired, onboarded, trained, and builds up to the previous home visitors' capacity.

We know that reductions were not your intention for CFSA home visiting and appreciate the support from your team to work to get clarity on the CFSA's funding for home visiting in FY25.

Home visiting programs in CFSA primarily serve families with unique needs that have been identified as priority groups for prevention and support programs.

Fathers are a priority group in CFSA's prevention outreach strategy, and Mary's Center Father Child Attachment program is the only home visiting program created specifically for fathers, focusing on the unique challenges they face in their parenting journey. Last year's additional funding primarily helped this program increase base salaries for home visitors, which supported retention of the current home visitor and recruitment of a new home visitor for a long vacant position, so that the program can serve its full capacity.

FCA also created a new position for a Fatherhood Supervisor, which is designed to carry half a typical caseload. This new position will provide much needed support for home visitors, as quality supervision is proven to improve service quality, home visitor satisfaction and retention, and family outcomes. The position will also increase the number of slots available for fathers from 50 to 62. Finally, the program added a budget line item for incentives for participants to complete program targets and for participants who refer a new participant that enrolls in the program. This encourages fathers to share their experiences from the program with their peers to increase the reach of the program.

Community Family Life Services' parent education and home visiting program primarily serves parents who are experiencing homelessness, survivors of domestic violence, or formerly incarcerated, which are also priority groups for CFSA prevention services. At CFLS, the FY24 investment allowed the program to move a part-time staff member into a full-time position. Because of additional staff hours, the program can serve more families and provide a wider array of times for home visiting through expanding the staff's after-hours capacity. This flexibility allows home visitors to more easily respond to parent needs and families' schedules.

At The Family Place, the majority of participants are immigrant families with low incomes, some of whom are displaced and currently living in shelters. The FY24 allocation allowed the program to move a part-time home visitor into a full-time role. The Family Place also

opened a position for a new home visitor and hired a data manager. High administrative burden is a long-standing challenge for home visitors and a significant source of dissatisfaction with the role. With the data manager, the Family Place is able to increase home visitor satisfaction on the job, which is key to retention. This also means that home visitors are able to spend more time with families in the field rather than completing data entry.

CFSA should also maintain its investment to DC Health's administration of Parents as Teachers (PAT) and Healthy Families America (HFA) through the First Families prevention Act, as they help prevent child abuse and neglect in the District.

In FY25, we are asking the Council to ensure the CFSA budget is stable at its FY24 level of $770,471. The increase to programs in FY24 was not intended to be a one-time increase, but an investment for programs to expand and support their workers for years to come.

The DC Council and CFSA have affirmed the importance and impact of home visiting through previous funding allocations. These investments have been valuable for program administration and must be sustained. Funding home visiting programs in the District promotes equity for both the workers and the families participating in these services. We ask that the DC Council prioritize preserving or restoring funding for home visiting programs to continue supporting programs, their workers, and most importantly, the children and families they serve.

Thank you for the opportunity to testify today, and I welcome any questions.

Mary Katherine West
Home Visiting Program Manager
DC Action
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Testimony before the Committee on Health
DC City Council
Budget Oversight Hearing for the
Department of Health

Melody R. Webb, Esq.
Executive Director, Mother's Outreach Network/ DC Guaranteed Income Coalition
April 10, 2024

Good afternoon, Chair Henderson and members of the Committee. I am grateful for the opportunity to testify today. My name is Melody Webb, and I am Executive Director of Mother's Outreach Network (MON), which convenes the DC Guaranteed Income (DCGI) Coalition. I'm also a native, third generation Washingtonian. Mother's Outreach Network is a 501 (c) (3) nonprofit that uses movement lawyering and organizing strategies to support DC's impacted, primarily, Black mothers in shrinking the child welfare/family regulation system and in pursuing economic security. Mother's Outreach Network has now launched a second guaranteed income cash transfer program for a small group of mothers navigating poverty and separated from their children in the foster system. This is a research program intended to shed light on the impact of poverty reduction on involvement with the Child and Family Services Agency. Our Coalition convenes impacted DC residents, allies, and advocates[1] for a guaranteed income program in Washington DC.[2] Our program provides legal services, funded largely through the Office of Special Victims Justice Grants, which we support full funding. Because of this grant we were able to deliver vital legal help on an issue that comes before the courts and may not be well known – issues with registering a birth that occurs at home.

We had the privilege of representing a client negatively impacted by the processes and gaps in process for registering a birth that occurs outside of a licensed health care institution.[3] It was court action that, undertaken on Ms. Williams' behalf, that eventually led to securing Ms. Williams' son birth certificate, order on March5, nearly 2 years after the birth of the child. It was court action that, undertaken on Ms. Williams' behalf, that

[1] https://mothersoutreachnetwork.org/home/ubi-dc-coalition/petition-campaign-page/

[2] The mission of the DC Guaranteed Income Coalition is: To mobilize, conduct research, and advocate with officials; To change the narrative and connect basic income to racial economic justice; To build a permanent, guaranteed income program in Washington, DC; To preserve social insurance and safety net programs; and
To build a solidarity economy that cares and liberates individuals and families to live their lives with dignity and agency

[3] Pursuant to D.C. Code § 7-231.08(h) "[w}hen a live birth occurs in the District outside an institution, the report of live birth shall be prepared by and electronically filed. It was a months' long ordeal attempting to satisfy the requirements to register her son's birth that led to her seeking counsel from Mother's Outreach Network
D.C. Code Sec. 7-231.01 et seq. governs the registration and issuance of vital records, including birth certificates. Section 7-231.08(f) provides: "If the Registrar does not register a report for a live birth that took place outside of an institution, court action can be pursued D.C. Code 7-231.08(h), 7-231.11(d)(2) and 7-231.16."

eventually led to securing Ms. Williams' son birth certificate, order on March5, approximately 16 months after the birth certificate application was originally submitted and nearly two years after the birth of het and her husband's second child.

Addressing this issue has implications for funding and for the operations of the DC Department of Health Vital Records. I will not here detail the difficulty that our client has shared with the public in the Washington Post article and Teresa Williams herself so eloquently explained in her written testimony at today's hearing. Our position on the budget under this agency's purview is stated fully in the written testimony I am herein submitting to you.

Today, I bring you highlights.

First, when reviewing the choices before us for this budget, I urge the Committee members to reject the scarcity mindset that would dictate choosing between the programs that help to alleviate poverty, particularly for Black and Brown people, and women, in DC. Also, we must think long-term in making choices: the District Child Tax Credit Amendment Act of 2023 *and* the Child Wealth Building Act of 2021 in the long term will address poverty. I am here to urge you to consider supporting the District Child Tax Credit Amendment Act of 2023 either through scheduling a mark-up of the bill or supporting its inclusion in the Budget Support Act of 2024. The health of our District residents impacted by poverty is at stake in our funding decisions related to poverty.

Specifically, I want to talk with you about the Department of Health and how you can both examine its performance and possible need for statutory or regulatory changes to achieve the following. These were illustrated as problems in the first-hand account of the situation encountered and detailed in the Washington Post and in what Teresa Williams described today. See the articles chronicling her difficulties in registering child's birth.[4]

We urge you to do the following to address and further elucidate the extent of the problems in the operations of the Department of Health Office of Vital Records:

- The DC Code should be more explicit in directing the DOH Vital Records Division to rely upon probative evidence that is not necessarily included in their checklist.
    - As seen in the analysy provided via chart, both MD and VA regulations frequently allow for "other evidence acceptable" to the decision-making body. Given this, the often lower number of required documents per category, and the significantly longer lists of acceptable documents: the regulations are more relaxed in MD and VA.

[4] **He was born at home in D.C. Now his parents have to prove he's theirs.** Ellie Silverman **(**Feb. 15, 2024) https://www.washingtonpost.com/dc-md-va/2024/02/15/dc-undocumented-baby-home-birth-certificate/ **Baby born at D.C. home in 2022 will finally get a birth certificate.** Ellie Silverman **(**March 5, 2024 at 3:13 p.m.) https://www.washingtonpost.com/dc-md-va/2024/03/05/dc-court-hearing-undocumented-baby-home-birth-certificate/

- 2. We recommend the statute include an appeals process within the agency and/or an appointed ombudsperson/customer service representative. While neither MD or VA has a specified intermediary appeals process, we recommend this as a step that will increase the efficient and fair processing of birth certificates. We recommend the adoption of this or consideration of appeals outside the agency to the Office of Administrative Hearings.

- We cannot herein discuss the extent of the problem, or its frequency given the Agency's assertion that it does not maintain such data. It is our recommendation that the Agency should be required to maintain data tracking of how many registration applications are rejected and the bases for the rejections, which may include requiring the agency to hire a quality assurance staff person. We are also, however, not aware of a database or record-keeping system in MD or VA.

I would be happy to answer any questions or meet with your office with my former client to discuss this.

Analysis of Birth Registration Requirements and Processes for Out of Institution Births in DC, Maryland and Virginia

	DC	Maryland	Virginia
Date by which out of institution live birth must be reported	Within 5 days after the date of live birth (But if report is submitted after 5 days but within one year of birth, it is registered in the standard format prescribed by law and is not marked or flagged as "delayed")	Within 5 calendar days after the date of live birth	Within 30 days after the birth *See 12VAC5-500-100(C) (linked here) for the specific requirements to file a Certificate of Live Home Birth *If the Certificate of Live Home Birth, Commonwealth of Virginia is not filed with the local health department in which the birth occurred within 30 days of the birth, then the following documents (included below in this chart) may be required to support a later filing of the Certificate
Who can report live birth (in order of priority)	1. Physician in attendance of birth or examines mother and child within 5 days of birth 2. Medical facility at which mother and child are examined within 5 days of birth 3. Any other licensed or certified healthcare provider in attendance of birth or examines mother and child within 5 days of birth 4. The mother 5. Second parent, spouse, or	1. The attending individual 2. In the absence of the attending individual, either parent of the child 3. In the absence or inability of either parent, the individual in charge of the premises where the birth occurred	1. Physician in attendance at or immediately after the birth 2. In the absence of such physician, any other person in attendance at or immediately after the birth 3. In the absence of such person, the mother or the other parent 4. In the absence of the other parent or inability of the mother, the person in charge of the premises where the birth occurred

	domestic partner if in attendance of birth 6. Individual in charge of premises where birth occurred		
What happens if the respective Vital Records Division does not approve of the application?	If report does not include minimum acceptable required documentation or Registrar has cause to question validity or adequacy of evidence, and the deficiencies are not corrected, the Registrar will supply a rejection letter detailing the reason for rejection and shall advise the registering party of their right to appeal the Registrant's decision in court.	If attending clinician is not in charge of the birth, then local health officer or designee of the jurisdiction where the birth occurs 1. Verifies facts regarding the birth by obtaining documents required (*see* below); 2. Signs the birth record; and 3. Files the birth record with the Secretary If the facts cannot be verified by the local health officer, then an individual amongst the above list (attending, parent of the child, or individual in charge of the premises) shall obtain an order from a court of competent jurisdiction that 1. Lists the facts about the birth; and 2. Authorizes the Secretary to create the birth record according to the facts	Process is not specified in the regulation.
Mother's identification requirements	**One** of the following: ● Non-expired drivers license ● Non-driver ID ● Passport	Valid, unexpired, government-issued ID in the form of **one** of the following: ● Driver's license ● State-issued photo ID	Specific documents are not listed in the regulation, but some form of identification is presumably required based on the information needed in the

	Additional parental information may be required (one of the following:) ● Marriage certificate ● Domestic partnership certificate ● Acknowledgement of Paternity Form ● Consent to Parent Form ● Alternate Surname Form	card ● Passport ● Permanent resident card ● Military ID card If mother has none of the above, needs to provide: ● Signed statement that mother has none of the above documents; and ● **Two** of the following documents that contain applicant's name and current address ○ Utility bill ○ Car registration form ○ Pay stub ○ Bank statement ○ Income tax return ○ Income tax W-2 form ○ Lease or rental agreement ○ Letter from government agency	Certificate of Live Home Birth.
Proof of pregnancy requirements	**Both** of the following: ● Prenatal records ● Signed statement from parent's licensed healthcare provider	**One** of the following: ● Prenatal or postnatal medical record consistent with date of delivery and includes ○ Mother's name, date of birth, and date of health exam; and ○ Health care	**One** of the following (but not limited to the following): ● Prenatal record ● Statement from physician or other healthcare provider qualified to determine pregnancy ● Home visit by a public health nurse or other healthcare provider

		provider's signature, printed name, signature date, and license number; ● Statement from a physician or certified nurse midwife licensed in the US, or direct-entry midwife licensed in MD, who has first-hand knowledge of the pregnancy and is willing to attest to the fact of the pregnancy ● Preregistration with the local health department during pregnancy, including a face-to-face interview and physical examination ● Documentation of a home visit by a public health nurse or other healthcare provider who has first-hand knowledge of the pregnancy ● Other evidence acceptable to the Secretary	● Other evidence acceptable to the State Registrar
Proof of live birth requirements	At least **two** of the following: ● Labor and delivery report ● Letter from licensed health professional who saw baby at the time of live birth ● Pediatric visit report	**One** of the following: ● Statement from physician, certified nurse midwife, or other licensed healthcare provider who saw or examined the infant within the first two weeks of life	**One** of the following (but not limited to the following): ● Statement from physician or other healthcare provider who saw or examined the infant ● Observation of the infant

		• Observation of the infant during a home visit by a public health nurse or licensed healthcare provider during first two weeks of life • Other evidence acceptable to the Secretary	during a home visit by a public health nurse • Other evidence acceptable to the State Registrar
Evidence of delivery in jurisdiction	Depending on the circumstances, certain of the following is required: • Fire and EMS (ambulance) report if 911 was called • Rent or mortgage payment receipt • Utility bill	If the birth occurred in mother's place of residence, **one** of the following: • Drivers license or other state-issued ID that includes mother's current MD address • Rent receipt, mortgage statement, or deed that includes mother's name and MD address • Recent pay stub that includes mother's name and MD address • Other evidence acceptable to the Secretary If birth occurred outside mother's place of residence and mother is resident of MD, **one** of the following: • Affidavit from the tenant of the premises where the birth occurred stating that the mother was present on those premises at the time of the birth	If the birth occurred in the mother's residence, **one** of the following (but not limited to the following): • Driver's license or state-issued identification card that includes the mother's current residence on the face of the license/card • Rent receipt that includes the mother's name and address • Any type of utility, telephone, or other bill that includes the mother's name and address • Other evidence acceptable to the State Registrar If the birth occurred outside of the mother's residence and the mother is a resident of VA, **all** of the following: • Affidavit from the owner, supervisor, manager and tenant of the premises

		• Evidence of the affiant's residence similar to that required in the above section (*see* "if the birth occurred in mother's place of residence") • Evidence of the mother's residence in MD similar to that required in the above section (*see* "if the birth occurred in mother's place of residence") If the mother is not a MD resident • Must present consist of clear and convincing evidence acceptable to the Secretary	where the birth occurred stating that the mother was present on those premises at the time of the birth • Evidence of the affiants' residence similar to that required in the "if the birth occurred in the mother's residence" subsection above • Evidence of the mother's residence in VA similar to that required in the "if the birth occurred in the mother's residence" subsection above If the mother is not a resident of VA • Must present clear and convincing evidence acceptable to the State Registrar, such as affidavits of the persons present at the time of birth, proof of such affiants' residence as set out in the "if the birth occurred in the mother's residence" subsection above, ambulance records, police records, or the like
Special requirements or comments	To initiate the process, one parent must email dc.vitalregistration@dc.gov with	MD Department of Health increased transparency in their regulations relatively recently.	VA refers to "outside of an institution" birth as "home birth," but the language of the statute

	their full name, telephone number, and date the birth occurred, and a DCVRD team member will follow-up within two business days with a list of requirements to begin the process. *How does this seemingly slow process align with requiring parents to file within 5 days of the birth? Does the initial email to the DCVRD qualify as "filing within 5 days?"*	The state passed a proposal for clarifying the requirements for filing birth certificates for outside of institution births in 2018. (Link to proposal here). *This may help justify encouraging change in DC	indicates that being in a literal home is not required.

MON's Goals

1. Statute should be more explicit in directing the DOH Vital Records Division to rely upon probative evidence that is not necessarily included in their checklist.
    a. As seen on the chart, both MD and VA regulations frequently allow for "other evidence acceptable" to the decision-making body. Given this, the often lower number of required documents per category, and the significantly longer lists of acceptable documents, the regulations are more relaxed in MD and VA.

2. Recommend the statute include an appeals process within the agency and/or an ombudsperson (appointed person)/customer service representative. It is noted that neither state has a specified intermediary appeals process.

3. Agency could be ordered to maintain data tracking how many registration applications are rejected and the reasons for why they are rejected, which may include requiring the agency hire a quality assurance staff person. There does not, upon information and belief, appear to not be a database or record-keeping system in MD or VA.

DC Regulations

Code of the District of Columbia § 7-231.08. Live birth registration. [link]
DC Health's "Powtoon" Presentation on "Instructions on how to register an out of institution birth in the District of Columbia" [link]
DC Vital Records - Important Notices (extra information) [link]

Mother's Outreach Network April 22 2024 to the DC Council - Not intended for Legal Advice, only to be used for informational purposes.

Analysis of Birth Registration Requirements and Processes for Out of Institution Births in DC, Maryland and Virginia

Maryland Regulations
Maryland Code, Health-General § 4-208 [link]
Code of Maryland Regulations, Section 10.03.01.16. Births Outside an Institution [link]

Virginia Regulations
Code of Virginia § 32.1-257. Filing birth certificates; from whom required; signatures of parents. [link]
Virginia Administrative Code, Title 12, Agency 5, Chapter 500, Section 100. Birth certificate items. (12VAC5-500-100) [link]

Testimony for the FY 2025 Budget, Catherine Romanowski, Ward 5 Resident

First and foremost, thank you Councilmember Henderson and the Committee on Health for allowing me this opportunity to weigh in on the proposed budget for next year.

While I support a number of the proposals outlined in Mayor Bowsers A Fair Shot Budget, I want to specifically speak about the $22.5M item funding a new animal shelter. As I know you are aware, the current campus at 1201 New York Ave, NE is quite frankly falling apart. It needs major renovations and upgrades just to be a functional facility. As is, it possesses a public health threat and the living conditions for the animals in care there are inhumane.

From February 2018 – February 2019, I was the Foster Orientation Coordinator for the Humane Rescue Alliance (HRA) working 15 hours a week. One of my job responsibilities was running in-person orientations for new foster parents at the 1201 New York Ave, NE location. During orientation, foster parents were given a tour of the shelter. My script for the tour was constantly being interrupted by rat sightings. Each week I had to worry about how many of my new foster parents were going to be lost because of what they might see while on campus for this event.

Rats running rampant was not the only issue I personally had to deal with. On multiple occasions we had to clean out the office I worked out of because it was being treated for mites. I would leave my shift with tiny bumps on my arms from being bitten by these bugs. I was only there at most 15 hours a week and couldn't help but imagine what the animals who were there all day, every day had to endure. While I haven't been back to the facility since 2020, I know that it has only deteriorated since the city has not invested the much-needed funding to bring the building to a functional state. Therefore, I fully support the $22.5M proposal and urge you to preserve the funding and begin moving ahead with a new shelter.

While some people may think this money can better be used to fund human services, please keep in mind that animal services are human services. A properly run shelter is a community resource that handles disease prevention (both zoonotic and species-specific) to helping pet guardians with resources to preventing animal bites and attacks. Staff should have a place to work that is safe and functional. This is only the short list. As the Capitol of the country, DC should be the leading example in how animal sheltering is done and we need a new facility to begin that process.

However, the proposed location of the new shelter at 4 District Village Lane, SW is problematic at best. Traditionally in the US, a city's dog pound has been situated in an out of the way location that discourages people from visiting, many times by an airport or the industrial part of town. Think of an out of sight, out of mind sort of mentality. Sadly, the SW location falls right into this thinking. It is not accessible for most of the city, especially those that rely on public transportation or don't drive. We need to look for a central site that serves all of our city's residents, not just a handful that live close by. The site should be very visible and something we can be proud of, not somewhere that is tucked away like a bad secret. I urge you to please find a location that all of our residents can utilize and not feel like they are being punished when using the services provided at the facility.

Thank you for taking the time to read this.

Respectfully,
Catherine Romanowski
1719 Holbrook St NE
Washington DC, 20002
cvromanowski@gmail.com

Thank you for the opportunity to provide testimony on DC's FY25 budget. My name is Charlotte Huffman, and I am a Ward 2 resident, member of Volunteers for HRA Reform, and a former Humane Rescue Alliance (HRA) volunteer. I am writing today to request that the DC Council fully fund animal services, which includes increasing funding for the upcoming animal care and control contract to at least $6.5M.

District communities desperately need investment in animal care and control, as the DC government is currently failing to provide its residents with the quantity and quality of services they deserve.

There are numerous problems with current animal service offerings. For the last five years, no low-cost spay/neuter services have been made available, despite being mandated in the code. The number of vaccination clinic hours that the current contractor offers does not come close to meeting the number of hours mandated in the contract. The supposedly "open access" shelter, according to DC Health's website, regularly turns away animals, leaving DC residents often on their own to handle owner surrenders and friendly adult cats found outdoors. Conditions at the government-owned New York Avenue facility (NYA) are inhumane for animals and unacceptably stressful for frontline staff, and the dogs housed there and people who care for them bear the brunt of the consequences from the DC government's insufficient maintenance of the facility.

Volunteers for HRA Reform has been bringing these concerns to DC Health, the Council, and the public's attention over the past few months, and we've been consistently met with one answer: the current contract is too weak. It contradicts itself in several places, doesn't contain enough definitions to have any teeth, and is essentially unenforceable. DC Health cannot intervene on behalf of DC residents and DC animals until it develops a new contract starting in October 2024.

If the upcoming animal care and control contract is going to be one that actually serves DC residents and is a good use of taxpayer dollars, then it must be an improvement from the current contract. It should mandate true open access intakes, funding for at least one additional veterinarian position, and low-cost spay/neuter services. All of this will require more funding to be done right, and the DC community is relying on the DC Council to ensure this happens.

It is now time to write and fund the new, sorely needed contract, and DC Councilmembers have a choice: invest in DC public health and safety services or allow the status quo of neglect and inadequacy to continue. DC residents are relying on the Council to choose investment — to choose to properly fund the animal care and control contract.

Thank you.

Carolyn Babendreier

Good Afternoon Council member
Henderson and the Committee for DC Health. My name is Carolyn and I serve as a Supervisor in Home Visiting at Mary's Center. I'm happy to be here today to share with you about one of your best impactful and most effective investments that you've offered the community through Home Visiting.

You have heard today from several witnesses advocating for Home Visiting across the city. Throughout each testimony its clear how essential funding and sustaining these programs are.

Home Visitors have access to struggling families in the district in a way that almost no other social service or public agency has. We often have public school workers, counselors, childrens teachers, pediatricians, and prenatal care providers etc reaching out to our home visitors to reach these families when no one else can.

In theory our programs should primarily be focused on curriculum based education and activities centered around individual health and child development, in actuality our Home Visitor do so much more.

Home visiting gives insight to the day to day challenges and struggles of DC families more than any other service that the district provides. Allowing them to identify Issues such as Domestic violence risks, mental health challenges or even risk factors associated with perinatal high risk conditions. Identifying these issues early allows families to access help and support that they may have never sought out on their own. Often times a home visitor is the only source a parent trusts to seek help and support. This speaks a larger impact of home visitor which is how they act as the bridge to a network of resources that council already funds. An essential lifeline to immediate necessary resources.

This is not without significant challenges for the home visitor. Year after year as more and more families experience challenging times home visitors are there with steadfast dedication and yet while the burden on hVs increases the investment has not. As a supervisor, an issue near and dear to me is how undervalued our Home visitors are. While Home visitors are not direct employees of DC Health, DC health and you the committee determine year after year whether or not they deserve a livable wage. Our home visitors deserve stability so that they can concentrate on supporting our DC families in achieving stability for their families. Putting funding aside the Administrative burden that accompanies funding reduces the capacity of home visitors to seek their families where they are. This can be changed even if the investment does not.

While home visiting does not generate immediate front end revenue for the district the true impact is immeasurable. In Mary's center programs alone we see numerous stories of families who were able to access career development support, and family goal planning which allowed them to gain economic stability that they were not able to achieve

without the support and resource access from their Home Visitor. Some of these parents went on to become medical assistants, another parent was able to complete a nursing school program during her time in homevisiting.

Home visiting is an evidence-based strategy that supports families and children during their most critical years of life. Home visitors support expectant parents and families with young children to create a safe and stable environment and reach their parenting goals. **While home visiting programs could effectively use an increase in funding, at a minimum DC should avoid further cuts to programs and pursue meaningful improvements to their processes, procedures and administration. Councilmember Henderson I was happy to hear you earlier acknowledge the positive impact of Home Visiting on the city. I heard you then acknowledge for another DC service that not upkeeping funding with inflation is effectively a funding cut to a program. I firmly agree and I ask that you consider why if the council is aware of the importance and the impact of Home Visiting why is this not reflected year to year in investments into our programs. If you have any doubts about what we do, how we do it, and how we support the Families in the district** I ask you please come to a home visit, meet our families, and we are certain that you will see the value in our programs by the end.

Good morning, Chairperson Henderson and esteemed members of the Committee. Thank you for the opportunity to address the Council today. My name is Chassis Hawkins-Younger, I am one of the home visitors within a program at Mary's Center, and I am testifying about home visiting programs within our area.

Home visiting is defined simply as maternal and overall family health support provided directly to the neighborhoods where it's needed. As home visitors, we meet families exactly where they are, where they are most comfortable, to provide support and connection to resources already within their community that holistically benefit them. I've had participants share with me that they weren't aware of certain resources for maternal and paternal support and mental health support prior to us having discussed their various challenges. I've also had a participant share with me the importance of having a direct line to assistance and support for perinatal education as a new mom in the area without any family or friends to rely on.

As a home visitor, my day includes enrollment calls, home visits, constant communication outside of home visits, and documentation. Visits to the clinic and community resources are also included. Maintaining flexibility is also a huge part of my day. Flexibility could be shifting the purpose of the visit to focus on what a family is currently facing or rearranging my schedule to support a participant based on their current needs. One of my participants who felt unheard by her provider went in for a routine prenatal appointment, so I accompanied her virtually for support. Our phone visit transformed from virtual support during her appointment, to me holding space for her, asking questions with her, and encouraging self-advocacy when the appointment turned into her being admitted into labor and delivery. Home visitors are there for their families, and with supporting families with diverse scenarios, having the ability to pivot and adapt to challenges is not always that simple.

In my role as a home visitor, one of the challenges that I face is supporting families that are displaced due to issues with housing insecurities. Supporting families who are waiting to become permanently housed can be difficult due to the families, including the children, being negatively impacted. Visits with families are tailored to what the family is currently navigating and what their needs are. The families that we support have a variety of needs, however, it's hard to address those needs when their most important one is unstable. Two other challenges home visitors face are decreased supplies and lower salaries. Budget cuts to home visiting programs impact our ability to effectively carry out our roles as home visitors because with the lack of supplies comes the inability to accompany the already-used resources funded by the community, such as mental health support, tangible items such as baby supplies, pregnancy and postpartum items, food and formula, and other socio-economic resources. Working with lower salaries makes it harder for home visitors to stay in our roles

because while we are passionate about the work that we do, we also have ourselves and/or our own families to take care of as well.

When I think about the future of Home Visiting and my role, I like to imagine increased funding so that home visiting programs can fund the resources and curriculum of the programs, provide continuous growth in training for home visitors that supports the population served, and livable wages that fit the work that we provide. I believe that it's important for DC Council to work towards and invest in the work that home visitors do because we serve your constituents. Some home visiting programs serve only wards 5, 7, and 8, which have been known to have significantly worse health outcomes than other wards in DC. These families are your constituents, too.

Studies show that home visiting positively impacts families during their most critical years of life. When families enroll into home visiting programs, these programs commit to these families for a certain period of time. When these programs go unfunded, promises are not kept, families are not given all of the support that they signed up for and need, and we ultimately fail. The programs fail, the home visitors fail, and DC fails its families. While home visiting programs could effectively use an increase in funding, at a minimum DC should avoid further cuts to programs.

Comments Submitted to the Committee on Health

by

The Office of the DC Long-Term Care Ombudsman

Budget Oversight Hearing for DC Health

Submitted May 7, 2024

Greetings Chairperson Hendersen and Members of the Committee on Health. I am Mark Miller, D.C. Long-Term Care Ombudsman with Legal Counsel for the Elderly (LCE). Thank you for the opportunity to provide these comments on behalf of the 9,000 District residents receiving long-term care services and supports (LTCSS) in nursing homes, assisted living residences, community residence facilities, and in their homes through the District's Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program.

The Ombudsman Program is part of the Department of Aging & Community Living Service Network and is charged by federal and D.C. law with representing the interests of some of the District's most vulnerable citizens. Our mission is to promote and help ensure the highest quality of life and quality of care for these individuals.

In FY 2023, the Ombudsman Program investigated 259 complaints, resolving 83% of those issues to the satisfaction of the care recipients or complainants. The Ombudsman Program educates individuals about their rights, empowering them to maintain their decision-making autonomy and to self-advocate when possible. In 2023, the program provided 713 individuals with information and consultation to help them

navigate the long-term care system, understand their rights, and to assist them with self-advocacy.

Better Oversight Requires More Surveyors

The Ombudsman Program supports additional funding for the Department of Health's Health Regulatory & Licensing Administration (DC Health/HRLA) so they can effectively protect residents by ensuring compliance with federal and District regulations, including conducting federally required standard surveys of nursing homes, and responding to resident complaints. I want to express my concern over the proposed cuts to the HRLA budget. It appears that the 2025 budget calls for a cut of $843k to the Office of Care Health Facilities, which equates to a reduction of 5.1 FTEs. If approved, this would significantly hinder HRLA's ability to survey nursing homes and assisted living residences and to respond to critical complaints in a timely manner. This places our most vulnerable residents at risk of poor care outcomes, including abuse and neglect. Survey agencies continue to struggle to keep up, stretching the time between surveys, making surveys more predictable, and having to divert resources to respond to complaints in a timely manner. Regulations that are designed to protect residents' care and rights are not self-enforcing. To ensure residents are receiving the care they need, and for which the District pays, and to hold providers accountable, we need more surveyors, not fewer. Therefore, the Office of the DC Long Term Care Ombudsman recommends not approving the proposed cuts to HRLA in the 2025 budget.

Thank you for your ongoing advocacy on behalf of the District's vulnerable residents and for the opportunity to share these comments on behalf of the Ombudsman Program and the residents we serve.

Submitted by Mark C. Miller
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COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH

ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Department of Behavioral Health

And

DC Health

ON

Thursday April 11, 2024, 9:30 A.M.
Hybrid in Room 123 and Virtual via Zoom
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Department of Behavioral Health

1. Dr. Barbara J. Bazron, Director of DC Health

DC Health

1. Ayanna Bennett, Director of DC Health

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

DC | HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

Budget Oversight Hearing on

"FY 2025 Budget Oversight of DC Health"

Testimony of

Ayanna Bennett, MD, MSPH, FAAP
Director, DC Health

Before the
Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson, Chairperson

Thursday, April 11, 2024
9:30 AM
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Good afternoon, Chairperson Henderson, Councilmembers, and staff of the Committee on Health. And thank you to the members of the public who testified yesterday or came today to share what they want and need from the Health Department. For those of you who don't know me, my name is Dr. Ayanna Bennett, and I am the Director of DC Health. On behalf of Mayor Muriel Bowser, I am pleased to be before you today to discuss DC Health's plans for Fiscal Year 2025 and our successes in Fiscal Year 2024 to date. I want to first thank the Mayor for her continued investments in public health services and infrastructure. Health equity for all residents and the economic and cultural vibrancy of the District are interdependent. We need healthy communities to drive an economy and a thriving economy to support the health of residents and families. With the continued investments in the Mayor's FY25 budget, we demonstrate our unwavering commitment to achieve Mayor Bowser's vision of health equity.

However, this is a year in which all District agencies have needed to right-size operating costs as revenue and growth are changing. At DC Health, that meant considering which programs and initiatives have delivered real outcomes, and what new resources are required to address unmet or emerging public health needs. The decisions evident in our budget are based on those considerations.

As you and the public look at the budget, I want to be sure it is with an understanding of the essential role public health plays in all our lives. Public health, done well, is invisible to the residents, visitors, and patients who it serves. When you are enjoying food at one of our many local restaurants, walking through our streets or parks, visiting your trusted primary care provider or local pharmacy, or even jumping into a public pool, you are seeing the hard work of DC Health staff and programs to ensure those services are delivered safely. About a third of the DC Health budget goes to supporting the inspectors, educators, licensing specialists and administrators that

do that work. DC Health staff also raise and administer the federal dollars that make up over 60% of our FY25 budget and fund many of our direct services.

Few residents know that two thirds of our sizeable budget (over $200 million of our FY25 proposed $304 million FY25 proposal), passes through DC Health as grants and contracts to an array of community organizations and providers. Those grantees and contractors provide our community with healthy food, support for managing a chronic illness, a lifeline to call when caring for a new baby, and many other essential needs. These needs must all be met within our budget, which means that prioritizing and managing our investments is a key part of our mission to protect and promote the health of the District's residents and visitors.

DC Health remains committed to those investments that ensure we all have a quality healthcare system, safe businesses and spaces to enjoy, and access to the resources we each need to stay healthy. Access to healthy food is a priority for both our agency and for the Mayor. We are pleased that our funding level for food programs remains consistent, despite budgetary pressures. I'd like to thank the Mayor and her team for being such strong advocates for those District residents that are food insecure. I also want to thank the Mayor and Council for continuing to support our high needs health careers scholarship – we believe this program, which should roll out this summer, will go a long way to address some of the health system challenges in recruiting and retaining qualified health professionals.

We are extremely pleased to share that our new staffing model for the school health services program this year has been a success despite some mid-year challenges. As of April 1st, of this year, 95% of the 182 approved health suites have 40 hours of on-site staff coverage, and the remaining have 24 hours or more. All schools have access to telephone coverage when staff are not on-site. This contrasts with the staffing in past years when as much as 40% of schools had

no assigned full-time on-site staff. We will continue to work on this model in response to school and parent feedback and will provide a more detailed update in advance of the new school year. We also will be instituting a new approval process for health suites. This will involve cutoff dates for the next school year so that DC Health and its partners can effectively budget and plan for the inspection, activation, and staffing of those new clinics. With FY25 funding equal to FY24, we are confident we can provide the same – or better – level of service to our public-school students.

One hard decision we made this year was to pause our school-based health centers. These centers are small in-school clinics that deliver care similar to the services provided in a traditional community clinic setting in partnership with some local providers. The original purpose of this program was to ensure that students who do not have access to traditional health services or who have other significant barriers to care, can still seek the necessary services in a place they already go, their school. However, we noticed that that the number of young people using the school-based health centers is well below what we would like to see with such a program. Additionally, we need to ensure that children who routinely seek care for basic needs in a school setting are not missing out on continuity and parent involvement, two essential elements of quality pediatric care. Therefore, we propose that for the upcoming fiscal year, these centers be put on pause while we work to better understand what healthcare needs our students have, and craft an effective solution that is aligned with other elements of our school health services and our access and quality goals for the health system as a whole.

Another topic of interest to this Committee is our continued work to ensure that the quality and stability of our animal care and control program. I am happy to announce that the Mayor's proposed supplemental budget this year includes enough to fully fund our existing contract with the Human Rescue Alliance. We are also aware of some of the concerns shared by members of the

community regarding the current contract with HRA, and our role as oversight of animal care facilities, of which HRA is one. My team and I have been meeting with HRA and other stakeholders over the past six months and have committed to an improved partnership and collaborative effort to keep our communities and our animals safe in the coming fiscal year and beyond. While we have not finalized all the details, we anticipate being able to share more concrete details this summer with the Council and the community.

Finally, I want to move beyond the specifics touch on the larger vision that drives our decisions. During my confirmation hearing, I talked about my vision for DC Health as an organization that was data driven, collaborative and inclusive, and focused on solving problems including health disparities. I have seen strong alignment with DC Health's leadership and staff around that future state. In the nearly 9 months since I arrived, I have seen examples of how DC Health is realizing that vision.

For example, our Health Emergency Preparedness and Response Administration has implemented a robust data analytics tool that helps us understand, in near real-time, what data provided by our colleagues at DC Fire and EMS is telling us about a variety of public health issues from traffic injuries to near-fatal opioid overdoses. We have added a Chief Performance Officer and Chief Health Informatics Officer (just posted) to develop and drive this data-driven problem-solving approach across all parts of DC Health. I have also engaged with community leaders through listening sessions to hear how stakeholders and residents believe funding should be prioritized. Lastly, I am very proud that our team has settled into our new headquarters in historic Anacostia. This is a very concrete act of community inclusion. I look forward to integrating with the community there.

Over the next several months we will be looking to continue this kind of work into the future. We'll focus on making sure our agency can best meet our core functions, create innovative solutions to persistent gaps and inequities, and prepare to address emerging health issues. We will be launching some strategic conversations this summer, both internally and with our partners, to plan for that near-future. One way to improve our ability to meet those core functions is reimagining the DC Health structured to support efficient, nimble and effective public health practice. By that I don't mean adding or removing functions, but rather optimizing communication and partnership. We anticipate sharing more our developing strategic plan and shifts in structure with Council in the coming months as we continue our conversations internally and with our sister agencies.

In closing, I thank the Council for providing DC Health with an opportunity to discuss its successes over the past year and our vision for the future. I am available to answer any questions.

ATTACHMENT
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COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH
BUDGET OVERSIGHT HEARING
1350 Pennsylvania Avenue, NW, Washington, DC 20004

COUNCILMEMBER CHRISTINA HENDERSON, CHAIRPERSON
COMMITTEE ON HEALTH

ANNOUNCES A BUDGET OVERSIGHT HEARING

ON

Deputy Mayor for Health and Human Services

And

Department of Health Care Finance

on

Monday April 29, 2024, 9:30 A.M.
Hybrid in Room 120 and Virtual via Zoom
To Watch Live:
https://dccouncil.gov/council-videos/
https://www.christinahendersondc.com/live
https://www.youtube.com/@cmchenderson

Public Witnesses

Deputy Mayor for Health and Human Services

In Person

1. Sarah Buckley, Public Witness

1. Deborah Thomas, Nurse Consultant, District of Columbia Nurses Association

2. Kenneth Page, Public Witness

3. Lucy Cosgrove, Public Witness

4. Brady Woodhouse, Public Witness

5. Evie Corr, Public Witness

Virtual

6. John Gloster, Board Chair, Ward 8 Farmers Market
7. Libbie Buchele, Parents United for School Health
8. Heidi Ellis, Coordinator, DC LGBTQ+ Budget Coalition
9. Deirdre Brown, Member of Housing Sub-Committee, The Committee of 100
10. Lara Pukatch, Chief Advocacy Officer, Miriam's Kitchen
11. Joshua Drumming, Washington Legal Clinic for the Homeless
12. Eric Walcott, Executive Director, District of Columbia Home Health Association
13. Hilary Kacser, Public Witness

Department of Health Care Finance

Virtual

1. James Jean-Claude, Public Witness
2. Kevin Moates**,** Public Witness

In Person

3. Mary Katherine West, Program Manager for Early Childhood, DC Action
4. Leah Castelaz, Policy Attorney, Children's Law Center
5. David Freeman, PsyD, Senior Director, Community Connections
6. Destynee Bolton, Childcare Organizer, SPACEs In Action
7. Terrence James, Organizer, SPACEs In Action
8. Catherine Crosland, Director of Homeless Outreach Development, Unity Health Care
9. Ruth Pollard, President and CEO, DC Primary Care Association
10. Kelly Sweeney McShane, President and CEO, Community of Hope
11. Dr. Jessica Boyd, President and CEO, Unity Health Care

12. Dr. Tollie Elliot, Chief Executive Officer, Mary's Center

13. Sal Selvaggio, Volunteer, DC Coalition on Longterm Care

14. Dereje Bereded, Public Witness

15. Sally White**,** Public Witness

16. Capri Romney**,** Public Witness

17. Claudia Balog, Assistant Director of Research, 1199SEIU United Healthcare Workers East

18. Jacqueline Bowens, President & CEO, DC Hospital Association

19. Gregory Argyros, Chair, DC Hospital Association

20. Aldwin Lindsay, Executive Vice President & Chief Financial Officer, Children's National Hospital / DCHA

21. Anita Jenkins, CEO, Howard University Hospital

22. Tony Coleman, CEO, Cedar Hill Regional Medical Center - GW Health

23. Amber Rieke, Children's Law Center

24. Blanche Mcleod, Public Witness

25. Mary Procter**,** Public Witness

26. Anna Pilskaya Dunn, President, Health Services for Children with Special Needs

27. Claudia Schlosberg**,** Public Witness

Virtual

28. Susan Sedgewick, Public Witness

29. Fernanda Ruiz, Home Visiting Director, Mary's Center

30. Travis Ballie**,** Public Witness

31. Ian Paregol, Executive Director, DC Coalition of Disability Service Providers

32. Mark LeVota, Executive Director, District of Columbia Behavioral Health Association

33. Makeda Vanderpuije, Executive Director, LeadingAge DC

34. Christy Respress**,** Public Witness

35. Marie Morilus-Black, CEO, MBI Health Services, LLC

36. Patricia Oholeguy, Director of Early Learning, The Family Place

37. Felix Hernandez**,** Public Witness

38. Adrian Thompson**,** Public Witness

39. Cheryl Dondero, Director of Government Affairs, Gaudenzia, Inc

40. Dr. Takeisha Presson**,** Public Witness

41. Edward Brown Jr. DDS, DMSc, Public Witness

42. Cheryle Baptiste, DDS, Public Witness

43. Kurt Gallagher, Executive Director, DC Dental Society

44. Rajan Thomas, President, DC Home Health Association

45. Veronica Sharpe, President, District of Columbia Health Care Assn

46. Abby Goldstein, Nurse Family Partnership Nursing Supervisor, Mary's Center

47. Jodi Ovca, Executive Director, Access Youth

48. Vanessa Lopez, Public Witness

Government Witnesses

1. Wayne Turnage, Deputy Mayor of Health and Human Services and Director of Health Care Finance

On March 14th, 2024, a Kindergartner at Shepherd Elementary School was hospitalized for a severe allergic reaction. According to news reports, the child had an established plan for her school allergies, but she did not receive the treatment she needed, and was placed on a ventilator at Children's Hospital. The news is unfairly portraying this epic failure as the fault of Shepherd Elementary School, thereby eroding confidence in DC Public Schools.

Let's be clear: this is a failure of the Department of Health's new model, authorized by DC Council, that seeks to cover most of the DC Public Schools with health techs rather than nurses. This model substitutes trained nurses for health techs, who may have only six months of training, and lack the deep knowledge and expertise of nurses. The tragedy at Shepherd Elementary School shows that health techs are not a substitute for school nurses.

At the January 4th DC Council oversight hearing, Dr Ayanna Bennet, District Department of Health (DOH) said that the era of all schools having a nurse is gone. Her remarks show that DOH and CNH intend to continue with a short supply of nurses, in direct contravention of DC B22-0027. As of January 5, 2024, Children's staffing report shows that they have "capped" the total number of RNs in the system at 56, and the total number of LPNs at 49. Even if these nurses float between schools, with 185 health suites to cover, this leaves 80 schools with either no nurse coverage or only sporadic nurse coverage. Why would we place a cap on RNs and LPNS? Years of low nursing pay has created the shortage in DC. We need to repair the damage and adequately fund this system.

There is no other alternative. If you continue this inadequate coverage and inadequate funding, you are placing all children in the District at risk. A child doesn't have to be medically fragile in this system. My kids have hurt their head in gym class. Without adequately trained staff to perform an assessment, who will determine the severity of their injury? Could my child develop a brain bleed and be sent back to class to die? You need to act now and stop playing Russian Roulette with our children's lives.

I have heard that the Council wants to give Children's another year to test this new model. The tragedy at Shepherd shows we don't have the time. Moreover, the staffing report shows that they are 86 staff members short, placing an already inadequate system in even greater peril. I urge the council to recognize that all children in DC public and DC Charter schools are at risk. I recommend:

1. Immediately increasing funding for the health suites program to assure above average salaries for nursing staff – our key public health defenders in this time of public health crisis.
2. Mandating that there be no cap on the number of RNs or LPNs hired.
3. Mandating a parent – DCPS team to provide input and on the ground information on what is happening in the schools

I realize we are facing a budget crisis of epic proportions. But if parents move their kids out of the District because they can't be kept safe at schools, the tax base will erode further. If DC faces costly lawsuits due to unsafe conditions in schools, the budget crisis will worsen. Please, invest in our kids and in DC's future. Thank you.

April 4, 2024

Health Budget Oversight Hearing for the Deputy Mayor of Health and Human Services.

My name is Nene Rhodes, a retired public health practitioner and a Policy advocate for the American Foundation for Suicide Prevention (AFSP) National Capital Area Chapter (NCAC). We appreciate the opportunity to testify in support of improving access to mental health care for the uninsured, underinsured individuals including youth in District of Columbia (DC). Unmet needs for counselling and behavioral therapy in individuals reporting mental health conditions (i.e. depression, anxiety, substance use...) are more likely to lead to death by suicide than in individuals without mental health conditions. Suicide is a leading cause of death in US. Suicide can be prevented by more investment in suicide prevention, education, research…

Research shows that 61%of communities did not have enough mental health providers to serve DC residents in 2023 according to federal guidelines. In 2021 Suicide was the 3rd leading cause of death for ages 10-24 and 25-34. Depression is the most common condition associated with suicide and is often untreated. 30.7 % In DC reported mental health conditions compared to national data of 32.3% in February 2023 survey. Unmet need for counselling and therapy in adults reporting symptoms of mental health conditions in an April - May 2022 survey was 49 .3 % in DC compared to 26.8% national average, higher in all states.

We urge therefore the Council to support the suicide prevention strategy of better advertising the 988-crisis helpline to youth by putting signs up in schools or having 988 on student IDs; advertising access to crisis services will help get youth connected to mental health care regardless of insurance status. In addition, we recommend putting up 988 crisis helpline signs in shelters, and substance abuse treatment centers, more investment in expanding mobile clinics, and crisis services to meet the mental health needs of vulnerable residents.

Please do not hesitate to contact me at gouba1@aol.com or (703) 255 1569 if you have any questions, or would like to discuss further.

Thank you for considering our views.

Testimony of
Susan Sedgewick
Before the Committee on Health
April 29, 2024

Thank you, Chair Henderson and members of the Committee on Health, for allowing me to testify today with regards to the city's FY25 budget and specifically the DHCF budget

My name is Susan Sedgewick; I will be 80 this year. My husband, now 84, has lived in DC over 60 years. We are lucky that our son and his wife, both born and reared in DC, have chosen to raise their three children in DC. We want to continue to live in our community as we get even older. DC is our home.

In 2017, as a volunteer with Capitol Hill Village, I became aware of the **shortage of home health care aides, specifically those who care for the elderly.** This direct care workforce is critical for older adults and their families; we will need aides to care for us as we become unable to care for ourselves. Through CHV's research, we learned that several city agencies have various responsibilities for supporting this workforce, including DHCF, the Medicaid agency. As this agency provides the funds for paying the great preponderance of aides in the city, it is very powerful as it "makes the market" in DC.

The current shortage of direct care workers is real. Thirty percent of the DC workforce did not renew their certifications in 2023. DHCF's current wage levels for these jobs are too low to retain or recruit people to this workforce. People can find jobs in other sectors that pay more and demand less; these jobs do not require the considerable out of pocket funds for training and certification required of those providing elder care.

Even though FY 25 is a tight budget year, the city needs to address the needs of its aging adults who no longer can care for themselves. Increasing the wages to the level required by OSSE and Department of Labor workforce

programs ($ 23.13) will ensure attention is paid to the development of this workforce. These programs do not want to invest in low paying jobs; higher wage levels will make the jobs eligible for such programs to include apprenticeship programs.

My ASK: The DC Council make funding increased wages for direct care workers a priority along side of funding for Child Care workers. I urge the Council to allocate $17.5M of local funds for DHCF to raise the wages for the Direct care or eldercare workforce to a level that will make these jobs eligible for OSSE's Career and Technical Education Training program. Recognizing a wage increase is not a "one time" budget event, the Council should let the administration know it is expected they will budget for this level of wages for direct care workers in future budgets.

Lastly, I want to thank the Chair for introducing the Direct Care Worker Amendment Act of 2023. I urge its earliest passage. Its provisions, if **implemented correctly and in a timely manner**, will help alleviate the current shortage.

Thank you for this opportunity,

Susan Sedgewick
223 8th Street SE

Council of the District of Columbia
Committee on Health
Christina Henderson, Chair

Testimony of Cheryl Dondero
Director of Government Affairs
Gaudenzia/RAP

Fiscal Year 2025 Budget Oversight Hearing
Department of Behavioral Health

April 10, 2024

Good afternoon, Chairperson Henderson and Members of the Committee on Health. My name is Cheryl Dondero, Director of Government Affairs for Gaudenzia/Regional Addiction Prevention, Inc. ("RAP"). I am pleased to be here today for the first-time presenting testimony on behalf of RAP in my capacity.

Thank you for holding today's Fiscal Year 2025 Budget Oversight Hearing on the Department of Behavioral Health. I would like to begin my testimony by offering a sincere message of gratitude to the District's Department of Behavioral Health and its excellent team of professionals, led by Dr. Barbara Bazron.

As we all know, the District is facing a very difficult budget season. Mayor Bowser's proposed Fiscal Year 2025 budget for the Department of Behavioral Health of $385,536,240 represents a 1.4% increase over the FY2024 approved budget. This extremely modest increase, however, masks the difficult choices and trade-offs, which resulted in a host of internal spending reductions, due to increased costs. We have no doubt of Mayor Bowser's commitment to meeting the behavioral health needs and challenges of District residents and are confident these reductions are temporary in nature. With that said, now is the time to stretch our existing resources while planning for better days.

To be sure, there is much to be done to confront the opioid crisis gripping the District. According to the most recent report from the DC Office of the Chief Medical Examiner, opioid related drug overdoses more than doubled between 2018 and 2022, from 213 to 461, respectively. Tragically, for the first 10 months of 2023, the District averaged nearly 43 deaths

per month – a 13% increase over the average of 38 deaths per month during the same period in 2022.

In response to the opioid epidemic, Mayor Bowser and the Council, including Chairperson Henderson, have undertaken a series of proactive actions, including public hearings, emergency legislation, Mayoral Orders, standing up and supporting the Opioid Abatement Advisory Commission, an exciting new Sobering Center, and a promising new Peer Specialist Certification Program. Most recently, on March 13th, the Mayor extended the Declaration of Public Emergency focused on the Opioid Crisis to September 17, 2024.

At RAP, we believe that a critical part of addressing the opioid crisis, and the accompanying deaths, is providing safe and effective substance use disorder ("SUD") treatment, including residential treatment. Regrettably, the District's residential SUD providers are still recovering from the collective impact of the COVID-19 pandemic. Increasing costs for supplies, difficulty in recruiting and retaining high-quality personnel, and residual fears associated with seeking residential SUD treatment, have imposed serious challenges on the operating budgets of the District's residential SUD providers. In the past couple of years, as you know, two of the District's seven residential providers ceased operations: Safe Haven Outreach Ministries and Salvation Army's Harbor Lights. More would have closed if not for the incredible efforts of DBH's Director, Dr. Barbara Bazron, and its Chief Operating Officer, Mr. Michael Neff, in securing additional funding for the remaining providers.

Notwithstanding its challenges, the importance of RAP to the District's recovery infrastructure cannot be overstated. For more than 50 years, RAP has been the indispensable provider of SUD services to the District's most vulnerable residents. Indeed, RAP is the *only* District entity that provides a full continuum of SUD treatment services, including:

- Crisis Stabilization/24-hour observation,
- Walk-in assessment and referral services (A/R),
- Withdrawal management/ detoxification (ASAM 3.7 WM),
- High intensity, clinically managed residential treatment (ASAM 3.5 & 3.3),
- Low intensity, clinically managed residential treatment (ASAM 3.1), and
- Intensive outpatient and standard outpatient treatment (ASAM 2.1 & 1).

During fiscal year 2023 RAP served over 860 individuals. Our clients are predominantly Black or African American (86%), males (74%), and over the age of 45-years-old (61%). Additionally, 62% of the clients we served were experiencing polysubstance use – using two or more illicit substances - more than one in two clients are experiencing homelessness, and at least one in ten clients is HIV+. This data does not capture the percentage of clients with a diagnosed co-occurring mental health disorder. Indeed, RAP serves the very population most at-risk from an opioid-related fatal overdose.

Going forward, we would like to work with the Mayor and Council on a few select initiatives that we believe will strengthen the District's residential SUD providers and increase our collective abilities to meet the challenges facing District residents in need of recovery. These initiatives include:

- Addressing the challenges of recruiting and retaining SUD providers in safety-net settings;
- Focused coordination between the sobering center and residential treatment options;
- Consideration of regulatory flexibility related to establishing new services; and
- A review of existing SUD residential rates to ensure their adequacy.

Finally, in the event that additional financial resources become available in FY 2025, as a result of the Opioid Settlement, we respectfully request that the Council consider including Budget Support Act language to target improvements in safety-net residential SUD services. To that end, we have attached draft language for the Committee's consideration.

Chairperson Henderson, thank you for the opportunity to testify. I am happy to answer any questions that you and your colleague have.

SUBTITLE X.

Sec. XXXX.

This subtitle may be cited as the “Safety-net Residential Substance Use Disorder Capacity Enhancement Act of 2024”.

Sec.XXXX. Safety-net Residential Substance Use Disorder Capacity Enhancement Report.

By September 30, 2025, the Office of Opioid Abatement, established pursuant to Section 8 of the Opioid Litigation Proceeds Act of 2022 (effective March 10, 2023; D.C. Law 24-315), shall submit to the Council a report detailing residential substance use disorder (‘SUD”) treatment services in the District for Medicaid and Alliance beneficiaries. The report shall include:

(1) A census of existing residential SUD bed capacity, based on The American Society of Addiction Medicine (“ASAM”) Criteria, for services at levels 3.1, 3.5 and 3.7, or comparable classifications;

(2) An analysis of whether the existing bed capacity described in paragraph (1) of this section is sufficient both quantitively and qualitatively to meet the needs of District Medicaid and Alliance beneficiaries, including pregnant women and women with children;

(3) Individual reimbursement rates for each of the levels of services described in paragraph (1) of this section, including for medical services and room and board;

(4) An analysis of the sufficiency of the rates described in paragraph (3) of this Section to properly treat Medicaid and Alliance beneficiaries, including a comparison of these rates with those of surrounding states and the federal government for the same levels of care; and

(5) Recommendations regarding how to address capacity and quality issues regarding residential SUD services, if any, as well as suggestions for establishing a rate methodology that will ensure sufficient capacity and quality for various ASAM Levels of Care.

Testimony of Justin Hills, MD
Pediatric Resident, Children's National Hospital
Committee on Health
Department of Health Care Finance
Fiscal Year 2025
Council of the District of Columbia

Good morning Chairperson Henderson and members of the Committee on Health. Thank you for the opportunity to address the Council as it conducts this budget oversight hearing for the Department of Health Care Finance. My name is Dr. Justin Hills and I am a Pediatrician and proud Ward 5 Resident. I write to you today not only as a pediatrician deeply committed to the health and well-being of our community's children but also as a concerned citizen who recognizes the vital role that home visiting programs play in shaping the environments in which our city's children grow and thrive.

First and foremost, I want to extend my heartfelt gratitude for your dedication to addressing the multifaceted needs of our city, including those pertaining to the health and development of our youngest residents. Your efforts to prioritize initiatives that promote healthy living, access to quality healthcare, and safe environments for children are invaluable in shaping their future.

In FY25, the Council should retain its commitment to children and families in the District and fund the Nurse Family Partnership Program and fund the updated FIS for the Medicaid Reimbursement Bill.

Home visiting programs provide invaluable support to families during critical periods of child development, particularly during the prenatal and early childhood years. By offering guidance, education, and resources directly within the home environment, these programs empower parents with the knowledge and skills necessary to promote their child's physical, emotional, and cognitive development.

Research consistently demonstrates the significant benefits of home visiting programs, including improved maternal and child health outcomes, increased parental confidence and competence, and enhanced school readiness for children. Moreover, home visiting has been shown to reduce the incidence of child abuse and neglect, as well as mitigate the long-term impact of adverse childhood experiences.

In the District, NFP has served over 100 families in the past 3 years and is actively serving over 80 families. NFP began as a pilot program and, in FY25, the pilot program is ending, and funds will lapse. Such a loss would be devastating for the 80 families that would be cut off from care; furthermore, all the nurses and healthcare providers who do this important work will be forced to find other jobs.

As a pediatrician working closely with families from various backgrounds, I have seen firsthand how unfilled gaps between the doctor's office and a child's home can have devastating impacts. For example, I am reminded of a 4-year-old girl with Sickle Cell Disease who presented to the hospital with a life-threatening blood infection simply because her mother could not afford to

refill her daily prophylactic antibiotic. Her mother was unsure of whom to contact for support and instead prioritized other crucial family needs. Families like these would benefit greatly from home visiting as these programs provide direct access to community health resources. Supporting home visiting programs further bolsters the Council's unwavering commitment to addressing healthcare disparities and building an equitable society for our children to inherit.

In conclusion, I want to express my sincere appreciation for your unwavering dedication to the well-being of our city's children. Your tireless efforts to create a nurturing and supportive environment lay the foundation for a healthier, happier, and more prosperous future for generations to come. As a pediatrician and a proud member of this community, I believe access to sustainable and reliable home visiting programs through the NFP and supported by the Medicaid Reimbursement Act strengthens our community. I stand in full support of your continued endeavors and humbly ask that we continue moving toward our shared goals by continuing to fund home visiting programs.

Thank you for your steadfast commitment to our city's children.

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DISTRICT OF COLUMBIA NURSES ASSOCIATION

Department of Behavioral Health Oversight Hearing

TESTIMONY

April 10, 2024

Deborah Thomas, RN, BSN, CDES, Nurse Consultant, DCNA

The DCNA represents all Registered Nurses in DBH. I am here on behalf of these members to discuss how we can assist management in creating a safe environment for nurses to practice. In January of 2019 one of our nurses was brutally attacked by a patient. This created an outrage in the health community forcing the hospital to begin to look at serious strategies of prevention. We commenced a meeting with administration as directed by the City Council (Vincent Gray) to produce a plan to deal with acute issues and to provide long-term solutions.

We began monthly meetings February 2019 with a multidisciplinary team from the administration nursing, psychiatry, and other union personnel. A plan was presented to look at the most acute problems that needed addressing immediately. This has continued since that time. There has been extraordinarily minor change since then. The

conditions of work currently foster all levels of risk for nurses and the patients they serve**. Is there a budget crisis in DBH?**

The first and major unsolved issue is overall safety. The hospital placed cameras on the units to observe nurses but has refused to place security barriers on each unit to protect nurses. During emergencies we are forced to work with limited resources for our security without the help of an emergency response team. The staffing matrix at the hospital was created years ago and is not applicable to the needs of a variety of clients. The nursing administration has refused to change this to reflect a new and different population.

Despite working very closely with administration no demonstrative change has occurred. The hospital has cut overall nursing education reflecting in poorly trained personnel and decrease in mandatory education, this includes CPR. All these factors contribute to an environment that is nontherapeutic and unsafe.

Secondly, there is a lack of supplies and or severe delay in supplies creating chaos daily. We consistently run out of supplies of daily living such as soap, toothpaste and detergent and underwear. Specialized items such as glasses and walkers take months to receive, creating gross delays of treatment and or discharge.

Thirdly, the lapses in technology have created a system that is creating errors in documentation and delivery of safe treatment. This is a departure from federal guidelines which mandated all hospitals create electronic charting systems to keep down errors and to provide appropriate internal communication among providers. The Avatar computer system cannot talk to the glucose monitoring system. The glucose monitoring system is over 20 years old. The system for validation of results is flawed

due to age. Research shows that validity of these system is related to age and the process of validation of results. Over 80% of St. Elizabeths patients have Diabetes Mellitus. Antipsychotic medications as a rule usually contribute to Diabetes development and treatment. This is the only system in house and there are no other systems to provide validation of results. Treatment is based on its results and its accuracy is highly questionable. Durable medical equipment and other supplies are hard to come by. The hospital has no method on how supplies are ordered, tracked, and kept at safe levels.

This is a request that the council in its oversight direct DBH to begin the process of looking at a new glucose monitoring system and the technology to support it. This is to include a review of systems for monitoring supply- chain issues to keep appropriate levels of supplies on hand. The creation of an expert panel to look at changing the staffing matrix and the creation of an emergency response team. The placement of safety barriers on all units and the standardization of safety policies on all units. There is supplemental testimony being submitted by our RN and Nurse Practitioner Staff.

Thank you,

Deborah Thomas, RN, BSN, CDE, Nurse Consultant, DCNA

Nancy Boyd, RN, MSN

Nurse Educator, St Elizabeth Hospital

Darryl Stewart, DNP, AGPCNP-BC

NP Primary Care, ST. Elizabeth Hospital

To: The Honorable Christina Henderson, Chair, Committee on Health
Members of the Committee on Health
From: Kelly Sweeney McShane, President and CEO, Community of Hope
Chair, DC Primary Care Association
Re: Budget Oversight Hearing for Department of Health Care Finance
Date: April 29, 2024

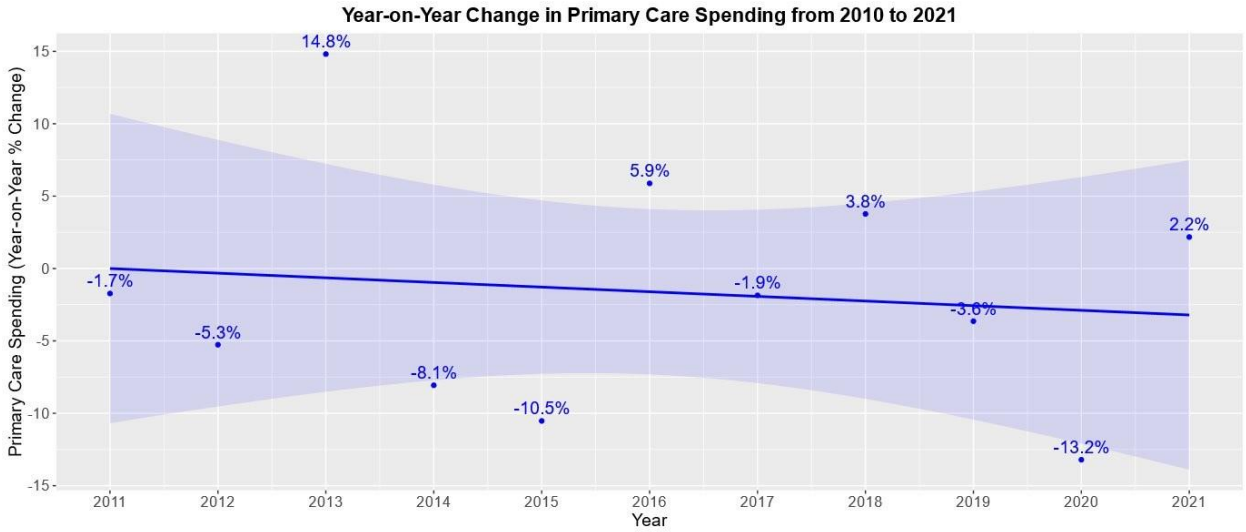
I am Kelly Sweeney McShane, President and CEO of Community of Hope. Community of Hope's mission is to improve health and end family homelessness to make Washington, DC more equitable. I am also here today in my role as the Chair of the DCPCA Board of Directors, and as a member of the DC Connected Care Network. I embrace the following recommendations for the Department of Health Care Finance to drive the improvements in outcomes and health equity our patients deserve:

1. Invest in infrastructure for Federally Qualified Health Centers and the DC Connected Care Network
2. Support comprehensive primary care models with a strong focus on team-based care
3. Require MCOs to develop primary care-centric value-based contracting models
4. Integrate social care into health care system transformation.

My testimony will focus on the need to invest in team-based care.

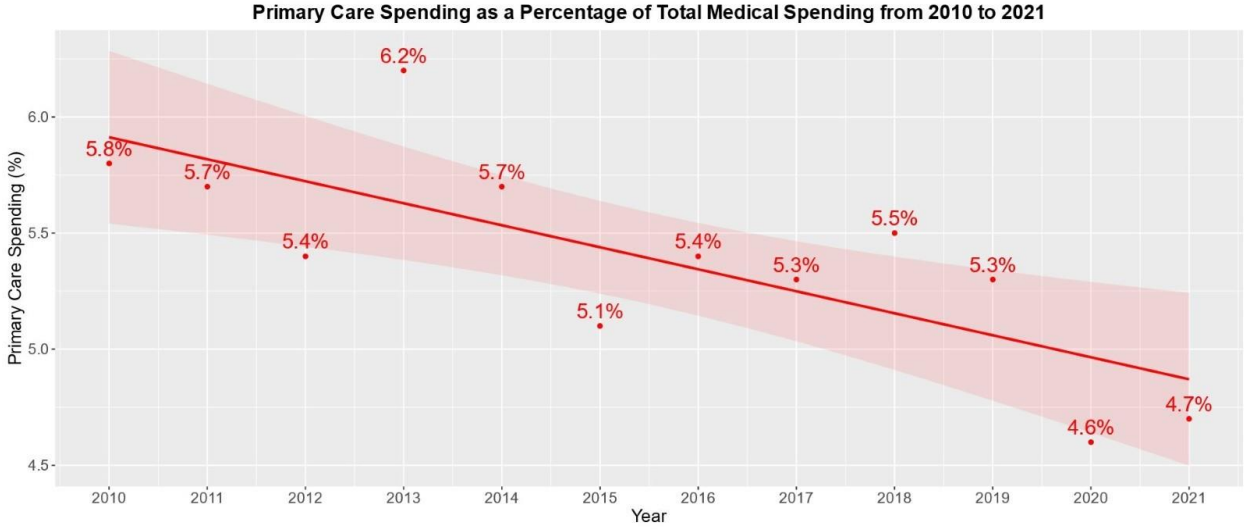
Despite its importance to overall health and well-being, primary care spending is in the single digits compared to spending on specialty and hospital care. The United States is experiencing a national shortage of primary care physicians and other advanced care providers resulting in diminished access to basic medical care, preventive services, overutilization of expensive specialist care, greater costs, and poorer health outcomes. At the same time, primary care spending remains stagnant in the U.S., with primary care spending as a percentage of total health spending never increasing by a single percentage point compared to the average of 5.4% between 2010 and 2021, according to data from the Milbank Memorial Fund.

Below, we show the year-on-year change in primary care spending nationally from 2010 to 2021. Overall, spending remains stagnant, with a nearly horizontal trendline. In the DHCF budget for FY25, primary care spend comes in at well under 5% of the total.

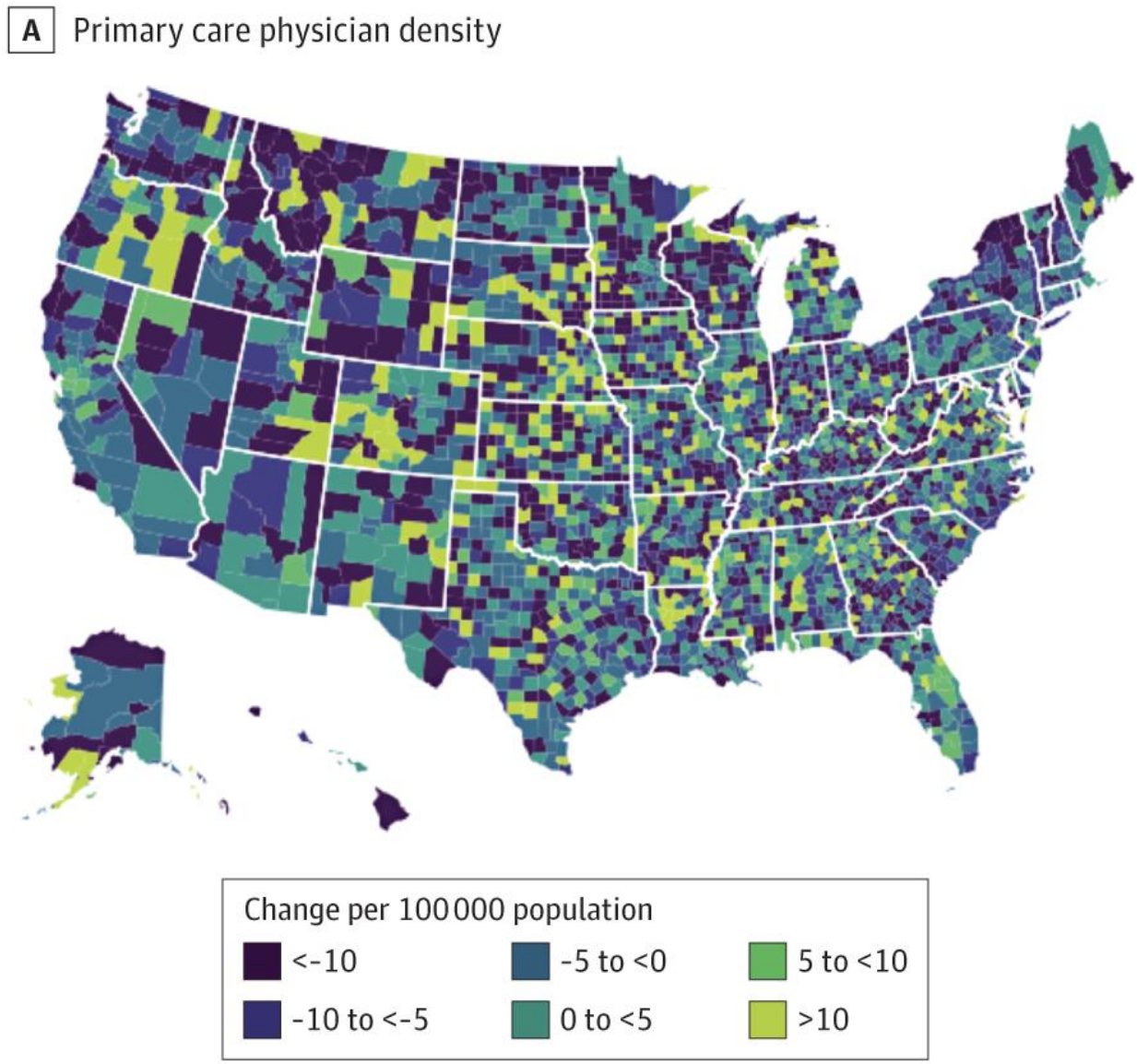


Source: Appendix, No One Can See You Now: Five Reasons Why Access to Primary Care Is Getting Worse (and What Needs to Change), Milbank Memorial Fund, 2024.

Below, we show that primary care spending in absolute terms has declined between 2010 and 2021.



The number of primary care physicians (PCPs) is decreasing. Darker blues represent decreasing PCPs, lighter greens represent increasing PCPs. The map of PCPs is becoming darker blue:



As the health system confronts the shortage of primary care physicians, we must increase investment in team-based care models that coordinate and integrate care between non-physician care providers and other support staff. Team-based primary care is associated with greater quality of care, responsiveness to change, and ability to adapt team roles, shown by an observational study published in the Journal of Internal Medicine. The CCN is an opportunity to improve care coordination, care management programs, and outreach and engagement strategies. Network members can access shared information systems and data, shared best practices, and enhanced capacity as a collective body vs as individual FQHCs.

Good evidence shows that increasing primary care spending and team based care does improve health outcomes. At Community of Hope, we have invested heavily in team-based care, primarily through DC grants and philanthropy. For example, we are implementing a Community Health Worker model through a DC Health grant. We have also deeply invested in perinatal care coordinators and other wraparound support services for the perinatal period, as shown in the below graphic.

We are seeing excellent results as a result of this care. For example, Community of Hope is rated in the top quartile of FQHCs nationwide with regards to patients with controlled hypertension and diabetes. Even as the total number of hypertensive and diabetic patients has grown at our sites, these measures have improved. At our Ward 8 site, the percentage of hypertensive patients with controlled blood pressures has reached 71%, and diabetic patients with A1Cs less than or equal to 9 has reached 79%—an all-time high. At our Ward 1 site, the hypertensive measure is at 83% and diabetic measure at 81%.

In terms of maternal health outcomes, at Community of Hope, the percentage of newborns with low birth weights dropped from 11% in 2022 to 9% in 2023. This is in comparison to 14% to 15% for residents of Wards 7 and 8. Also, the preterm birth rate dropped from 11% to 10%, in comparison to 13.3% for Black birthing people in DC. As you know, these are very hard numbers to move and we are pleased to see that our model is making an impact.

Unfortunately, these interventions are currently all covered with grants, and we need a sustainable funding mechanism that would allow all providers to scale these interventions.

We need investment in the CCN's primary care infrastructure to secure the greatest benefit for the greatest number, and at least cost. DHCF has opportunities to increase investment in primary care in general and team-based care specifically including:

- Direct investments in the CCN and FQHCs by DHCF to help build team-based care capacity.
- The 1115 waiver for health-related social needs (HRSNs) that includes resources for primary care infrastructure.
- State plan amendment that facilitates sustainability for community health workers and perinatal navigators
- Several CMS primary-care focused initiatives,
- Alternative payment methodologies for federally qualified health centers, and
- A Managed Care quality strategy that requires reporting on and increases in primary care investment.

We appreciate the Department's consideration of all of these vehicles to best align with our shared goals to increase primary care capacity, improve access, and support health centers' delivery of high-quality team-based care. We look forward to further progress and welcome the opportunity to brief this committee on defined strategies for improved primary care investment and the impact of team based care.

DISTRICT OF COLUMBIA NURSES ASSOCIATION

Department of Health Oversight Hearing

Children's School Services

TESTIMONY

April 10, 2024

My name is Deborah Thomas, I am a Nurse Consultant employed by the District of Columbia Nurses Association. We represent Registered Nurses and Licensed Practical Nurses in Children's School Services. This testimony is being resubmitted, there have been increasing incidents of near misses and inappropriate responses to children in need. Parents of children with needs are fearful that medical IEP will not be followed safely without assessment and input from professional nursing. This is a request to DOH oversight to amend the budget to include an additional thirty million dollars to begin the process of assuring a nurse in every school. To provide funding and education to CSS on education and training of paraprofessional personnel, that their jobs will be commissure with their job description and gives the BON authority over their practice. There was one incident last month, a child was not given the appropriate treatment and had to be hospitalized. Please consider that we are playing Russian

roulette with our children and breaking the law. Our children deserve better, they have a right to an environment of safety. Thank you.

The testimony to follow was presented January 16, 2024.

On November 22, 2023, we sent a letter to the DC Board of Nursing (DCBON) seeking assistance in looking at the Cluster model which was unceremoniously started in September 2023. This letter outlined growing concerns that CSS administration has been allowed to circumvent The DC Nurse Practice Act and HORA. Creating a model that would allow unlicensed personnel to have greater responsibilities in the Health Suites and require the professional nursing staff to provide remote delegatory support to three to four schools in each Cluster, this leaves most schools without professional nursing support. Delivery of service is being inappropriately delegated to unlicensed personnel who have not been trained as set forth by the DC BON Trained Medication Employee program (TME).

This model violates *The Public-School Amendment Act of 2017*, which states in part beginning August 1st, 2018, a Registered Nurse shall be assigned to each public and public charter school for a minimum of 40 hours per week. The DC Nurse Practice Act which states, DC Code 38-621 (a) A registered nurse shall be assigned to each DC elementary and secondary school a minimum of 12 hours per week, then increase 16-20 hours per week beginning 2 years later. *DC law 17-1707*, The Student Access to Treatment *Act of 2008(SATA*) states in part, Allied health professionals perform

selected tasks, including medication administration, under the supervision of Registered or Licensed Practical Nurses.

There are violations of the Americans with Disabilities ACT (ADA) as well in providing care to children with chronic illnesses such as Diabetes and Asthma. This ignorance points to a lack of knowledge of nurse practice in this setting and the legal liability associated with DOH allowing CSS to violate the law, most importantly, the safety of our most vulnerable children. Let the record show that the DC City Council sanctioned these actions in June 2023 Budgetary hearings without consulting the DC BON or the DCNA, these are your experts. CSS has lost at least 30% of their professional staff since September 2023. Mostly to schools in Prince Georges County, which provides a level of respect and stability. There is maddening chaos in the schools now, the unlicensed personnel are confused about their responsibilities, nurses are practicing remotely without satisfying their professional responsibilities.

This report was sent in by a school nurse on January 12th ,2024 and it illustrates these points vividly.

“One RN cannot properly do case management and make sure plans are implemented for that number of students. In most of the care plans I and other DCPS nurses do. We have never seen the students because there is not enough time to go to every school and assess the students. I am not at any one school long enough to follow up. Techs cannot follow-up with major diagnosis. One RN cannot oversee a tech with no license working remotely, one RN cannot respond to emergencies at various locations while already caring for students at your assigned locations. My tech wants more time with me, they thought they were collaborating with the nurse, not replacing

them. The telehealth system cannot substitute for nurse assessment. Many of my colleagues left for Maryland schools where the administration understands the role of the nurse and laws that govern healthcare."

In conclusion this is a request that the DC City Council Committee on Health intervene on this issue before a child suffers from our lack of legal accountability. We have an opportunity to create a model of change, A nurse in every school is just the beginning. We can attract and create a pool of trained personnel; the city has the resources in education systems to do just that, but CSS must at least be held to the standards of appropriate care delivery as outlined in DC law. We need leaders that have experience in school health and understand the needs of all our children.

Thank you,

Deborah Thomas, RN, BSN, CDES

Nurse Consultant, DC Nurses Association

Testimony of Claudia Balog, Assistant Director of Research

1199SEIU United Healthcare Workers East

FY 2025 Budget Oversight of the Department of Healthcare Finance

Council of the District of Columbia Committee on Health

April 29, 2024

Dear Chairperson Henderson and members of the Committee on Health,

Thank you for the opportunity to testify at this Budget Oversight Hearing. My name is Claudia Balog. I am an Assistant Director of Research with 1199SEIU United Healthcare Workers East. We are the largest healthcare union in the country, with 400,000 members across healthcare settings in New York, New Jersey, Maryland, the District of Columbia and Florida. In the District of Columbia, we represent thousands of healthcare workers in Hospitals, Clinics, Skilled Nursing and Assisted Living Facilities. I submit this testimony on behalf of all healthcare workers who are struggling to survive on poverty wages, while consumers who depend on them face the impact of severe staffing shortages.

We urge this council to identify funding in the District's Budget that would support the goals of the Direct Care Worker Amendment Act. This is a necessary step in addressing the documented direct care workforce crisis facing District of Columbia residents. The failure of this proposed budget to include money to address the wage gap for the workers who provide care for the elderly and disabled will exacerbate the documented direct care workforce crisis facing District of Columbia residents. We need to raise these workers' wages, while creating a progressive wage scale that recognizes workers' experience and credentials is equally important to retaining workers in this industry.

The shortage of home health aides and CNAs in the District is not new. These jobs have always been characterized by high turnover. Our members include CNAs at Skilled Nursing Facilities who often moonlight as Home Health Aides, to make ends meet. We know that from the perspective of long-term care workers, their skills and experience allow them to jump from one setting to another. We know that they make the decision to work across multiple care settings because their wages are too low.

Multiple national studies have confirmed that the District's wages for direct care workers are too low. In the last year, according to the Board of Nursing, 4,489 direct care workers did not renew their certifications and left the DC workforce. This is an astonishing 30% drop in the

number of aides who can work in DC in just one year. This data is reflective of the lived experience of our members who work in long-term care congregate facilities. Workers are exhausted, caring for increasing numbers of residents with complex medical needs. These workers are unable to pay their bills, and they are leaving the healthcare industry.

Meanwhile, this reverberates throughout the healthcare continuum. Our members in other post-acute settings, such as Federally Qualified Health Centers, have personally described to me how they see the impacts of this staffing crisis on their patients. One of our members at the Whitman Walker clinic described to me how patients regularly miss medical and legal service appointments, because they had no aide to get them there. Patients are also seeking additional legal services because they are not receiving the number of hours of care that they were approved for.

It seems as if everyone in our fragmented healthcare delivery system recognizes that there is a problem, and yet there doesn't seem to be the will to dedicate the funding necessary to address it.

This workforce crisis is an equity crisis. More than 87 percent of direct services workers in the region are people of color. Black or African American women constitute most workers across all these care settings and many in this workforce are immigrants.[1] Looking at direct care workers across care settings, 71% are on a form of public assistance.[2]

Any plans to address the systemic staffing crisis that stakeholders are experiencing in healthcare must address the low wages of direct care workers – both the home health aides and CNAs who comprise the "Care force"– across the long-term care delivery system. The American Rescue Plan provided a unique opportunity to address these systemic workforce issues by jumpstarting a new wage **floor.**

Unfortunately, the Districts efforts to increase wages for workers in this sector did not go far enough. You have seen workforce survey data collected by the DC Lont-Term Care Coalition that shows a drastic decline in the number of workers currently certified to provide care in both home and congregate settings. Meanwhile, our members in skilled nursing facilities have experienced drastic changes in their day-to-day work as the acuity levels of residents in Skilled Nursing Facilites increase. CNAs report caring for more residents on ventilators, with traches, or who need wound care, or the services in memory units. T**he higher demands of their jobs should be reflected in their pay. We therefore believe that the District should build career ladders into the entry-level jobs of the long-term care workforce**.

In a study highlighting the wage gap between direct care workers and other entry level jobs, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health & Human Services found that, in 2019, home health and personal care aides earned lower wages than other entry-level workers in all states and nursing assistants earned lower wages in 40 states and the District of Columbia (DC).[3]

I would like to use the rest of my testimony to provide examples of how states are investing in their workforce infrastructure. Some of the states below focused on DCWs in Home and Community Based Services, some in Skilled Nursing, while a few targeted workers across the

LTC industry. There has not been a one-size fits all approach to this investment. Looking to other states, 1199SEIU believes that successful approaches to workforce investment have included some of the following

- **The jurisdiction is trying address the wage and working conditions for direct care workers across the Long-Term Care industry, not just the HCBS or nursing home/congregate setting segment of the industry;**
- **The approach includes strong investment to create a stable workforce, ideally with wages that reflect the skills and experience of care givers;**
- **The approach includes strong Government Executive-level engagement, characterized by multi-agency collaboration to enable industry reform**

Workforce Investments Across the United States

I. **Example of Wage Pass Through**

To date, twenty-two (22) states have adopted "Wage Pass Through" policies through their State Medicaid Agencies, and many of these mandate that a certain percentage of Medicaid dollars are devoted to staffing.[4] In the District, the Department of Healthcare Finance passes through a specific payment to Medicaid Home Care agencies that funds an average wage now set to 117.6% of the District's Living Wage. Wage Pass Throughs can be an important tool to raise wages, however they require two things: 1) That the rates are adequate to fund these jobs to be good jobs with progressive wage scales, and 2) Active auditing of Medicaid Cost Reports filed by providers to ensure that the reimbursement is being directed appropriately. **Unfortunately, as evidenced by data collected about workforce retention, the District's current pass-through is inadequate to fund jobs to sustain a qualified workforce.**

Michigan, notably, used ARPA funds as a launchpad to implement wage pass-throughs for workers including CNAs providing care in both long-term care facilities and in-home settings.[5] These increased wages were later made permanent in the State budget.[6]

New Jersey released a report in 2020 outlining key steps to strengthen the resilience of nursing homes, finding that low wages were responsible for high turnover. In response, New Jersey increased Medicaid nursing facility rates with requirements that this additional revenue be spent on wages.[7]

II. **Examples of Investment in New Wage Floors**

States within the 1199SEIU footprint that have created new wage floors for DCWs in the home care space include **New York**,[8] **Massachusetts**[9] and **New Jersey**.[10]

Maine is a notable state for the progress it is making in addressing its DCW shortage. Upon the recommendations of a Commission to Study Long-Term Care Workforce Issues, Maine created a wage floor policy that applies to both CNAs and Home Health Aides.[11] Much of the progress that is being made in Maine is the result of collaborations between their Department of Health,

Medicaid Agency, their Department of Labor and Department of Education, as well as the Maine Community College System, the University of Maine.

The state initially used pandemic relief funds to create wage bumps for direct care workers. Then, in 2021 Governor Janet Mills dedicated $123 Million in funding, including $30 million in General Fund dollars for nursing facilities, residential care facilities, and adult family care homes to help address workforce issues by retaining current staff or hiring new staff. This is in addition to a recent $19 million investment in Skilled Nursing Facilities to improve the salaries of direct care staff.[12]

North Carolina. In 2022, North Carolina's legislature increased the hourly wages for direct care workers under the State's Medicaid HCBS waiver program to $15 per hour from the then-current rate of $7.25 per hour. This amounted to a $210 million dollar investment by the State, and these rate increases are intended to be permanent.[13]

Washington. Washington state has allocated close to $48 million in the 2023 state budget to target wage increases for certain job categories. The intent is to provide Medicaid funding to raise wages for some of the lowest-paid jobs in nursing facilities; these include direct care (DC) and indirect care (IDC) staff (dietary, laundry, medical assistant; IDC- housekeeping, reception, transportation, etc.) In an example of multi-agency collaboration, the Department of Social and Health Services (DSHS) is directed to work with stakeholders to develop a verification process to demonstrate how providers will use this increased funding to increase the targeted wages.[14]

III. Examples Where States Created New Wage Scales and Incentivized Experience/Training

Illinois created a pay scale for direct care workers based on years of experience and the promotion of career ladders. Governor Pritzker signed legislation that will invest more than $700 million in Medicaid funding for nursing home rate reform. The reform includes a new pay scale for certified nursing assistants (CNA) that will increase wages based on years of experience. This legislation created the CNA incentive program, an optional program in which participating nursing facilities can receive funds subsidized by Medicaid if they implement the CNA experience pay scale. For CNAs with at least one year of experience, their wage will increase by at least $1.50 per hour. The pay increase goes up by $1 for each year of experience and tops out at a $6.50 per hour increase for those with six or more years of nursing experience. In addition to years of experience, Medicaid will also subsidize CNA raises for promotions or added duties at a rate of an additional $1.50 per hour.[15]

Tennessee is similarly using their enhanced FMAP funding to invest nearly $140 million in wage increases for direct care workers in their Medicaid HBCS Waivers. This is on top of dedicating $60 million to workforce development initiatives. Tennessee agency officials have also stated their commitment to finding ways to source these wage increases when the federal dollars run out in March 2024.[10] Tennessee provides a great example of the kind of multi-agency collaboration necessary to impact the industry. State Agencies are coordinating with the Tennessee Board of Regents to award 18 hours of college credit and a post-secondary certificate for completion. Courses will be embedded within multiple degree paths and rolled

out through Community Colleges and Technical schools. The State Medicaid Agency is the key driver to underpin their workforce development plan. Under this plan, for each competency a worker achieves, they will receive a pay bump. The total incentive is as much as $6,000 a year for a Full-Time worker once certification is completed. Enhanced FMAP funds will be used to reimburse providers for these higher wages.

Minnesota, Ohio, Oregon and Pennsylvania also have workforce policies in place that provide for increased wages upon completion of certification or training programs.[16]

This list is not exhaustive, and even today, Medicaid Agencies, State Departments of Health and legislatures across the country continue exploring ways to bolster their states' direct care workforces. Please do not hesitate to reach out to me at claudia.balog@1199.org should you have any additional questions concerning what has been presented in this testimony.

Brady Woodhouse

Hi all, my name is Brady Woodhouse and I am a Type 1 Diabetic Student at School Without Walls, and the founder and president of the Health Justice Club. One of the first things I asked about in my Interview for Walls were the accommodations that were provided for students with chronic illnesses like me. I noticed that my interviewer was flustered, and though I thought it was because he simply didn't know any students with chronic conditions, I know now that it's because he was afraid to explain to me the real state of nursing in DCPS schools. I'm here to advocate against the utilization of the cluster-model that DCPS adopted as a result of DC's nursing shortage. For most DCPS schools, a region of 4 schools has to split the time of only one registered nurse, with other medical staff filling in despite not having the full capacity of a registered nurse. As a result of this system, I, as a Type 1 Diabetic, have a subpar support system when it comes to my low or high blood sugar levels. If none of you here know exactly what a diabetic low blood sugar is like, I'd first consider you lucky, but then I'd add that it can become hard to maintain consciousness, and even in less extreme circumstances, it is impossible to fully focus on the content at hand. Walls is lucky to have its own part-time nurse, but I have type 1 Diabetes more than 3 days a week. When I was fed up with having my medical resources in a closed nurse's office because she isn't full time, I decided to start the Health Justice Club. I learned I was one of many DCPS students who are negatively impacted by the nursing system that DCPS uses. Our club has been working with SBOE representatives Henderson and Goulet, and they have advised us to express our concerns about the cluster-model. When thinking of solutions, it always comes back to *money*. Nurses need to be paid competitive wages if they are going to stay at DCPS and money must be invested into enhancing the nursing industry in DC. We hope to convince you that addressing the nursing shortage in DC and DC schools is both within the ability *and* the *respons*ibility of DCPS schools. We then hope to identify pathways with you all in order to implement our changes, or other changes that help to address the nursing shortage.Thank you for your time and I hope to work with you all in the future to start making a difference both in and outside of DCPS schools.

TESTIMONY
by Mary Procter
Capitol Hill Village

before the Committee on Health
Budget Oversight Hearing on April 29, 2024

Good Afternoon, Chair Henderson and members of the Committee on Health. My name is Mary Procter and I am a member of the Advocacy Committee for the Capitol Hill Village (CHV) and also of the Workforce Subcommittee of the Long Term Care Coalition. I am here to advocate equitable budgets for the care of elders and the disabled.

At the beginning of the DCFH budget portion of the hearing, two people, James Jean-Claude and Kevin Moates, testified virtually on how their health and lives suffer when Home Health Aides do not come or who come ill-prepared to care for them. Neither is ambulatory and both need hands on assistance to take care of their most basic needs. They represent hundreds of “Hidden Voices” who cannot come to the Wilson building to testify in person or wait many hours to testify virtually. I am very grateful for their testimony.

Both my husband and I are 82 and creeping towards the age when we will need Direct Care Workers at home or in a nursing home. We have lived 50 years on Capitol Hill, ever since we married and we have a grown son and his family with three children 5 blocks away. We WANT to stay on the Hill as we age, ideally in our house where there are no stairs to the entrance.

My husband and I and other CHVillage members are alarmed by the following aspects of the current outlook for Direct Care Workers:

1. **There has been a sharp drop** in the number of Direct Care Workers from 2022 to 2023. Almost 4500 (30 percent of) Direct Care Workers did not renew their certifications and left the direct care workforce.
2. AARP and the much respected PHI journal (expert on the Direct Care Workforce) **rank DC LAST among US states in paying wages that compete with easier DC minimum wage jobs (such as working for Walmart).**
3. Training for jobs earning less than $23.13 per hour cannot receive money from OSSE (DC School Superintendent) or other Federally funded program that only fund "good jobs". (Current Direct Care Worker pay ranges from $17.50 to $23 per hour.) This limit will prevent workers interested in career paths in health from applying for direct care worker jobs. Even the highest paid direct care workers would not be eligible for such training.

What is Equitable for DC Families? This past week Council Chair Mendelson decided to use $217 million in funds, currently earmarked to replenish a DC reserve fund, **to restore the Mayor's cuts to the 2021 Pay Equity Fund to raise wages for child care workers**. From a family's point of view there is no difference in needing childcare or elder care. Both make it difficult to work or retain their health if there are no well-trained care-giving workers. Full Equity for elders and direct care workers' better access to training would cost less than $18 million. **Decent lives for elders and the disabled and their families are as important as decent lives for parents and their small children** and are less expensive.

Testimony for FY25 Budget Oversight Hearing for the Department of Health Care Finance
Committee on Health

Written Testimony of Disability Rights DC at University Legal Services
Lyndsay Niles, Managing Attorney

April 29, 2024

Disability Rights DC appreciates the opportunity to submit written testimony on the Department of Health Care Finance's (DHCF) FY25 budget. Disability Rights DC (DRDC) is the designated protection and advocacy agency for the District. We advocate on behalf of District residents with disabilities to promote their right to live in the community under the integration mandate of the Americans with Disabilities Act (ADA) as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). My testimony focuses on the urgent need for the District to invest equitably in all care workers in the District, including direct care workers. Although the District faces a budgetary shortfall, investments in this workforce and the long-term care population cannot wait until later budget cycles. The District's inaction to invest in this workforce continues to threaten the life-sustaining Medicaid personal care aide services (PCA) people with disabilities need to age in place and threatens to reverse decades of progress in community living.

DRDC urges this Committee to ensure that DHCF has an adequate FY25 budget to address the staffing shortages in the long-term care service delivery system, including Home Health Aides and Certified Nursing Assistants. Specifically, DRDC is troubled by the Mayor's failure to include any investments in the District's FY25 budget to increase the wages of the direct care workforce, reduce training costs, and allow for career advancement. According to cost analysis from the DC Coalition on Long Term Care, the District needs to budget $15-18 million dollars to support increased wages for this workforce. DRDC remains concerned that without a significant wage increase, vacancies will remain, workers will continue to exit the workforce, and providers will not be able to retain quality staff. In 2023, the District lost 4,489 direct care workers – a 30% decrease.[1] As a result, people with disabilities are at risk of harm and neglect.

As DRDC testified during this Committee's public hearing on the Direct Care

[1] DC Coalition on Long Term Care, DC Must Invest In The Care Economy!, April 4, 2024, at 1, https://www.dclongtermcare.org/wp-content/uploads/2024/04/Talking-Points-4.9.24-docx.pdf.

Worker Amendment Act of 2023, people with disabilities depend on reliable, quality, and competent staff to meet their long-term care services and support needs and to avoid unnecessary institutionalization. Without significant investments in the direct care workforce, the District will not be able to support the basic health and safety of individuals with disabilities living in the community, in violation of their right to live in the community. We appreciate the DC Council's ongoing leadership to address the direct care workforce crisis.

For further information:
Lyndsay Niles, Managing Attorney
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To: The Honorable Christina Henderson, Chair, Committee on Health
Members of the Committee on Health
From: Tollie B. Elliott, Sr., MD, President and CEO, Mary's Center
Vice Chair, DC Primary Care Association
Contracting Team, DC Connected Care Network
Re: Budget Oversight Hearing for Department of Health Care Finance
Date: April 29, 2024

I am Dr Tollie Elliot, President and CEO of Mary's Center. Mary's Center's mission embraces all communities and provides high-quality healthcare, education, and social services to build better futures. I am here today as the Vice Chair of the DCPCA Board of Directors, and as a member of the DC Connected Care Network Contracting Team. I embrace the following recommendations for the Department of Health Care Finance to drive the improvements in outcomes and health equity our patients deserve:

1. Invest in infrastructure for Federally Qualified Health Centers and the DC Connected Care Network
2. Support comprehensive primary care models with a strong focus on team-based care
3. Require MCOs to develop primary care-centric value-based contracting models
4. Integrate social care into health care system transformation.

My testimony will focus on the need to integrate social care into health care system transformation and the way in which the 1115 waiver renewal can support the Connected Care Network.

Mary's Center recognized early on that only caring for a patient's physical health concerns was simply not enough. To facilitate patients and their families on a path toward better health, stability, and economic independence, we knew we had to look at every part of their life and offer the appropriate combination of healthcare, education, and social support. With this in mind, we developed our Social Change Model (SCM), which allows us to offer medical, dental, and behavioral health services for the entire family, along with social services and family literacy services – all under one roof. All our fellow FQHCs in the CCN have similarly innovated to make whole person care core to their models. The Community Health Center model itself has been anchored in this approach since its inception during the Civil Rights movement.

Now, the entire health care system is recognizing the importance of Social Drivers of Health (SDOH), and Health-Related Social Needs (HRSNs). The conditions in which people are born, grow, live, work and age--which are shaped by the distribution of money, power, and resources--drive more than 80% of variation in health outcomes. We applaud DHCF's draft 1115 waiver renewal that will provide resources to address HRSNs.

We urge the following recommendations to leverage the waiver to invest in primary care:

- Support direct contracting between Medicaid and the DC Connected Care Network to meet care coordination goals and ensure community social services are integrated with clinical care
- Leverage FQHCs already-strong relationships with key social services partners
- Invest in care teams, peer navigators, and community health workers to achieve better outcomes
- Drive resources at the provider level closest to beneficiaries

Recent waiver approvals show that CMS is favoring this kind of community social health/clinical integration. DHCF should embrace the opportunity to strengthen primary care infrastructure and work force.

We appreciate the Department's consideration of these recommendations to integrate social care into health care long-term. We look forward to further progress and welcome the opportunity to brief this committee on our identified policy levers for improving the social drivers of health.

DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION

DC CONNECTED CARE NETWORK | Building Linkages Increasing Access Improving Outcomes

To: The Honorable Christina Henderson, Chair, Committee on Health
Members of the Committee on Health
From: Ruth Pollard, President and CEO, DC Primary Care Association
Executive Director, DC Connected Care Network
Re: Budget Oversight Hearing for Department of Health Care Finance
Date: April 29, 2024

The DC Primary Care Association (DCPCA) works to build a healthier DC by sustaining community health centers, transforming DC health care delivery, and advancing racial and health equity. I am Ruth Pollard, President and CEO of the DC Primary Care Association and Executive Director of the DC Connected Care Network. Thank you for the opportunity to provide testimony regarding the work and budget of the District of Columbia Department of Health Care Finance (DHCF.) I am joined on the panel by three dynamic FQHC leaders with decades of experience serving patients in need of robust, effective, and connected primary health care. Our testimonies today focus on the opportunity for health care transformation driven by our FQHC clinically integrated network, the DC Connected Care Network.

In pursuit of greater quality and better outcomes for DC residents, DCPCA has partnered with seven Federally Qualified Health Centers (FQHCs) to establish the DC Connected Care Network (CCN). The CCN heralds a new era in provision of high quality comprehensive, primary care that integrates with acute care settings and addresses behavioral health and health-related social needs. All of the District's residents deserve to thrive—DHCF's leadership and resources are needed to ensure the CCN can realize its unprecedented promise in reaching that goal.

Participating health centers are:

- Bread for the City
- Community of Hope
- Family and Medical Counseling Services
- La Clínica del Pueblo
- Mary's Center
- Unity Health
- Whitman-Walker Health

The CCN provides a structure and methodology and coordinates resources to support coordinated care to prevent avoidable hospitalizations and readmissions, minimize duplication of services, and address gaps in care. Combining the services, partnerships, and practice culture of the member FQHCs, the Network establishes a continuum of care that addresses the diverse needs of each patient. Collectively, we provide comprehensive pediatric and adult primary care,

specialty care services, chronic disease management, and various social support services, at over 45 locations throughout the city.

Primary care is the cornerstone of any developed healthcare system, providing crucial curative care, preventive services, and chronic disease management while bridging gaps in racial and ethnic disparities. DHCF has the opportunity to realize the benefits of high quality and comprehensive primary care by implementing the following recommendations:

1. Invest in infrastructure for Federally Qualified Health Centers and the DC Connected Care Network
2. Support comprehensive primary care models with a strong focus on team-based care
3. Require MCOs to develop primary care-centric value-based contracting models
4. Integrate social care into health care system transformation.

We selected these recommendations based on their significant impact on four broader targets for primary care improvement:

- Increase patient trust, which is associated with greater patient confidence in their own health and a higher likelihood of immunizations and routine check-ups.[i]
- Increase the number of primary care teams that can deliver similar services to combat the decreasing number of primary care physicians nationwide.[ii]
- Increase regularity and continuity of care, which is associated with lower costs, fewer hospitalizations, fewer emergency department visits, and decreased odds of mortality.
- Improve primary care models using components from CMS' Advanced Primary Care (APC) and Total-Cost-of-Care (TCOC) models, which show reduced hospitalizations and acute care usage while either keeping costs constant or lowering costs.

Federally Qualified Health Centers (FQHCs) achieve these four targets. The Health Resources and Services Administration recognizes all DC FQHCs as Patient-Centered Medical Homes (PCMHs), which means they provide comprehensive, patient-centered, and coordinated care. All of DC's FQHCs provide enabling services, defined as non-clinical services that increase access or improve health outcomes. FQHCs help address the primary care physician shortage by incorporating team-based care through care coordination and enabling services. FQHCs increase regularity and continuity of care by embedding themselves within communities and by increasing accessibility through enabling services. They also already incorporate some features of CMS' innovation models, such as health information exchange (HIE) of social determinants of health data (SDOH) and clinical encounter data.

Federally Qualified Health Centers (FQHCs) are the standard for high quality primary care. FQHCs serve not only as the nation's safety net, but consistently achieve better outcomes both on the national and local level here in DC. According to the National Association of Community Health Centers (NACHC), FQHCs provide more preventive care services compared to other primary care providers.[iii] In DC, FQHCs achieve higher rates of cervical cancer screening,

effective diabetes control, and effective high blood pressure control compared to MCOs and national FQHC averages.

These are all achieved while containing costs. FQHCs are well-demonstrated to reduce the rate of hospitalizations, acute care service utilization, and prescriptions. Among Medicaid enrollees, we observe 25% lower hospitalizations, 33% lower spending on specialty care, and 27% lower spending on inpatient care.[iv] Among all claims, we observe 24% lower spending overall compared to non-FQHCs.[v]

The CCN is dedicated to improving the health of DC residents through comprehensive, patient-centered primary care that incorporates innovative technology and team-based care, leverages value-based contracting, and integrates social care to deliver the best outcomes to patients. As primary care spending remains stagnant and the number of primary care physicians decreases nationwide, greater primary care investment is essential to ensuring DC resists this trend.

DCPCA and our member health centers are grateful for the partnership of Deputy Mayor and DHCF Director Wayne Turnage, Senior Deputy Director and Medicaid Director Melisa Byrd, Senior Deputy Director of Finance Angelique Martin, Director of the Health Care Delivery Management Administration Lisa Truitt, and their dedicated teams. We believe in our collective capacity to build a health system that gives every District resident a fair shot at a full, healthy life, and we stand ready to support the DC Council Committee on Health to engage in that effort.

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[i] [ii] Trust and Health Care-Seeking Behavior, National Bureau of Economic Research (NBER), 2024.
[ii] Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015, Journal of the American Medical Association (JAMA), 2019.
[iii] Community Health Center Chartbook 2023, National Association of Community Health Centers, 2023
[iv] Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings, American Journal of Public Health, 201
[v] Cost savings associated with the use of community health centers, Journal of Ambulatory Care Management, 2012.

Testimony of Claudia Schlosberg, J.D.
Chair, Workforce Development Subcommittee
DC Coalition on Long Term Care

Before the
Committee on Health
On the
FY 2025 Proposed Budget for DHCF
April 29, 2024

Good morning, Chairperson Henderson, and members of the Committee on Health. My name is Claudia Schlosberg. I am 70 years old, a 45-year resident of Ward 1 and serve as Chair of the DC Coalition on Long Term Care's Committee on Workforce Development. The Coalition on Long Term Care brings together consumers, providers, organized labor, and advocacy organizations to advocate to improve access and quality to long term care services across all settings. We are a volunteer organization, with no paid staff.

For the past four years, our number one priority has been to raise awareness of the growing shortage of direct care workers that has left seniors and people with disabilities alone and without needed care and to advocate for needed reforms. Unfortunately, since the pandemic, the workforce shortage has only grown, while demand continues to escalate. The numbers of direct care workers leaving their jobs in the DC labor market is astonishing. Last year alone, according to the Board of Nursing, the District's direct care workforce shrunk by 4,489 workers – a loss of 30% from just the prior year. The Coalition's Annual Workforce Surveys, discussions with our members and testimonies from direct care workers themselves make clear that the primary reason why workers leave is low pay and burn out. Not only does this leave seniors and people with disabilities without care, it places additional burdens on family members and threatens the viability of critical LTSS services. It will also undermine DHCF's admirable efforts to develop new value-based payment models for home health and other LTSS services.

We appreciate the fact that DHCF has used ARPA funding to provide supplemental payments to providers of home and community-based long term care services and supports (HCBS) that since the beginning of this calendar year has raised the average hourly wage of these workers to 117.6% of the living wage or $20.05/hour. However, as the BON numbers show, the wage rate increases funded by ARPA through this mechanism, have not been enough to stem the tide of workers who are leaving the District's direct care workforce. The pipeline of new workers is also shrinking. We can only replace a fraction of the workers who are leaving, and many of these new workers do not stay long. The gap between the number of workers needed to meet current demand and future need continues to grow with no discernable strategy to address it effectively.

Given these uncontroverted facts about our shrinking workforce, it is concerning that DHCF's proposed FY 2025 budget includes no increase in the wages for these workers and

no new initiatives to address the workforce shortage. In FY 2025, DHCF intends to use a portion of remaining ARPA funds to make a lump sum supplemental payment to providers to pay for HCBS workforce wages in FY 2025, but payments will be at the same rate as FY 2024. In FY 2026, DHCF plans to bake the new rate into provider reimbursement rates, but again, the average wage will remain 117.6% of the Living Wage. In other words, except for the Living Wage inflation adjustment, wages for direct care workers will remain stagnant for the foreseeable future.

As you know, Chairperson Henderson, CNAs and HHAs in DC must pay training costs that can reach nearly $2,000, complete 125 hours of training, pass an exam, take continuing education credits, and recertify every two years. The job can be physically, mentally, and emotionally demanding and to do it well takes skill, compassion, and hard work. Yet, even after DHCF increased payments to HCBS providers to enable them to page an average wage of 117.6% of the living wage, direct care workers make, on average, $4.00 an hour less than a comparably trained and certified Child Development Associate, based on the standards established by this Council under the Pay Equity Act. We fully support the goals of the Pay Equity Act, and wholeheartedly support you and the Council for committing to restoring its full funding.

But as Mayor Bowser noted when she testified before the Committee of the Whole, the District has not made a similar investment the direct care workers who care for older adults. With variable hours and often no assurance of full-time work, direct care workers often can make more as a cashier at Target or Walmart, where they can get more benefits, do not have to pay for training or take continuing education credits and are not subject to Board of Nursing oversight and discipline. In short, as both AARP and PHI, a national, respected think tank on the direct care workforce have concluded, wages for DC direct Care workers are not competitive with other comparable jobs in this labor market.[1]

Our ask is simple. We know this is a very challenging budget year, but it is critical that we find a way to raise the wages of the workers who care for the growing population of older adults and people with disabilities above the current average wage of 117.6% of the Living Wage. Through Medicaid and through DACL contracts, the District is the largest payor for these services. We therefore ask the Council to require the District to reimburse providers to enable them to pay wages to direct care workers that are comparable to the wages paid to childcare workers. While it may not be feasible to fully fund this increase in one year, we must move in this direction or more and more seniors and people with disabilities will go without care.

Thank you. I am happy to answer any questions.

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[1] How States Are Expanding Home Care," AARP Bulletin, December 2023, Vol 54, No. 10, accessed on 1/31/24 at: https://states.aarp.org/ltss-in-the-mid-atlantic

Good morning Council member Henderson. My name is Sal Selvaggio, and I am a retired dentist and member of the Iona Senior Services Citizen Advisory Group, Northwest Neighbors Village, and the DC Coalition on Longterm Care. I am here today to provide testimony on our current lack of a sufficient healthcare workforce, which is becoming amplified as DC's population becomes older, and more in need of their services.

From attending these hearings, and listening to the needs of other groups who testify before you, I've come to appreciate the difficult and important decisions you and our other government officials need to make regarding how to spend our tax dollars.
In deciding how to allocate our resources, it is most important to remember that our first duty is to protect the welfare of our most vulnerable populations. You have heard from individuals whose lives depend upon the availability of trained healthcare workers to help with their most basic activities of daily living. Their ability to be fed and to have hygienic services are not optional. When trained workers are not available, these folks must then depend on family members or friends who many times need to take off from their work. Or worse, they are left unattended for hours, to suffer the physical and psychological consequences.

The solutions needed to rectify our healthcare workforce crisis are complex. I'd like to highlight a few keystone issues that must be addressed.

The first one is providing a reasonable wage.

You have been provided the data from surveys taken from employers of direct care workers that documents that the

pool of qualified healthcare workers in the District is shrinking, and doing so at an alarming rate. There are many reasons for this, but the driving factor is that when potential workers decide on whether to take a job that will compensate them enough to feed their families and pay their bills, and one that does not, that choice is not difficult.

I have heard the argument that these potential workers will enter the field because of their deep desire to help those in need. I'm sure that this is a motivation, but as has been seen by their exodus from the healthcare workforce, the practicalities of life will trump altruism.

The second keystone issue is to create educational pipelines to ensure we will have a sufficient number of potential healthcare workers. With our District's population shifting to the older demographic, this is something that needs to be addressed now.
Some of the provisions in the Director Care Workers Act will aid in recruitment and incentivizing individuals to consider this occupation. We need to build a workforce for today and tomorrow. Students need to see these occupations as skilled careers that will provide adequate compensation, have potential for advancement, and give meaning to their work by helping others.

Finally, the DC government needs to realize that this healthcare worker crises will require a multiagency approach, with a department or agency given the authority to coordinate and initiate solutions. A successful approach will need to have a clear and realistic vision of what can be accomplished with available resources, and the desire to break through the bureaucratic barriers that a project of this scope will encounter.

I want to thank you and your staff for your efforts that has kept this issue front and center, and I’d be happy to answer any questions.

To: The Honorable Christina Henderson, Chair, Committee on Health
Members of the Committee on Health
From: Jessica Boyd, MD, President and CEO, Unity Health Care
Chair, DC Connected Care Network
Re: Budget Oversight Hearing for Department of Health Care Finance
Date: April 29, 2024

I am Dr. Jessica Boyd, President and CEO of Unity Health Care. Unity's mission is to reach people wherever they are to provide compassionate, comprehensive, high-quality health care that is accessible to all and advances health equity in Washington, DC. I am here today as the Chair of the DC Connected Care Network (CCN) Unity has invested significant time and financial resources in the CCN because we believe it is the path forward for rightly centering primary care as the cornerstone for our health system.

Crucially, health centers provide integrated and comprehensive services including preventive services such as immunizations, screenings, and health education and critical chronic care management to address health equity gaps and improve the quality and longevity of life.

I support the following recommendations for the Department of Health Care Finance to ensure a thriving health care safety net:

1. Invest in infrastructure for Federally Qualified Health Centers and the DC Connected Care Network
2. Support comprehensive primary care models with a strong focus on team-based care
3. Require MCOs to develop primary care-centric value-based contracting models
4. Integrate social care into health care system transformation.

I will focus my testimony on the need for robust engagement of the CCN in total cost of care value-based contracts with the Medicaid MCOs.

The 2023 DHCF-commissioned report *Medicaid Business Transformation DC: Recommendations for Technical Assistance* indicates that states that succeed in moving their Medicaid systems to value-based care have key features including:

- Upfront investment in the primary care system,
- Support for formation of provider-led entities
- Resources to address social domains.

As the District further invests in the managed care approach, the need for DHCF oversight of Medicaid MCOs grows. Our health centers upon which so many residents impacted by inequity rely, have come together as a provider-led organization, the CCN, to strengthen our ability to meet the service needs of patients and improve outcomes.

The CCN needs the support and engagement of DHCF and our MCO partners to engage in proven strategies for value-based care, to create capacity for care management, coordination across the care continuum, and capacity to address social needs at the point of primary care delivery. Specifically, we need a model that financially invests in the right care for the right patients in a way that transforms care and drives value to patients to address health inequities..

Key to the network's objectives for value-based payment framework:

1. Shared savings based on Total Cost of Care (TCOC) performance
    - Total cost of care arrangements bring the right level of investment to providers to build capacity to impact outcomes
    - Glide path to risk: FQHCs' are willing to take on risk once appropriate infrastructure and reserves have been established
2. Quality Program Metrics
    - Alignment across the CCN and payers on a core set of quality measures to allow focus and progress
    - Quality performance measurements that acknowledge improvements and the starting point for FQHCs
3. Up-front Infrastructure & Admin Payments
    - Resources necessary to build the infrastructure and maintain the administrative capacity to coordinate care, monitor network performance, and identify the highest value opportunities
    - Resources necessary to build CCN capacity to take on downside risk
4. Aligned MCO contracts with the CCN on behalf of FQHCs

DHCF has the power to both invest in primary care and hold MCOs accountable to improve the functioning and sustainability of a comprehensive, coordinated system prepared to meet the primary care needs of high- priority District residents. We can work together to end the persistent, pervasive inequities that drive disparate health and well-being in the District. The CCN's success in achieving shared savings means investment in the very communities that need those resources the most. FQHCs are mission-driven to use those dollars for the benefit of the communities and people they serve.

Thank you to Deputy Mayor and DHCF Director Wayne Turnage, Senior Deputy Director and Medicaid Director Melisa Byrd, Senior Deputy Director of Finance Angelique Martin, Director of the Health Care Delivery Management Administration Lisa Truitt, and their teams. I am confident that our shared commitment to improving outcomes and equity aligns us as partners in the important Primary care transformation work ahead.

Testimony before the

Council of the District of Columbia

Committees on Health

FY25 Budget Oversight Hearing

for the

Department of Health Care Finance

* * *

Presented by

Aldwin Lindsay

Executive Vice President & Chief Financial Officer

Children's National Hospital

April 29, 2024

Good Morning Chairperson Henderson and members of the Committee on Health. My name is Aldwin Lindsay, and I am the Chief Financial Officer for Children's National Hospital.

Children's National has delivered care to the District's pediatric community for over 150 years. We firmly believe that every child deserves the chance to grow up strong in mind and body and are inspired by their hopes for their future and their limitless potential.

I appreciate the opportunity to present testimony at the Department of Health Care Finance's FY25 Oversight Hearing. The Directed Payment program included in this budget will allow hospitals to supercharge their efforts to serve **Medicaid** beneficiaries as well as all residents of the District.

The enhanced reimbursement is especially important to Children's National. As you know, last year's budget included a Medicaid rate cap on hospital reimbursements that disproportionately impacted Children's National. While the directed payment plan is not the final solution, it effectively mitigates the more than $17 million cut to payments for the care we provide our children.

At Children's National, we recognize that the health and well-being of our children and families goes beyond the care within the four walls of our hospital. This program will allow for further investments in our community.

We are dedicated to addressing health inequities and their root causes by focusing on social determinants of health. Through our patient-level screening, referrals to social services, educational programs, and community partnerships, we care

for and connect children and families to needed resources with the goal of improving health outcomes.

The directed payment program will help us expand our response to community health needs. This work is specifically focused on the social factors that impact health outcomes. In our last community engaged process, we learned that workforce development and employment; food insecurity and early childhood education are areas that would benefit from our investment. We also know how important it is to improve health literacy among our patients and staff.

Children's is committed to the collective hospital investment of nearly $15 million per year as the health sector works together to address the needs of our community.

Finally, it is significant to note that none of these investments rely on local funding from the District. The hospitals are making the investment through provider taxes. Moreover, these investments allow for DSH hospitals to move away from DSH payments and be supported through utilization. For HSC Pediatric Center this means they will no longer be eligible for DSH, by design.

Thank you for allowing me to testify today, and I am happy to answer any questions you may have.

Testimony before the

Council of the District of Columbia

Committees on Health

FY25 Budget Oversight Hearing

for the

Department of Health Care Finance

* * *

Presented by

Jacqueline D. Bowens

President & CEO

April 29, 2024

Greetings Chairperson Henderson and members of the Committees on Health. My name is Jacqueline D. Bowens, and I am the President & CEO of the District of Columbia Hospital Association. I am joined today by Dr. Gregory Argyros, President of MedStar Washington Hospital Center, and Chair of the DCHA Board of Directors, Anita Jenkins, CEO of Howard University Hospital, Tony Coleman, CEO of Cedar Hill Regional Medical Center and Aldwin Lindsay Executive Vice President and CFO for Children's National Hospital. I appreciate the opportunity to present testimony at the Department of Health Care Finance's FY25 Budget Oversight Hearing.

DCHA is a unifying force advancing hospitals and health systems in the District of Columbia. We are committed to promoting policies and initiatives that strengthen our system of care, preserve access, eliminate disparities, and promote better

health outcomes for patients and our community. Our driving vision is to achieve an efficient and effective health care delivery system that supports a healthy, equitable and vibrant community.

As many have noted this is the most challenging budget we have seen in recent memory. We appreciate the efforts of the Mayor, Deputy Mayor Turnage and the Council to ensure that the Department of Health Care Finance's proposed budget continues vital investments in the health of District residents and the providers that serve them.

Included in the FY25 Budget is a Medicaid Managed Care Directed Payment Program. Through this new initiative the District will be able to join at least 39 other states in securing additional resources to invest in the health system, residents and most importantly beneficiaries. Through a provider tax

voluntarily imposed on hospitals this comes with no cost to District taxpayers and is born completely by the hospitals. In fact, this program frees up over $32 million in local funding within the District's budget to be reinvested in the Medicaid program. When matched with federal funds this means over $100 million can be invested in Medicaid beneficiaries.

This new funding will provide District hospitals with the opportunity to make strategic investments to improve patient outcomes, expand access to services and support Medicaid beneficiaries. As part of the Directed Payment Program, hospitals will be required to report quality metrics to the District and CMS on several measures including Maternal Morbidity, Social Determinates of Health Screening, Transitions of Care, and the flow of information to the next level of care. These efforts, taken together, are aimed at improving maternal

morbidity and maternal health, care coordination and treatment with laser beam focus on quality and equity that meets the patients where they are.

The Directed Payment Program is a once in a lifetime transformative opportunity to advance health in the District. Additionally, hospitals will make individual and combined investments totaling nearly $30 million annually in workforce development, maternal health, care transitions, pediatrics, improving patient throughput, along with initiatives to address social determinates of health. Let me be clear, while this investment will help meet some of the increased costs incurred as a result of the pandemic, this funding is to move the needle and invest in the medical care and health of Medicaid & Alliance beneficiaries it is not designed to pay more for the same services we provide today.

Thank you for allowing me to testify today, the hospital leaders will provide additional perspectives on the Department's budget and the directed payment program. I am happy to answer any questions you may have.

Capri Romney

Hi everyone, My name is Capri Romney. I am a Junior at Washington Latin High School and the founder and president of its Health Justice Club branch. I'm here to convince you of the worthy cause to make budget changes that assist DCPS in paying Nurses competitive enough wages to station a full-time nurse in each school. In February of last year- On a Monday to be exact- I got increasingly dizzy as my morning classes progressed. This was very unusual for me and I was scared. When I dizzily left the class I was in to walk to the nurse's office, I was met with the big letters "NO NURSE UNTIL WEDNESDAY" taped to the door. In this instance, we have been told at Washington Latin to go to the front desk as they can help with medical needs in the absence of a nurse- but when I went to the school's secretary in the condition I was in she could find no way to help. I know it was not her fault. Nursing requires years of school and they have much more knowledge to diagnose and aid a student than a secretary or faculty member does. Unaware that I had a temperature of 103, the lady at the front desk told me to get back to class because she was certain it was just "The Mondays". what she couldn't have been certain about was that I would pass out on the stairs back to class and have to be taken straight to the children's hospital by my Mom. There it was suspected, and later confirmed that I had a condition called Postural Orthostatic Tachycardia Syndrome (aka POTS). POTS is an abnormality of the functioning of the autonomic (involuntary) nervous system. It makes me and over 3 million American people (mostly young girls) have symptoms of nausea, dizziness, and fainting daily. Though I am fortunate my symptoms can be mostly managed with lifestyle changes, I still need many breaks at school to rest and have a high-sodium snack, and because of the nursing system in DC, that is not accessible to me when I need it. Just last week a school director with many important daily responsibilities had to halt what she was doing just so I could have someone monitoring me in the empty nurse's office during a dizzy spell. Additionally, I was informed by a teacher of mine that there is a young student with a colostomy bag attending a DC public school, and because that school doesn't have a nurse consistently the vice principal has to change that student's bag multiple times a day. Not only is that dangerous for the student and inconvenient for the teacher, it is not acceptable. Teachers and superintendents are not nurses- don't make them be. While most schools in the cluster Nurse system, have 1 RN for every 4 schools- meaning not every school has a nurse at all times- Our school's Middle school, the Cooper campus, doesn't have a nurse at all. These are just examples of the many hardships that come along with the lack of budget and system for nurses in DC which has not only negatively affected me- but many of my fellow students and teachers. I am lucky to be able to access healthcare for my medical needs, but I know many of my peers can not, and the school nurse is the best healthcare they can receive. We need more nurses in our schools- and DC has the means to do it. I strongly urge you to consider all children, healthcare, and education workers whose lives are being impacted every day, and I thank you for your time.

Brady Woodhouse

Hi all, my name is Brady Woodhouse and I am a Type 1 Diabetic Student at School Without Walls, and the founder and president of the Health Justice Club. My club and I have come here today to condemn the nursing-cluster-model that DCPS uses, and demand that the department of health work to keep school nurse wages stay competitive as the future budget is decided. For most DCPS schools, a region of 4 schools has to split the time of only one registered nurse, one Licensed Practical Nurse, with other medical staff filling in despite not having the full capacity of a registered nurse. As a result of this system, I, as a Type 1 Diabetic, have a subpar support system when it comes to my low or high blood sugar levels. If none of you here know exactly what a diabetic low blood sugar is like, I'd first consider you lucky, but then I'd add that it can become hard to maintain consciousness, and even in less extreme circumstances, it is impossible to fully focus on the content at hand. Even if the nurse is in the building from Wednesday to Friday, I have diabetes more than 3 times per week, and my condition-induced episodes don't follow the same schedule that she does. However it is not just my voice condemning this system. The CDC recommends that each school building have a nurse for every 750 kids. Groups we've been working with including Parents United for School Health and the DC Nurses Association demand at least one nurse in every school. The unseen members of the health justice club at Walls and Washington Latin that are currently at school have far too many stories that detail the negative effects of the cluster-system. When thinking of solutions, it always comes back to *money*. Nurses need to be paid competitive wages if they are going to stay at DCPS and money must be invested into enhancing the nursing industry in DC. We hope to convince you that addressing the nursing shortage in DC and DC schools is both within the ability *and* the *respons*ibility of the department of health. The city owes its future generation the nursing coverage that is so essential to creating equitable and productive school environments. Thank you for your time and I hope that my words are considered when deciding how much money is allocated to school nursing support.

Lucy Cosgrove

Hello everyone, my name is Lucy Cosgrove and I am a member of the Health Justice Club at School Without Walls. I'm here to convince you of the importance of assisting DC public and charter schools in paying Nurses competitive enough wages to station one full-time-nurse for every school, as a student who has been negatively affected by the system of shifting nurses that schools call the Nursing-Cluster-Model. I am one of the many students at my school who suffers from a chronic illness called Postural Orthostatic Tachycardia Syndrome or POTS, a dysautonomic condition that causes fainting, nausea, dizziness, and many more difficult symptoms. My condition causes me to often need breaks, snacks, and a place to lay down. It is also hard to convey to an outsider how I am feeling or what I need when these symptoms occur. The needs of my condition, in conjunction with a lack of a full-time nurse, has caused me to miss a lot of school since I do not always feel confident in the safety and health measures that my school can offer under the nurse-cluster system that DCPS schools currently use. I struggle with both my condition and keeping up with school content as a result of my condition, and this inequity stems from the 3-day a week schedule that our nurse has, or rather the nearly 70 school days a year that no medical professional is there to support me in the likely case of enhanced symptoms. I can only imagine the fear of students with POTS at schools that are worse off in their nursing schedule than Walls is. As a junior and a member of the Health Justice Club, I see it as my duty to create a more health-aware and caring environment in the DCPS system for those my age and the following grades. That is why it is so crucial that each school has a designated, full-time nurse. One that is aware of my condition, and one that I can count on being there when I need assistance. I want to reaffirm that it is well within the ability *and* responsibility of policy makers and budget planners to help address the Nursing shortage from its roots, and following suit with increased nursing staffing for schools. For it is not just me, since many students throughout DCPS have chronic illnesses. So I urge you to please create a more caring, understanding, and safe school environment, by making progress towards addressing the lack of nursing support in DC schools.

District of Columbia Behavioral Health Association
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202-929-3757

Testimony of the District of Columbia Behavioral Health Association
Department of Health Care Finance FY '25 Budget Oversight

To the District of Columbia Council
Committee on Health
April 29, 2024

Chairperson Henderson and Members of the Council,

Thank you for the opportunity to testify today. My name is Mark LeVota. I am the Executive Director of the District of Columbia Behavioral Health Association and a Ward 2 homeowner. The District of Columbia Behavioral Health Association works to advance high-quality, whole-person care for District residents with mental illnesses, substance use disorders, or both, including the 32,000 District residents our 33 member organizations serve annually.

Financing of behavioral health services for District Medicaid beneficiaries is one of the many important responsibilities held by the Department of Health Care Finance. The Mayor's proposed FY '25 budget stays the course of recent changes to service definitions and payment rates for many Medicaid community based behavioral health services. My testimony will highlight efforts to update the payment methodology for Assertive Community Treatment, provide context regarding updates to multiple other service definitions and payment rates, and continue to urge the establishment of a more permanent rate setting process for community behavioral health services.

I am returning to the topic of Assertive Community Treatment today to express gratitude to Medicaid Director Melisa Byrd, as well as to DBH's director, Dr. Bazron, for working with the provider network to address several of the concerns previously shared about implementation of the new ACT monthly billing process.[1] I am grateful to DHCF and to DBH for their efforts to extend the onramp period as ACT provider organizations build capacity and capabilities to meet the new requirements, and I appreciate

[1] As I shared with this Committee at the time of the Department of Behavioral Health Performance Oversight hearing, "Assertive Community Treatment was shifted from typical fee-for-service based fifteen-minute billing intervals to a monthly payment rate. The rate is a reasonably high amount, but qualifying for payment requires navigation of a matrix of contact requirements, which must be completed by multiple team members, has strict limits on the number of contacts that are eligible for reimbursement unless delivered by people with health professional licenses, and that do not account for the frequency with which people who receive these services spend parts of the month incarcerated or hospitalized."

adjustments to some of the requirements in response to meaningful operational and workforce constraints. While ACT providers admittedly remain far from national model fidelity standards, and while DBH and DHCF requirements remain the most stringent in the nation, I am grateful to acknowledge progress toward a shared goal to ensure substantial quality improvement in care delivery for the individuals who need this exceptionally high level of community-based care.

I next turn the Council's attention to implementation of recommendations from DHCF's community behavioral health rate study, undertaken in conjunction with a service definitions review by DBH and DHCF. I want to express gratitude to DHCF Senior Deputy Director for Finance Angelique Martin and her team for the effort they have undertaken. As Ms. Martin shared during the DHCF Performance Oversight hearing in February, over twenty behavioral health service lines have been reviewed and are in the process of having payment rates updated. Payment rates for many services with directly comparable previously established rates have seen increases of twenty or thirty percent, and in some cases literally hundreds of percent, higher than previous rates, reflecting long-overdue adjustments to catch payment rates up to at least a 2020 cost basis.

It is important for the Council to understand that these twenty-plus rate adjustments do not include any adjustment to Community Support Services, which account for 63% of all services delivered by DBH provider organizations, according to information that DHCF shared in a presentation to Providers and Associations on April 11. Instead, as this Committee knows, the DBH budget proposes an $11.6M reduction of spending for Community Support Services, and the payment rate for spending that is expected to occur remains based on 2016 costs, adjusted cumulatively 6.2% since rates were established, despite 23.5% medical inflation since 2016.[2] Despite DBH and DHCF desire to make changes to the design and volume of Community Support Services as currently delivered, asking the provider network to continue to bear the inflated cost of these services until such adjustments are made places an undue burden on the DBH provider network until such time as those adjustments actually become policy. The increased payment rates for other services show that Community Support Services likely need at least the 17.3% adjustment that an inflationary adjustment solely based on inflation minus previous adjustments would indicate, a cost of about $4.9M that should be restored from the $11.6M reduced in the DBH proposed FY '25 budget and directed to this purpose.

Let me also briefly note that the rate study did not appear to include rate setting for youth substance use residential treatment. This is a disappointing omission, and I hope DHCF will provide a separate update soon to offer a path for Medicaid billing for substance use residential treatment for youth.

[2] I am happy to provide a copy of the material that DHCF shared during the April 11 Providers and Associations budget briefing upon request. Medical inflation is calculated using DHCF's preferred inflation adjustment tool, the Medicare Economic Index, using the change from 2016Q2 to 2023Q2, consistent with federal CMS procedures for evaluating the lookback period to the second quarter of the previous year when adjusting fee schedules. Available online April 26, 2024: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

The DHCF rate study third-party consultant's finding that DBH provider network services were underpaid at approximately the rate of overall medical inflation confirms the need for establishment of a more permanent rate setting process for community behavioral health services. This Committee will recall my request in multiple hearings for DBH and DHCF to agree to a methodology for DBH provider network payment rates to receive annual inflationary adjustments subject to periodic rebasing. The provider network was told that the rate study that is the basis of many of the payment rate changes that I have highlighted today would include a framework for implementation of that kind of methodology, and DBH and DHCF both at least verbally agreed that annual inflationary adjustments deserved to be incorporated moving forward. Nothing that has been shared about the rate study findings indicate that the requested framework was provided, and nothing about the transmittals or rulemaking updates undertaken to implement the rate study recommendations includes authority or commitment to make such inflationary adjustments. The Council should direct DBH and DHCF to make good on previous verbal agreement to incorporate annual inflationary adjustments for the DBH provider network's payment rates into routine rate setting, and this Committee should consider whether adjustments to the DBH or DHCF budgets are needed to begin to accomplish those changes in FY '25.

Thank you again for the opportunity to testify today. I look forward to answering any questions that you might have.

Evie Corr

Hi all, my name is Charlie Cole and I'm speaking on behalf of Evie Corr. I am a member of the Health Justice Club, and a student who has witnessed firsthand the consequences of inadequate medical support in DC public schools. Today I want to demonstrate to you the importance of assisting DC public and charter schools in paying Nurses competitive wages in order to combat the Nursing-Cluster-System. Though the Nursing Cluster System has particularly problematic effects for students with chronic conditions, I want to make it clear that the nursing system that DCPS uses is a hardship for all of us. As members in a community with insufficient health staffing, me, other students, and teachers need to pick up the slack. For example, my friend has Type 1 Diabetes. On those days of the week that our nurse isn't in the building I'm more conscious about whether he might be experiencing a low blood sugar or is managing all his medication correctly. Afterall, on those days, there is no safety net for him in the building other than me, one of the few members of the community who would have an idea of what to do in case something goes awry. He's not the only member of our community who is affected by the nursing system. I know three students in our grade with something called "POTS" which is a syndrome related to reduced blood volume that occurs when standing up or laying down quickly. Some of you might not know what that is, and I certainly didn't know the name before joining the Health Justice Club. All I knew was that those students would experience fainting spells during class, and a teacher could only respond "try water in her face," when one student did faint. I think this attests to the fact that no matter how hard we try, community members cannot pick up the slack for a missing nurse. But the lack of a nurse hasn't only tightened my stress for those with chronic illnesses in my community. Students get sick, students get hurt, and students need medical advice any day of the week, not on a schedule. Nurses can help students with their physical and emotional well-being, offer guidance on healthy habits, and be a trusted adult to turn to in times of need. Building a positive connection with nurses promotes a safe and nurturing environment for students to thrive in. This positive relationship again, could only be possible with a present nurse everyday, not on a schedule. Thank you for your time, and I hope that you better understand the importance of amending the budget to address the school nursing shortage.

THE HSC HEALTH CARE SYSTEM

Health Services for Children
with Special Needs, Inc.

Fiscal Year 2025
Budget Oversight Health of the
Department of Health Care
Finance

Testimony of
Anna Pilskaya Dunn
President
Health Services for Children with Special Needs, Inc.

Council of the District of Columbia

Before the Committee
on Health and the
Committee

April 29, 2024

Health Services for Children with Special Needs, Inc. 1101 Vermont Avenue NW, Ste 1201, Washington, DC 20005 (202) 467.2737,
Family and Community Development Outreach Department 3400 Martin Luther King Jr. Avenue SE, Washington, DC 20032 (202) 580.6485
hscsnhealthplan.org

THE HSC HEALTH CARE SYSTEM

Health Services for Children
with Special Needs, Inc.

Good morning, Chairpersons Hendersen, members of the Committee on Health, Deputy Mayor Turnage and representatives of the Department of Health Care Finance. My name is Anna Pilskaya Dunn, and I am the President of Health Services for Children with Special Needs, also known as HSCSN, a Medicaid health plan, licensed in DC. We are part of the HSC Health Care System (a subsidiary of Children's National). Thank you for the opportunity to testify today at the FY2025 Budget Oversight Hearing of the Department of Health Care Finance.

HSCSN partners with the Department of Health Care Finance (DHCF) in serving over 5,000 special needs children and young adults with disabilities from birth up to age 26 in the District, through the Child and Adolescent Supplemental Security Income Program (CASSIP). We provide specialized benefits and services for some of the District's most vulnerable children. Continuity of services with HSCSN is key in ensuring that our enrollees and families receive the specialized care they need and the supports they deserve. With the unwinding of the public health emergency (PHE) in late 2023, we became concerned with the number of enrollees set to lose Medicaid eligibility as the District resumed its redetermination process. Nearly 500 HSCSN enrollees were identified as 'at risk' of losing their health care coverage. In partnership with the Department of Health Care Finance (DHCF), we were quickly able to implement interim solutions to ensure service continuity and avoid disruption in health care coverage alleviating the concerns of Caregivers and families. We thank Deputy Director Turnage and Director Byrd for their continuing support and partnership in addressing these eligibility concerns that uniquely impact our enrollees and in identifying policy solutions.

The availability of home care services in District continues to be a key area of concern. What is more, the matter of limited home health agency capacity can present further risks to FY2025 budget pressures linked to heath care spending. Over, 10% (~500+) HSCSN enrollees require home care services which include personal care aides services to support activities of daily living (ADLs), nursing care, and/or services such as physical, occupational, speech therapy (PT, OT, ST). As such, our ability to deliver on pediatric-focused home care is a key component in many of the personalized care plans we develop for enrollees and serve as a strategic lever in driving quality outcomes including the reduction of avoidable health care costs.

As we continue to partner with DHCF to develop innovative payment solutions to enhance home health care delivery (such as VBC), we ask DHCF and the Council's consideration and support towards exploring opportunities with the State Health Planning and Developmental Agency (SHPDA) to increase pediatric network capacity in the District. Potential opportunities include establishing expedited processes to modify existing

Certificates of Need (CONs) of existing agencies to increase pediatric care hours as well as expedited review and approval of new entrants. Other areas of opportunity lie with policy and benefit expansion such as alternative, long-term solutions to expand access such as a Caregiver payment program which offers direct payment to Caregivers and/or family members such as the benefits offered under the Elderly and Physically Disabled (EPD) waiver.

In closing, we are committed to being a valuable asset to the District in supporting Children and Youth with Special Health Care Needs (CYSHN)in the District. Thank you for your leadership on the health of District residents. HSCSN looks forward to continuing the ongoing partnership with the Department of Health Care Finance.

Testimony before the

Council of the District of Columbia

Committees on Health

FY25 Budget Oversight Hearing

for the

Department of Health Care Finance

* * *

Presented by

Anita L.A. Jenkins, MBA, RCP, FABC

CEO

Howard University Hospital

April 29, 2024

Greetings Chairperson Henderson and members of the Committees on Health. My name is Anita Jenkins, and I am the President of Howard University Hospital. As you know, Howard has a rich tradition of providing uncompensated care to the residents of the District of Columbia. Approximately 90% of our patients are Medicaid or Medicare and we have a distinguished 162 year history of delivering the finest primary, secondary and tertiary health care services. Howard University Hospital has become one of the most comprehensive health care facilities in the Washington, D.C. metropolitan area and is designated a DC Level 1 Trauma Center.

I am pleased to be here today with my colleagues, to testify in support of the Department of Health Care Finance's FY25 budget and to support the Medicaid MCO Directed

Payment Program included within it. The Directed Payment Program will allow the District's hospitals to make strategic investments in the services provided to their patients and, as a result, improve quality and outcomes for those we serve.

For Howard University Hospital this means allowing the hospital to move away from Medicaid Disproportionate-Share Hospital payments, which are considered risky as they are targeted for Congressional cuts, to a more predictable stable funding model based on utilization. In short, these funds will stabilize our funding and allow Howard University Hospital to continue to provide specialty care for the underserved in the city.

In the area of workforce development, this funding will help us recruit and train the next generation of hospital associates. This year our hospital will be launching an

apprenticeship program to address critical needs within our workforce and the additional funding will help us expand our work in creating a workforce pipeline and career advancement opportunities for residents of the District.

As Ms. Bowens said, this is a transformational opportunity for the District, and I am excited for the new doors this program can open for our patients and our hospitals and the stabilization it will bring to Howard's funding.

Thank you for allowing me to testify today, and I am happy to answer any questions you may have.

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The availability of home care services in District continues to be a key area of concern. What is more, the matter of limited home health agency capacity can present further risks to FY2025 budget pressures linked to heath care spending. Over, 10% (~500+) HSCSN enrollees require home care services which include personal care aides services to support activities of daily living (ADLs), nursing care, and/or services such as physical, occupational, speech therapy (PT, OT, ST). As such, our ability to deliver on pediatric-focused home care is a key component in many of the personalized care plans we develop for enrollees and serve as a strategic lever in driving quality outcomes including the reduction of avoidable health care costs.

As we continue to partner with DHCF to develop innovative payment solutions to enhance home health care delivery (such as VBC), we ask DHCF and the Council's consideration and support towards exploring opportunities with the State Health Planning and Developmental Agency (SHPDA) to increase pediatric network capacity in the District. Potential opportunities include establishing expedited processes to modify existing

Certificates of Need (CONs) of existing agencies to increase pediatric care hours as well as expedited review and approval of new entrants. Other areas of opportunity lie with policy and benefit expansion such as alternative, long-term solutions to expand access such as a Caregiver payment program which offers direct payment to Caregivers and/or family members such as the benefits offered under the Elderly and Physically Disabled (EPD) waiver.

In closing, we are committed to being a valuable asset to the District in supporting Children and Youth with Special Health Care Needs (CYSHN)in the District. Thank you for your leadership on the health of District residents. HSCSN looks forward to continuing the ongoing partnership with the Department of Health Care Finance.

DC Council - Committee on Health
FY25 Budget Hearing: Department of Health Care Finance
April 29, 2024

Chairperson Henderson, and members of the Health Committee, my name is Ian Paregol, and I serve as the Executive Director of the DC Coalition of Disability Service Providers. The DC Coalition currently represents over 50 provider agencies, supporting over 2,300 persons with intellectual and developmental disabilities and employing over 4,700 staff - most of whom are residents of the District of Columbia. Member organizations provide residential, day, employment, in-home and other home and community-based waiver services as well as Intermediate Care Facility ("ICF") which provide supports to residents of the District with intellectual and developmental disabilities.

We testify today regarding the proposed DHCF FY25 Budget, specifically as it relates to the IDD community. At the outset, the DC Coalition is pleased that in a time of perceived fiscal pause, there were no planned cuts to the DHCF portion of the funding for the IDD community. However, there were cuts to the HCBS waiver portion of the IDD community funding through the Human Care Agreement ("HCA") specifically a 50% reduction in administrative funding amounting of $1.4M of cuts which directly impact IDD providers. While we recognize that this is not a direct DHCF cut, it is a reduction in funding from a governmental unit and it will have an impact on IDD services.

In the event you were unaware, on March 4, 2024, the disability provider community received communication that with less than one month's notice, that DDS would reduce payments for administrative residential costs by 50%. "[E]ffective April 1, 2024, the fixed-fee paid to residential providers for the pass-through payment of occupancy related residential expenses will be reduced by 50%." This notice served as a unilateral alteration to the IDD provider Human Care Agreement, and providers were advised that failure to sign and "approve" this reduction would result in DDS seeking new placement determinations for persons presently receiving residential supports. Needless to say, the forced FY24 administrative fee reduction with less than one month's notice prior to implementation is having an adverse impact upon providers.

Now the service providers are faced with the continuation of this reduction for the entirety of the 2025 fiscal year as noted in the Mayor's Budget. According to DDS, this reduction amounts to $1.4M savings for the District – a nominal amount at best for District governmental operations - but the harm this reduction will have within the provider world is substantial. IDD providers have been operating in the red as a result of the unrelenting turnover and vacancy rates in the industry because funding for front-line staff is not competitive with virtually every other

employment opportunity in the District. Further, the DD providers have demonstrated that funding for nursing needs (LPNs and RNs) is inadequate compared to the DC market. In addition, DD providers have been losing mid-managers and supervisors by the dozens since there has been no proper corresponding funding increase in hourly rates for these critical quality assurance cohorts for years. All of this makes for the perfect storm of a staffing crisis.

IDD providers were using the *administrative fee funding* that is being eliminated to offset the growing costs of staff. The $1.4M reduction proposed for this line item in the FY25 Budget only pushes human service providers further behind and destabilizes supports, and ***we ask for your Committee on Health's support in the event that the Facilities and Family Services Committee recommends that this $1.4M be reinstated in the FY25 Budget.***

With continually mounting staff turnover and vacancy rates - in spite of the recent funding allocations - DD providers are *just too far behind* to reach sustainability without further action by DHCF. In 2019, when we sought legislatively-endorsed increases for our direct support professionals, vacancy rates were around 12% on average. Unfortunately, the 2019 DSP Rate Payment Act remained largely unfunded by the Mayor, and turnover and vacancy rates continued to swell. And then Covid struck, which resulted in a parabolic rise in vacancies from an already dangerously high baseline. Vacancy rates now exceed 20% in the industry, with some providers reporting vacancy rates as high as 35%.

In 2023, the DC Coalition recommended "*that any continuing wage enhancements for front-line staff include allocations for expected continued overtime costs resulting from the unsustainable vacancy and turnover rates within the industry*." ***Service Providers need some accommodation or additional funding to account for the overtime*** generated by these staff vacancy rates which now result in even higher operational expenses. We continue to advocate for overtime support from DHCF and that it be included within the FY25 Budget.

As hourly rates for the substantial direct support workforce have increased, we need to address the wage compression impact that those increases are having upon the mid-level managers and supervisors. In part because of the difficulties in recruiting and retaining front line workers have resulted in significant overtime wages occasioned by the unsustainable vacancy rate among front line workers, those who are providing direct supports are now earning - on an annual basis - more than their supervisory team. Albeit more weekly work hours are required to attain those weekly pay levels, but the consequence has been that *mid-level staff and supervisors are vacating their supervisory positions because they can earn far more with overtime as a direct care worker*.

This has left a supervision gap and an inability to recruit mid-level leadership for the IDD provider community. In 2023, we recommended that *"**additional fiscal support for these mid-level staff so that providers can maintain appropriate supervision ratios**."* We continue that recommendation in 2024, as the funding rates for LPN, RNs, Qualified Intellectual Disabilities Professional (QIDPs), Supervisors and House Managers has only been adjusted by the CPI over the last several years and even less than the CPI percentage from FY23 to FY24's funding.

Similarly, funding for our nursing cohort lags behind the wages that these same nurses can earn in more traditional or institutional settings where they have a more clearly defined work schedule and actual hours where they can be "off duty." As a result of severe nursing shortages in community-based services, IDD nurses are on-call *all day, every day*, and are not funded at comparable levels to those in more traditional settings even for a 40-hour work week.

We do recognize that there are nursing shortages throughout the region, but we are also asking for ***funding so that our IDD providers can pay their nurses at least a competitive rate with hospitals and governmental employers***. Presently, our LPNs and RNs are funded at $26.05 to $27.43 per hour and $41.75 to $43.95 per hour respectively between ICFs and DD Waiver services. That is not even remotely close to the DC market rate with RNs earning in excess of $100,000/year annually. We recommend that these hourly rates be adjusted to at least those which the District is paying for its nursing staff.

In addition, **we would urge DHCF to allocate additional support in FY25 for the Direct Support Workforce**. As we know you are aware, the Budget does not adjust the 117.6% funding factor that presently exists for direct care/ direct support workers, but an adjustment is needed in order to recruit workers in our field. The average waged funding of $20.05/hour is not attractive enough to bring in new workers let alone fund the existing workforce. While we support the design of the wage funding structure that DHCF has developed, at a minimum, **we need the percentage for the average funding reimbursement to reach 125% threshold, which would push the AVERAGED hourly rate for direct care to $21.31, which merely aligns with a projected calculation for the BASE hourly rate in the childcare worker industry.**

Lastly, DHCF and DDS are conducting a rate study of the IDD community. We are hopeful that the recommendations that are made by the contractors who are conducting that study will be thoughtfully considered by DHCF and the Mayor for the FY26 Budget, and proper funding allocations for IDD services will be forthcoming.

On behalf of the DC Coalition of Disability Service Providers, I thank you for the opportunity to provide this testimony at today's Budget Hearing, and I welcome any questions that you may have.

Respectfully submitted,

Ian Paregol
Executive Director, DC Coalition of Disability Service Providers

Testimony of Sally White, MS
Member, Workforce Development Subcommittee
DC Coalition on Long Term Care
LeadingAge DC Board of Directors

DHCF Budget Oversight Hearing
April 29, 2024

Good Morning Chairperson Henderson, and members of the Committee on Health. My name is Sally White. I am a member of the DC Coalition on Long Term Care and the LeadingAge DC Board of Directors. I have been an advocate and leader in organizations for older adults in the District of Columbia for close to 40 years. I am here today in support of funding for the direct care workforce caring for the District's most vulnerable older adults.

As you well know, we are faced with a critical shortage of direct care workers, the majority of whom are Home Health Aides and Certified Nursing Assistants. According to the Board of Nursing, we lost 30% of this workforce at the end of 2023, when 4,489 individuals did not renew their license to work in DC in 2024.

Solving the crisis requires work on many fronts, including expanded training opportunities for residents who want to be HHAs and CNAs, developing a reciprocity practice so that Maryland and Virginia residents can easily work in DC, and achieving the additional goals outlined in the Direct Care Workers Amendment Act which you introduced, and which must become law—and funded--as soon as possible. Of all the needs stated in the DCWAA, the most urgent is the need for higher wages. Until wages are increased, the exodus will continue and more and more older adults and adults with disabilities will suffer.

During his testimony on the Act, Director Turnage expressed that he is not convinced that wages remain a serious issue at least in part because most providers are not turning in audit reports to DHCF showing that funding is not adequate. I have several concerns about this approach to the issue. The first is that the audit/expense reports are not required, but are optional, so perhaps agencies don't understand the potential impact these reports may have on their reimbursement rates. Secondly, and more concerning to me, is how exactly those reports would show that the

reimbursement rates are not high enough. Can DHCF glean from the reports how many staff have left in the past year? Will they be able to see how many staff slots are proving impossible to fill? Do the agencies have to show a significant deficit to be considered for a higher reimbursement rate? How can they remain in business if so? If difficulties attracting and retaining staff are the primary impacts of low reimbursement, then I don't think the financial audit will give DHCF the information they say they need to make a decision about increasing reimbursement. Vacancies, high turnover, aides telling employers that they are leaving for higher paying retail jobs, non-renewal of licenses, the turning away of potential clients because of understaffing—these are measures of low reimbursement rates which must not be ignored.

We urge the Council to fund reimbursement for direct care workers serving older adults and adults with disabilities at an average wage that is 135% of the living wage. The $17.58M estimated annual price tag for this increase is critical to the future of this city—for young workers and older care recipients alike.

Thank you.

Testimony before the

Council of the District of Columbia

Committees on Health

FY25 Budget Oversight Hearing

for the

Department of Health Care Finance

* * *

Presented by

Gregory J. Argyros, M.D., M.A.C.P, F.C.C.P.

DCHA Board Chair &

President, MedStar Washington Hospital Center

April 29, 2024

Good Morning Chairperson Henderson and members of the Committee on Health. My name is Dr. Gregory Argyros, and I am the DCHA Board Chair for 2024, Co-Chair of the Association's Equity, Diversity and Inclusion Collaborative, and President of MedStar Washington Hospital Center.

MedStar Washington Hospital Center is a 912-bed, major teaching and research hospital. We are the largest private, not-for-profit hospital in the nation's capital, among the 100 largest hospitals in the nation, and a major referral center for treating the most complex cases. We are the busiest and largest hospital in Washington, D.C. and the surrounding area. Our services help our community's residents get and stay healthy

and help to improve patients' quality of life by managing chronic illness.

I appreciate the opportunity to present testimony at the Department of Health Care Finance's FY25 Oversight Hearing. The FY25 Budget presents a lot of challenges but also opportunities. As Ms. Bowens mentioned, the District's hospitals have been work over the last two years to create a transformative opportunity through a Directed Payment Program in the District.

State Direct Payments provide us an opportunity to invest in the care the city's Medicaid beneficiaries receive and to address long standing challenges that hospitals have faced. At

the MedStar Washington Hospital Center this additional funding will allow us to:

1) Continue our work on identifying and addressing social determinants of health such as food insecurity, housing insecurity, transportation insecurity, and interpersonal safety
2) Continue our work to reduce Maternal Mortality and Morbidity by expanding the services provided by our Safe Babies Safe Moms program
3) Improve communication at the time of transitions of care so that safe and seamless care can be provided across the healthcare continuum
4) Continue to address overcrowding in our Emergency Rooms by expanding utilization of Community Health

Advocates to improve patient and family education and optimize utilization of the most appropriate level of care

All of these investments are being made possible with no local funding. The District's hospitals are funding this opportunity through 2 provider taxes and the program is designed not to have a financial impact to the city. Importantly it impacts all of the District's private district hospitals and United Medical Center.

Additionally, the District hospitals are committed to funding a community impact fund through the hospital association which will provide nearly $15 million to invest in maternal & infant health, workforce, transitions of care and addressing social determinants of health.

Thank you for allowing me to testify today, and I am happy to answer any questions you may have.

Testimony of Rajan Thomas
President, District of Columbia Home Health Association
Chief Financial Officer, Health Management, Inc./HMI Home Health Agency

Before the
District of Columbia Committee on Health
Budget Oversight Hearing – April 29, 2024

Chairperson Henderson and Members of the Committee on Health, thank you for the opportunity to testify before the committee today.

The District of Columbia has a stated commitment to provide seniors a quality of life as they age through various Home and Community Based Services.

Testimony has been given, with statistics and analysis, in this and other Council hearings about the mounting staffing challenges that home health agencies are now facing, to provide the level of care needed for our aging population.

The reimbursement rate for Home Care agencies for services provided for DC Medicaid funded services is tied directly to the hours of services performed. Hence the wage and reimbursement rates are critical for the agencies to be able to attract direct care workers to provide home care services, especially as the shortage of home health aides has become more pronounced post-PHE.

We request Deputy Mayor Turnage to accept our support of the pending "Direct Care Worker Amendment Act of 2023" which included the provision to increase the DSP base wage to 120% of the living wage in determining reimbursement rates to the provider agencies and to include that in DHCF's proposed FY25 Budget. The current proposed budget provides an "average" of 117.6% of the living wage.

Increased wages, however, by itself will not address the total shortage of home health aides.
We encourage the Mayor's budget to also include funding to enable training more workers in this core service as noted:

- Provide grants for increasing the capacity of training schools & facilities. Currently there are not enough institutions providing training for home health aides.
- Provide grants to organizations to provide "free training" for enhanced services such as for medication aides.
- Scholarships for high needs workers… home health aides fit into this.

We encourage and support the Committee on Health and the whole Council to adequately fund the DHCF budget to enhance the ability of provider agencies and organizations to fulfil the mission to take care of the health and well-being of our Seniors.

Thank you for your time and hearing our testimony today.

Verbal testimony before the Committee on Health
Budget Oversight Hearing for the Deputy Mayor for Health and Human Services
Delivered by Lara Pukatch, Chief Advocacy Officer at Miriam's Kitchen
April 29, 2024

Good afternoon Chairperson Henderson and members of the Committee. Thank you for the opportunity to testify. My name is Lara Pukatch and I am the chief advocacy officer at Miriam's Kitchen, where we offer on-site meals and case management, street outreach, and Permanent Supportive Housing (PSH). In addition, we convene The Way Home Campaign, an advocacy movement to end chronic homelessness that is supported by 7,000 individuals and 110 organizations.

I am testifying today on behalf of Miriam's Kitchen and The Way Home Campaign to express concern about upcoming encampment evictions. As you may know, the National Park Service (NPS) and the DC government are slated to evict and permanently close 5 encampment sites in Foggy Bottom in May, a harmful approach that will displace up to 70 people. While a small NPS encampment closure was scheduled months ago, NPS has recently expanded the scope of these evictions and DMHHS has taken this opportunity to close various sites on the same timeline.

Displacement harms our neighbors
Clearing encampments damages trust and relationships that outreach case managers have worked hard to build with residents. These are some of our most vulnerable neighbors and evictions will make it difficult for them to access the life-saving support and services they need to survive. Homelessness is traumatic and the forceful eviction of encampments, often under threat of arrest, only adds to that trauma.

Encampment evictions make it harder to end homelessness
An estimated 20 people living in the encampments slated for eviction are matched to a housing voucher. While DC must accelerate its housing process, displacing individuals will only make

their housing process longer – or disrupt it all together. National and local experts and leaders agree: housing and supportive services end homelessness, while encampment evictions make it worse.

Everyone needs a safe place to sleep – encampment evictions take that away
DMHHS is moving forward with encampment evictions in the context of a proposed local budget with no new housing vouchers, decreased funding for street outreach, and cuts to DC's social safety net. There are not enough shelter beds for those being displaced and many individuals were already displaced from McPherson Square, underscoring that there is nowhere else to go. If DMHHS moves forward, they will be clearing encampments without any resources to offer residents.

New, non-congregate shelter provides a safe solution to unsheltered homelessness
A small, dignified non-congregate shelter, the Aston, was scheduled to open close to the encampments in question last fall, but has been delayed until August. Clearing encampments when there is a non-congregate shelter solution just months from opening is particularly egregious.

We urge the Office of the Deputy Mayor of Health and Human Services, and this Council to:

- Address health and safety concerns in encampments without evicting residents;
- Stop evictions until The Aston opens and every resident is provided with a solution;
- Address barriers to DC's larger shelter system and expand non-congregate shelter capacity;
- Shift DMHHS financial and personnel focus from closing encampments to connecting residents to housing;
- Fund programs and services that end homelessness such as permanent supportive housing, street outreach, and more.

No matter our race or income, we all need a safe place to sleep. Homelessness is increasing across the country as more households struggle to make ends meet. Clearing encampments

and threatening arrest will make homelessness worse and make it even harder for people to get and keep a roof over their head.

Thank you and I'm happy to answer any questions.

DisordeRThePlay.blogspot.com
"DisordR, The Play," about Pakrat Patty, the self-identified Hoarder who comes out of the Clutter closet uses humor to educate about Mental Health. Stop stigma, & advocate Recovery. http://mentalhealthsf.org/join-us-18th-conference-on-hoarding-cluttering/

Hilary Kacser

SAG-AFTRA Actor, Educator, Speaking Coach, Advocate

(she/her/hers;
last name: "KACK-sir")

TESTIMONY FOR
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH

Councilmember Christina Henderson, Chair
Fiscal Year 2025 Budget Oversight Hearing
Office of the Deputy Mayor for Health and Human Services
April 29, 2024

DC Council Committee on Health Chair Councilmember Christina Henderson, and Councilmembers of the Committee on Health and Staff:
Thank you for this opportunity to submit written testimony about the Office of the Deputy Mayor for Health and Human Services's FY24 budget to you. I am Hilary Kacser, a DC resident, product of DC Public Schools, and long time District advocate for behavioral health.

Hoarding disorder has been defined as a behavioral health diagnosis by the American Psychiatric Association in the DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders) ***for over a decade***.

District residents live with the behavioral health diagnosis defined as hoarding disorder in great though hidden numbers. ***The Washington Post*** article, **"Hoarding is a serious disorder — and it's only getting worse,"** stated up to six percent of people live with HD. (http://www.washingtonpost.com/national/health-science/hoarding-is-serious-disorder--and-its-only-getting-worse-in-the-us) If our Washington, DC, census counts more than 700,000 individuals, then six percent means as many as 40,000 or more District residents live with this behavioral health condition, but receive no behavioral health support from DBH for HD.

This testimony today very strongly urges Councilmember Committee on Health Chair Henderson and the Committee on Health to take – what is an overall budget saving step– by allocating support to the Office of the Deputy Mayor for Health and Human Services, so that the DMHHS fulfills their mission to support the Mayor in

coordinating, across multiple agencies including Department on Aging and Community Living (DACL) – which houses Adult Protective Services (APS) – and Department of Behavioral Health (DBH), to provide behavioral healthcare for the estimated 40,000 District residents living with the diagnosis defined as HD, rather than the current situation in which DBH refers HD out to Adult Protective Services. APS is not a healthcare providing agency. Further, APS interventions are far more costly, radical, emergency, triage interventions, which cost far more than if our Department of Behavioral Health actually provided early behavioral healthcare for HD.

Especially in this tight budget, early DBH intervention would be a cost saving -- not to mention life saving.

Deputy Mayor Wayne Turnage has in the ODMHHS cluster both APS and DBH. Deputy Mayor Turnage directing DBH to allocate very small funding – $50,000 for a week of training DC stakeholders, including DC DBH Certified Peer Specialists and CSA CSW's – can help to save the budget by intervening with early HD behavioral healthcare. Addressing and providing early intervention, harm reduction services for the estimated 40,000 DC residents living with the behavioral health diagnosis HD – would save APS the larger cost of:

- APS performing costly heavy duty clean out,
- APS placing people living with this untreated HD diagnosis under costly guardianships, and
- APS housing people living with late stage, crisis HD in costly long term nursing care.

Can you, Committee Chair Councilmember Henderson and the DC Council Committee on Health, direct FY25 budget support – at relatively very low cost to DC taxpayers – for Deputy Mayor Turnage to allocate some funding for DBH to take measures on behalf of District residents living with an HD diagnosis – before the condition becomes a danger, not only to the person with the lived experience, but also to other members of our community?

Surely the cost saving measure of Deputy Mayor Turnage putting some small money toward DBH early intervention makes sense in this extremely tight financial time?

DBH contracts out to Core Service Agencies (CSAs) providing behavioral healthcare to DC residents. DBH currently has no mandate for Core Service Agencies (CSAs) to provide behavioral healthcare for HD. Front line, in home care providers, the CSA's Community Support Workers (CSWs), have no support, no guidance, and no training in HD behavioral healthcare services.

No DBH mandate for its CSAs to provide HD healthcare raises the question of what – if any – behavioral health supports and services DBH are directly providing for people in the District living with a diagnosis of "hoarding disorder" (HD)!

Deputy Mayor for Health and Human Services Wayne Turnage's Fiscal Year 2025 Budget Hearing written testimony before this DC Council Committee on Health today mentions the American Psychiatric Association defined, clinical diagnosis hoarding disorder not at all.

What is DBH doing for people living in DC with a diagnosis HD? What is the Deputy Dayor for Health and Human Services doing for people living in DC with a diagnosis of HD?

Penny wise and big dollar foolish to sweep this behavioral diagnosis -- one steeped in shame, stigma, and judgment -- under the rug.

Especially in this particularly tight FY25 budget, how many car wrecks before we put in a traffic light? How many heavy duty cleanouts, involuntary guardianships, and long term nursing home admissions – all extremely costly, crisis, emergency, radical, late stage, triage interventions by APS (within this Deputy Mayor's cluster) – before the Deputy Mayor for Health and Human Services directs DBH (within this Deputy Mayor's cluster) to begin to provide some early HD intervention, at far lower cost, to reduce these very costly harms?

Beyond DBH and APS in DACL, agencies within the Office of the Deputy Mayor for Health and Human Services cluster, DC Fire and Emergency Medical Service Department (FEMS) encounters high cost – both in dollars and in life and limb of our heroic and invaluable first responders – directly due to HD that has progressed to crisis because the person living with the behavioral health condition has gone without early behavioral healthcare. If DBH don't address early intervention that could prevent a bad -- and costly -- outcome, 911 is not activated until it is too late. The Deputy Mayor for Health and Human Services supports the Mayor in coordinating across agencies.

An article in ***Fire Fighter Quarterly***, called "**Hoarder Fires Pose Special Risks For Firefighters,"** says:

- Containing a fire in a home where hoarding is an issue can take twice as many fire fighters and twice the time.
- Fire fighters are discovering that — treasure or trash — too much of it packed into a structure will turn all of it into one thing: dangerous fuel.
- Fire fighters … are increasingly battling fires made vastly more dangerous by hoarding.
- Fire fighters in communities across the country say they are seeing more home dwellers packing their living spaces with stuff.
- Hoarding poses a dangerous challenge for fire fighters professionally committed to saving lives and property.
- Psychologists say that hoarding often is a symptom of deep-rooted mental trauma.
- Hoarders hail from across the economic spectrum.

https://www.iaff.org/wp-content/uploads/Fire_Fighter_Quarterly/2012-Jul- Aug.pdf

What can this Committee and the Deputy Mayor do to address this severe unmet need and behavioral health service gap – especially when taking action to fill this unmet need and to provide early intervention would not only reduce harm and but also save DC FY25 budget money?

Just for the sake of history and institutional memory, this testimony acknowledges and thanks Councilmember Vince Gray, who yet serves a little longer on this Committee on Health, for having established the original, very first DC Office of the Deputy Mayor of Health and Human Services. In a spirit of great gratitude and appreciation for all of you, this testimony asks you all please to put a little bit of money into addressing hoarding disorder. Now, cases of HD go unaddressed, go without any early behavioral healthcare, and so are allowed to deteriorate, over time, to become the extreme cases that cost us all – cost our city, cost our DC taxpayers, cost the FY25 budget that you will pass – cost a lot more money, and sometimes cost people's lives.

Please, put some FY25 money into HD training -- a small investment of $50,000 for a week long training for stakeholders. Our neighboring jurisdictions have hoarding task forces. Understood that hoarding is a challenging -- but that is not a good reason to sweep it under the rug. HD has been around a long time, and there has been progress on behavioral healthcare services for hoarding disorder, so let's save some FY25 budget money and also improve quality of life for DC residents.

Individuals in DC living with HD do not receive timely behavioral health support that could reduce harm long before the case of HD reaches Stage FourLack of early behavioral healthcare intervention for HD comes at exceedingly high costs to DC residents for these late stage APS and FEMS interventions – high costs not only in dollars, but also in trauma for the person living with the diagnosis. DBH fashions itself as person centered, trauma informed, and recovery based. Where are these essential features of care for folks living with HD?

A small investment -- in training DBH providers to recognize and mitigate harm (to the person with lived experience, to family members, to neighbors, to the community at large, including to our brave and essential first responders) associated with symptoms of HD -- would save significant taxpayer funds.

DC Council Committee on Health Chair Councilmember Christina Henderson, Councilmembers of the Committee on Health, and Deputy Mayor Wayne Turnage, please allocate for DBH to spend a little money to do a training on evidence based Peer Response Team treatment approach to the diagnosis "hoarding disorder." $50,000 would cover one week for stakeholders, including our Certified Peer Specialist cohort. Low cost funding for DBH for peer training for HD would save money, and additionally provide early intervention and harm reduction. **"Randomised clinical trial of community-based peer-led and psychologist-led group treatment for hoarding disorder"** concludes, "Peer-led groups were as effective as psychologist-led groups, providing a novel treatment avenue for individuals without access to mental health professionals." https://pubmed.ncbi.nlm.nih.gov/30083381/ That scientifically reviewed NIH research last statement, about "individuals without access to mental health professionals," means
(1) Lower cost, evidence based intervention does not require costly clinician care.
(2) Our large cohort of DC DBH Certified Peer Specialists, along with CSA CSW's – if trained – can help to save the budget by intervening with early HD behavioral healthcare.

"1 in 40 people in the US has a hoarding disorder," says December 21, 2023, National Geographic article, and people living with this diagnosis "are compelled to hold onto the majority of their belongings, even when doing so means severely cluttered surroundings that decrease their quality of life and jeopardize their safety through increased risk of fire, mold or rodent infestation, ..."

(https://www.nationalgeographic.com/premium/article/new-virtual-reality-hope-hoarders-declutter-clean)

Finally, this testimony very much thanks this Committee on Health, Committee Chair Councilmember Christina Henderson, and committee staff for your receptivity to these important behavioral health concerns. The much appreciated and essential efforts on the part of this committee and committee staff must continue, and the ODMHHS must join in the effort to fill the unmet DBH need for HD behavioral healthcare services, an early intervention service gap which leads to extremely high cost harm for DC residents.

Thank you again for this opportunity, and this witness is grateful to answer questions from you.

--END--

Kristina Izett

Testimony for Department of Health Care Finance Committee DC Council Budget Hearing

April 29, 2024

Good morning, Chairperson Henderson and members of the Committee on Health Care Finance. Thank you for the opportunity to share my experience with the Council today. My name is Kristina Izett, I am a nurse home visitor at Mary's Center and am testifying to advocate for Nurse Family Partnership.

As a former staff nurse on a postpartum unit, I was drawn to home visiting after witnessing how overwhelmed new parents would be going home with their newborn and wishing I had more time to support them. This journey into parenthood is particularly challenging in the context of socioeconomic burdens that many of your constituents' face. Nurse Family Partnership is an evidence-based home visiting program that supports participants from pregnancy through their first child's second birthday. By developing therapeutic relationships with our participants over time and acknowledging the impact of social determinants of health, we not only support families with navigating their medical needs now, but also address the upstream factors in their life that impact their health and success as parents. Home visiting allows us to meet the participants where they are at, in a place that is most comfortable for them, and to create the space needed to realize and work towards the goals that they have as parents and in life. In this role, we can improve health outcomes and support positive parenting relationships. By developing the parents' self-efficacy over the approximately 2 ½ years we have with them, we work to ensure continued lifelong success beyond graduation from our program.

The nature of home visiting requires us to bridge the gaps specific to each participant. Whether it's understanding more about a diagnosis, how to improve their health, navigating transportation to their appointments or connecting with local resources, nurse home visitors need funding to be able to operate in the way that best suits our participant's needs.

I would like to first thank Mayor Bowser for including $225K in the DHCF budget to support the NFP home visiting program, and the Council for the passage of the Home Visiting Services Reimbursement Act. However, NFP still has a funding gap of $475K. We ask that the council consider further investment of local dollars to support our program until it can be funded by Medicaid Reimbursement.

Thank you for your time.

The Committee of 100
on the Federal City

The Committee on Housing, Budget Oversight Hearing on April 29, 2024
Regarding the Office of the Deputy Mayor for Health and Human Services
Testimony of Deirdre P. Brown, J.D.
on behalf of the Committee of 100 on the Federal City

My name is Deirdre Brown, and I am submitting this testimony for the record on behalf of The Committee of 100 (C100) regarding the Mayor's proposed budget for the Ofiice of the Deputy Mayor for Health and Human Sevices (DMHHS) for the FY 2025.

The Mayor is pushing for the largest budget in DC's history, yet it puts critical programs, especially in housing, education, and social services, at risk of cuts while directing new funds primarily to Downtown. Despite the Mayor's call for shared sacrifice, it's crucial for the Council to carefully examine the budget's priorities. We believe that any sacrifices should not unfairly burden the most vulnerable, particularly our Black and Brown communities. The Committee of 100 argues that the budget fails to strike a proper balance between revitalizing the central core and meeting the needs of our most vulnerable residents.

DMHHS stands out as one of the few offices still set to receive significant federal funding, despite the expiration of $80 million in American Rescue Plan Act (ARPA) funds. We recognize that with an additional $184 million from federal grants boosting its operating budget, the proposed FY25 budget exceeds that of FY24 by $15 million. While C100 supports the Mayor's initiative to augment the Temporary Assistance for Needy Families (TANF) program, there are concerns regarding proposed cuts to critical housing programs. Specifically, the Mayor's plan includes a reduction of over 25%, amounting to more than $63 million, for the Emergency Rental Assistance Program (ERAP), Permanent Supportive Housing Program, and Rapid Re-housing Program. While acknowledging the strain on local funds due to declines in commercial real estate revenue, C100 urges the Council and the Office of the Chief Financial Officer (OCFO) to carefully assess the duration and extent of this financial impact. In the interim, drastic cuts to programs aiding residents with limited alternatives appear unjustified and avoidable.

The C100 also notes that the Mayor has proposed Budget Support Act amendments that will affect the Rapid Re-housing Program and ERAP reporting requirements to the Council. We do not support repealing the monthly reporting on ERAP at a time when its budget could be significantly reduced. We recommend that the Council consider these reporting admedments via the regular legislative process to allow for public comment and more thoughtful consideration of the proposal.

In conclusion, the proposed budget cuts to vital programs within DMHHS represents a troubling shift away from supporting the city's most financially vulnerable residents. These reductions will significantly impact the city's ability to address and prevent homelessness. It is imperative that these budget priorities be reconsidered to ensure equitable access to housing and support for all residents, particularly those most in most need. For theses reasons, we are asking that the the Council undertake a comprehensive review of the budget's priorities and make significant adjustments accordingly.

Thank you,
/s/ Deirdre P. Brown, J.D. for The Committee of 100 on the Federal City

Testimony of Mary Katherine West
Home Visiting Program Manager
Committee on Health
Department of Health Care Finance
Fiscal Year 2025
Council of the District of Columbia

April 29, 2024

Good morning Chairperson Henderson and members of the Committee on Health. Thank you for the opportunity to address the Committee as it conducts this budget oversight hearing for the Department of Health Care Finance. Thank you, Chairperson Henderson for your ongoing support for families in the District. My name is Mary Katherine West, and I am the Chair of the DC Home Visiting Council and Program Manager for Early Childhood at DC Action. I am a member of the Under 3 DC Coalition, and a Ward 1 resident.

DC Action uses research, data, and a racial equity lens to break down barriers that stand in the way of all kids reaching their full potential. Our collaborative advocacy initiatives bring the power of young people and all residents to raise their voices to create change. We are also the home of DC KIDS COUNT, an online resource that tracks key indicators of child and youth well-being.

The DC Home Visiting Council is a body of home visiting providers, local government agency representatives, early childhood advocates, managed care organizations, and other partners that works to strengthen the understanding, implementation, and sustainability of home visiting as a strategy to support positive child and family outcomes in the District of Columbia.

We thank the Mayor and the Department of Health Care Finance for the addition of a recurring $225,000 home visiting grant in the FY25 budget, which will support the Nurse Family Partnership program. However, this year, this program needs additional one-time funding of $475K.

We also want to thank you for working with us over the past several months to adjust the FIS for the Home Visiting Services Reimbursement Act. We hope that the OCFO will make these adjustments, and ask that the Council fund this bill at $137K for FY25.

Home visiting plays a valuable role in the District's early childhood system.
Home visiting is an individualized service that connects expectant families through families with children five and under with a trained professional to create a safe and stable environment for child development and for parents to reach their parenting goals. To learn more about the scope of home visiting programs in the District, please refer to my performance oversight testimony.

The Nurse-Family Partnership Fills Critical Gaps
The Nurse Family Partnership program is an evidence-based home visiting model that is over 50 years old. NFP programs create an alternative pathway for families to access quality health care by matching expecting parents with registered nurses. Families enroll in the program prenatally and their nurse delivers high-quality visits and interactions through the child's second birthday. To learn more about NFP's evidence base, refer to my performance oversight testimony.

With support from the District, the Nurse Family Partnership began in the District in 2021 and has been operating successfully as a pilot program over the last three years.

In the District, the Nurse Family Partnership supported positive health outcomes for families. In 2023, 98% of pregnant Nurse Family Partnership participants took prenatal vitamins, 84% attended all recommended prenatal visits, 94% received perinatal mental health screenings and 100% received mental health referrals when appropriate, attending postpartum visits, 0% of babies were very low birthweight, 99% had a medical home, 71% used safe sleep practices, 99% engaged in breastfeeding, and 100% children receive up-to-date immunizations at 6 months.

Supporting these positive health outcomes is vital as the District works to combat maternal and infant health disparities, especially in the context of high adverse birth outcomes for Black women and their babies, as compared to other demographics. DC Health data show that over the past six years, severe maternal morbidity, defined as the "outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health," has increased across all demographics. Black women in DC continue to experience severe maternal morbidity at almost double the rate of all other races. A failure of our health systems, inadequate access to health care for Black families, and racism in health care drive these disparities. The Nurse Family Partnership works to combat both of these problems by delivering high-quality care and support in ways that align with families' needs and goals.

NFP nurses not only address risk factors in the home, but serve as a support for parents in the health care system. Nurses help parents learn to navigate interactions with medical professionals and advocate for themselves if their concerns are being dismissed.

Without additional funding, the District is at risk of losing the program entirely, or the majority of the nurses in the program. The District is currently experiencing a nurse shortage, and without guaranteed funding, nurse home visitors may worry about supporting their own families, and can easily find work elsewhere.

Abby Goldstein, the supervisor for the NFP program, shared that it takes a unique person to be a nurse home visitor. You can't just plug any registered nurse into this job and expect that they will be successful. The program worked very hard to staff to capacity, and find skilled nurses who have the interpersonal skills and dedication to do this job.

One nurse home visitor, Jen, shared, "I have had the great opportunity to provide my participants to unveil their strengths and confidence, to take back control of their lives. Some participants remained or enrolled in a higher education when at first they did not believe they could do so while pregnant or with a child. Other participants found the strength in them to leave their abusive relationships, knowing they and their child deserve better. I have assisted some participants with building their resumes, resulting in them being accepted to a few jobs."

Nurse home visitors have committed to serving District families who face some of the greatest barriers. If we lose this program or funding to support the all program staff, these nurses will no longer be able to support the families they have made a commitment to for the first two years of a first-time parent's journey and the well-being of their child. Losing nurse home visitors will be detrimental to families in the program and costly for the program to replace and rebuild the program in the out-years. As Black women and children continue to be disproportionately harmed by our health system's failures and racism, we cannot afford to lose one of the few services meant to ensure that they are safe, healthy, and supported.

As we approach the end of the pilot, funding for NFP is expected to lapse. While we are thankful for the Council's allocation of a $225,000 grant to support home visiting in DHCF, this is not sufficient to support the program for an entire year. We ask the Council to invest one-time funding of $475,000 to sustain the program for FY25. F*or the $475,000 investment to be a one-time investment in the program, the Council must begin the implementation of the Medicaid Reimbursement Bill to provide a pathway for sustainable funding for NFP and other home visiting programs.*

Medicaid Reimbursement for Home Visiting is an Opportunity

Thank you for your leadership, Chairperson Henderson, in the DC Council's passage of the Home Visiting Services Reimbursement Act of 2023. This bill represents an exciting

opportunity for the District to stretch the impact of its investment of local funds in home visiting and gain additional federal support.

With consistent, long-term investments, the District can maximize impacts for families and create a path to achieving long-term stability for home visiting program budgets so that they can best serve families.

We believe that the OCFO has overestimated the cost of this program. We appreciate the coordination with the Council and the OCFO over the past several months to reconsider the original analysis.

We believe the current fiscal impact statement fails to account for other federal program dollars that support home visiting, overestimates the cost of covering Alliance beneficiaries, expects significantly higher growth rate of programs than historical growth patterns support, and includes an incorrect number of eligible programs. In addition, the Council could delay the implementation of the State Plan to Q4 of FY25 to provide time to establish reimbursement and support program take-up, which would reduce the number of quarters the funding would need to cover in FY25. If, in partnership with the OCFO and the Council, we can make these adjustments and lower the FIS, the funding needed in FY25 would be approximately $137K and FY26 and FY27 will be under $950K.

To support the critical services that home visiting programs provide to District families, we ask the Council to fund the Nurse Family Partnership's $475K funding gap in the FY25 budget, and to update the program's FIS, and fund the Home Visiting Services Reimbursement Act of 2023 Medicaid Reimbursement for home visiting based on corrected cost estimates.

Thank you for the opportunity to testify today, and I welcome any questions.

Mary Katherine West
Home Visiting Program Manager
DC Action
mkwest@dckids.org

Jennifer Vega

Testimony for Department of Health Care Finance Committee DC Council Budget Hearing

April 29, 2024

Good morning Chair and committee members overseeing the Department of Healthcare Finance. Thank you for the opportunity to address the Council today. My name is Jennifer Vega, I am a Nurse Home Visitor. I am testifying for the continuation of the home visiting program Nurse Family Partnership and for the funding of the Medicaid Reimbursement Bill that will help us survive and continue to support First time expectant Families navigating new pregnancy in the District.

According to NFP research, mothers in NFP improve their diets and reduce their use of tobacco, alcohol and illegal substances. They also learn how to effectively care for themselves and their children and recognize their children's developmental milestones along with educational resources. Parents in NFP learn about children's behaviors and develop positive approaches and nonviolent parenting techniques. They also develop a vision for their future and find ways to stay in school, seek employment and plan future pregnancies so they can achieve economic self-sufficiency.

According to gathered data by NFP, in this program: 48% children are less likely to suffer child abuse and neglect, 56% in reduction of ER visits for accidents and poisoning, 67% are less likely to experience behavioral and intellectual problems at age 6, 72% of fewer convictions of mothers, 35% of fewer hypertensive disorders of pregnancy, 82% in increase of mothers employed.

NFP nurses play a critical role in the lives of first-time mothers and their children. We visit the families in their homes, help moms and their partners through their pregnancies, birth, postpartum, up until their children are 2 years old. During these visits we talk about a wide range of topics such as following a healthy and safe pregnancy, breastfeeding, newborn care, childhood development activities, and parenting skills. We also focus on helping them identify their personal strengths and guide them to achieving a better future for themselves and their families.

I would like for NFP to continue to expand throughout all the states in the US. NFP is currently serving in 40 states, including Washington DC, the US Virgin Islands, and some Tribal communities. In Washington DC, we have a team of 4 NFP nurses with a caseload capacity of 25 participants. It would be greatly beneficial to our community

if this committee funded the Medicaid Reimbursement Bill that 28 other states have already implemented to make sure programs like mine have the resources to keep our commitments to families.

It is essential that DC supports and invests in prevention programs like Home Visiting if we would like to see our community thrive. Prevention is key, it is our duty as members of this community to assist with building a brighter, safer, and healthier future for all those around us and you are in the position to make this possible. Please fund this MR Bill and make sure the NFP team can continue to make healthy pregnancies possible for our neighbors in DC.

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Testimony Before the District of Columbia Council
Committee on Health
April 29, 2024

Public Hearing:
Budget Oversight Hearing
Department of Health Care Finance

Leah Castelaz
Policy Attorney
Children's Law Center

Introduction

Good morning, Chairperson Henderson, and members of the Committee. My name is Leah Castelaz. I am a Policy Attorney at Children's Law Center and a resident of the District. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today regarding the Mayor's proposed budget for the Department of Health Care Finance (DHCF). In the past few years, DHCF has spearheaded both the Perinatal Mental Health Task Force (Task Force) and the newly restarted Maternal Health Advisory Group (MHAG).[1] Both groups have identified myriad opportunities for the District to improve perinatal health outcomes.[2] Specifically, the Task Force report identifies home visiting as a critical support in the continuum of care to address perinatal health concerns – both physical and mental health.[3]

Children's Law Center agrees – home visiting in the District has provided significant supports across a multitude of populations to help build solid foundations for

children and families. As of FY23, there are 17 home visiting programs throughout the District.[4] One of those programs is implemented by Mary's Center, and is known as Nurse Family Partnership First Time Mother's Home Visiting Program (NFP FTM).[5] In 2021, Mary's Center piloted NFP FTM to help address a gap in the populations being served by home visiting programs in the District. NFP FTM focused on supports for first-time mothers facing financial barriers.[6] NFP FTM is a widely researched, evidence-based home visiting model with proven long-term positive outcomes for both the child and parent participants.[7] Since the launch of NFP FTM, Mary's Center has seen many positive outcomes for its participants.[8]

We are grateful for the Council's efforts to support the establishment of NFP FTM in the District. In FY22 and FY23, DC Health local funds were used to support the launch of NFP FTM in the District.[9] Mary's Center secured the necessary additional funding through private philanthropic dollars. In FY24, the funding for NFP shifted from DC Health to DHCF with an increase in the total funding allocation.[10] The goal of the shift from DC Health to DHCF was to support the inclusion of NFP FTM and other evidence-based home visiting programs in the District into Medicaid reimbursement.[11] In FY24, DHCF awarded NFP FTM a one-time grant funding of $225,000 to continue to support their work while waiting for Medicaid reimbursement to become available.[12] Unfortunately, as of today, Medicaid reimbursement for home visiting is not yet available and there is no clear timeline for when it will become available.

We were, therefore, very pleased to see that the Mayor's proposed budget includes recurring funding of $225,000 for home visiting grants.[13] Unfortunately, this is not sufficient to keep the District's NFP FTM program open in FY25. NFP FTM costs $800,000 per year – this cost covers staff, all of whom are registered nurses, training, services and resources for families, and supervision.[14] Based on Mary's Center past fundraising performance, we are hopeful that Mary's Center will raise approximately $100,000 to support this program. The Council, therefore, needs to invest an additional $475,000 in one-time funding to keep the program running in FY25.

We are asking this Committee for one-time funding (instead of recurring funds) because we believe – with the right strategy and investments – the District can ensure home visiting is Medicaid reimbursable before the end of FY25. To do this, the Committee must also fund the Home Visiting Services Reimbursement Act of 2023 ("Home Visiting Medicaid Reimbursement"). Investment in Home Visiting Medicaid Reimbursement means that the District will be able to strategically leverage federal Medicaid dollars to support NFP FTM and other evidence-based home visiting programs beginning in FY25. Sustaining NFP FTM for FY25 and investing in its future through Medicaid dollars is a smart move for the District. Difficult budget years – like this one – often highlight how unstable grant funding is. Grants can easily be cut or repurposed, leaving programs unsure of their futures. Medicaid funding is significantly more stable and ultimately allows the District to move away from heavy reliance on local dollars to fund programs.

We, therefore, ask this Committee to also invest in Home Visiting Medicaid Reimbursement.

My testimony today will therefore focus on the steps this Committee must take to ensure home visiting services for first time mothers remain available to District families. Specifically, the Committee must: (1) invest one-time funding of $475,000 so the program survives in FY25 and (2) invest in and support Home Visiting Medicaid Reimbursement, ensuring the sustainability and longevity of NFP FTM.

DC's First Time Mothers' Program is at Risk of Ending if an Investment is Not Made in the FY25 Budget

Overall, DC ranks as one of the lowest in the nation for perinatal and infant health outcomes.[15] To begin to remedy this grim reality, the District has made several key investments in perinatal and infant health programs meant to support the whole family.[16] One of those programs has included the Nurse Family Partnership First Time Mother's Home Visiting Program (NFP FTM).

NFP FTM is a home visiting program that utilizes registered nurses to provide home visits to first-time mothers, beginning during pregnancy and continuing through the child's second birthday.[17] The program is aimed at new mothers with additional risk factors such as low income, single parenting, and age (under 19).[18] The home visitors work with parents to improve perinatal health outcomes, promote the parent-child relationship, and enhance child development.[19]

NFP FTM is a great investment in the continuum of care for the District's perinatal and infant population. Specifically, NFP FTM targets negative outcomes with proven strategies such as clinical assessments, individualized goal setting, educational materials, and self-advocacy skill building. In 2021, Mary's Center piloted NFP FTM in the District with support from local funding from the DC Council.[20] The original goal was to work with 12 families over two years in specific DC neighborhood clusters and populations identified by DC Health to have the highest rates of preterm delivery.[21] As we approach the end of the pilot period, the program has exceeded expectation – serving 96 first time mothers.[22]

Further, the program is reporting positive outcomes and improvements in perinatal and infant health across the two full calendar years. NFP FTM has supported no infants being born with a very low birth weight in 2023, ensuring all infants have up-to-date immunizations at 6 months, and providing all participants with mental health referrals when appropriate. Additionally, Mary's Center reported on father involvement in child's care and play – growing the scope of the home visiting program to include all relevant caregivers. The outcomes of mothers enrolled in NFP FTM are better than perinatal and infant health outcomes in the District as a whole.[23]

Despite the immensely positive impact of NFP FTM in the pilot period and the continued support across the District, all funding for NFP FTM is set to end by September 2024. Without additional funding, this program will be discontinued in FY25. There are

families currently enrolled in the program who will experience a direct loss in services if this program closes. The skilled and experienced staff currently working in the program will also be laid off. In sum, not providing further investment would result in a loss of trust within the community, impact the healthcare workforce, and be a missed opportunity to continue to solidify the continuum of care needed for perinatal health in the District.

The program currently costs $800,000 per year. We are pleased that the Mayor has provided a $225,000 investment in the proposed budget. However, that is not enough. There remains a gap of $575,000 to fully fund the program in FY25. Mary's Center has been working diligently to fill the gap and based on conversations with funders, we are hopeful they can fill in an additional $100,000 to support the continuation of NFP FTM in FY25. Therefore, we are asking for this Committee to provide one-time funding of $475,000 for NFP FTM to ensure the program does not have close in FY25. Ultimately, it is more cost effective to sustain this successful program now than to reestablish it later.

Investing in Medicaid Reimbursement for Home Visiting Will Make the Program Sustainable and Require Less Local Funding

It is clear the current funding structure for NFP FTM as well as other home visiting programs is not sustainable. Utilizing grants to fund home visiting means that programs are subject to yearly changes in their budget. Home visiting programs in the District have been plagued by fluctuations in funding causing instability particularly around hiring.[24] Grant funding is also subject to expiration like NFP FTM is experiencing. There are,

however, pathways towards more sustainable funding for home visiting programs in the District – by making applicable home visiting services eligible for Medicaid reimbursement.

The Mayor, DHCF, and the Council have all recognized and shown support for this path forward for home visiting. The Mayor included money for home visiting in the proposed FY25 budget.[25] DHCF during their budget briefing shared that they have chosen to make home visiting funding reoccurring to support the future incorporation of home visiting into Medicaid.[26] The Council passed the Home Visiting Services Reimbursement Act of 2023.[27]

Specifically, Home Visiting Medicaid Reimbursement requires DHCF to submit a State Plan Amendment (SPA) to make home visiting services reimbursable in the District. Eligible, evidence-based home visiting programs' ability to draw down Medicaid dollars opens up the possibility for more consistent and stable funding for these vital home visiting programs.[28] The legislation requires a per-member per-month payment for home visiting programs, which would allow programs to consistently budget as it would be primarily dependent on the number of enrollees and the reimbursement rate established by DHCF.[29] Per member per month reimbursement is well-suited to cover the work of home visitors and support provided services like breastfeeding education, parenting skills, family planning, nutritional information, case management, referral to services, screening and health promotion and counseling.[30]

We, therefore, ask this Committee to fund Home Visiting Medicaid Reimbursement. Funding Home Visiting Medicaid Reimbursement would help ensure that the funding for NFP FTM needed in FY25 is truly only one-time dollars. If funded in FY25, DHCF would be able to write the SPA, submit it to the Centers for Medicare and Medicaid (CMS), and, hopefully, receive approval. The ultimate goal is to begin to reimburse for home visiting services in FY25. If the investment in Medicaid reimbursement is reoccurring, the funding needed for NFP FTM would shift to Medicaid and the grant investment of $475,000 would not be needed in FY26. By providing a little more funding in FY25, the Council is strategically shifting local dollars to federal dollars in FY26 and beyond.

There are some obstacles to funding Home Visiting Medicaid Reimbursement. To fund this Act, the fiscal impact statement (FIS) must accurately reflect the true cost to the District. In an independent review of the FIS for Home Visiting Medicaid Reimbursement we believed the Office of the Chief Financial Officer (OCFO) had inflated the cost of home visiting Medicaid reimbursement in the District. We believe the FIS overestimates the cost to the District to provide Medicaid coverage of home visiting based upon multiple factors, including:

- Failing to account for other federal program dollars that currently support Home Visiting programs serving District Residents.
- Overestimating the cost of covering Alliance beneficiaries.
- Expecting significantly higher growth rate of programs.
- Sharing an incorrect number of eligible home visiting programs for Medicaid coverage.

For further explanations please see Attachment A, a letter to the Committee on Health detailing the changes that could be made to the FIS.[31]

Additionally, we would like to note that the FIS for FY25 can also be lowered with an amendment to the legislation to delay the start date for the SPA. Currently, the legislation requires that health insurance coverage through Medicaid or DC Healthcare Alliance and the Immigrant Children's Program begin on January 1, 2025.[32] This is likely too quick of a turnaround for DHCF to create a SPA, submit it to CMS, and receive approval. Therefore, we have suggested delaying the date to July 1, 2025. This would follow a similar timeline to the doula Medicaid reimbursement work that DHCF undertook in 2022.[33] We want to ensure DHCF has sufficient time to create a SPA that has stakeholder input and provides a sufficient reimbursement rate for eligible programs to be sustained by Medicaid reimbursement.

We appreciate this Committee, its staff, and the councilmembers including Councilmember Nadeau, the introducer of the Act, for leading on amending the FIS for Home Visiting Medicaid Reimbursement. We are glad to continue to work with this Committee, DHCF, and the OCFO to establish a lower FIS for FY25 and beyond.

Given the difficult budget year, we are hopeful we can lower the FIS, so it is reflective of the true cost to District to establish Medicaid reimbursement of home visiting. While we are confident it will be lower than the $3 million originally estimated, we also want to ensure that Medicaid reimbursement for home visiting programs can

come online in FY25.[34] Therefore, we ask that this Committee fund the final FIS provided by the OCFO for Home Visiting Medicaid Reimbursement.

Ultimately, funding Medicaid reimbursement in FY25 will be the most cost-effective way to support home visiting in the future and ensure during future years with difficult budget forecasts that home visiting programs across the District are not susceptible to cuts. Additionally, investing now in Medicaid reimbursement is a strategic way to support NFP FTM so they can continue this program for years to come. For home visiting to continue to be part of both DC Health's and DHCF's strategies to reduce poor perinatal health outcomes, the District must invest in this Act.[35]

Conclusion

In a time of economic difficulty, the DC Council can choose to take the long view; it can choose to protect important investments in our community's future health and economic development. As the Council considers spending to drive business and tourism, we ask that you to also recognize that the growth and vitality we want in our city requires multi-dimensional investments inclusive of all parts of our community. We must act from the District's values.[36] Even with budget pressures, we urge this Council to not forget what residents have repeated in public hearings over the last year – that public safety, academic achievement and economic development require sustained investment in access to housing, education, and healthcare.

While not investing further funding in home visiting may appear to balance the budget books, it will likely destabilize DC families. Losing home visiting, specifically NFP FTM, could be devastating for DC children and families as it might be *the one thing* helping a family make it work when everything else seems to be working against them. We cannot achieve long-term stability without a budget that prioritizes the well-being of DC residents.

In addition to the impact on families, there will be consequences for the District's economy in the long run. Just as eviction is a short-term fix that is ultimately more costly than prevention services like rental assistance, it is ultimately better to sustain programs through a tough budget year than to try to rebuild them later. Critically, the District cannot afford to disinvest from our labor market. We are already desperate to retain and expand our education, social service, and healthcare workforces. Cutting their jobs will only worsen the existing and future crises in these fields.[37]

Creating a balanced budget that ensures investments in the above budget asks does not always require cuts – the District can and should also consider opportunities to raise revenue. The District must ensure that it is doing everything to leverage federal dollars like Medicaid. Funding the Home Visiting Services Reimbursement Act of 2023 at a lowered FIS is a step in that direction.

To truly maintain our values and the programs that support economically vulnerable District residents, and ensure a stronger economic future, we encourage the

Council to consider revenue-raising proposals. The Council must be mindful that other revenue-raising options are balanced and do not wrongly burden low-income residents. We welcome the opportunity to work with the Council as it navigates a difficult budget season to ensure that revenue raised goes to support children and their families through funding home visiting in the District. Thank you for the opportunity to testify. I welcome any questions the Committee may have.

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[1] Department of Health Care Finance, Maternal Health Projects, *available at*: https://dhcf.dc.gov/maternalhealthprojects; Department of Health Care Finance, Perinatal Mental Health Task Force, *available at*: https://dhcf.dc.gov/publication/perinatal-mental-health-task-force.

[2] *Id.*

[3] Department of Health Care Finance, Perinatal Mental Health Task Force Report, (January 2024), p. 27-29, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf.

[4] District of Columbia Home Visiting Council, 2023 Annual Report, *available at*: https://wearedcaction.org/wp-content/uploads/2023-Home-Visiting-Council-Annual-Report.pdf.

[5] *Id.*

[6] FY2021 DC Health Performance Oversight Responses, response to Q41 and page 199, *available at*: https://dccouncil.gov/wp-content/uploads/2022/02/dohpoh.pdf; Nurse-Family Partnership, *available at*: https://www.nursefamilypartnership.org/; U.S. Department of Health & Human Services, Home Visiting Evidence of Effectiveness, *Implementing Nurse-Family Partnership (NFP), available at*: https://homvee.acf.hhs.gov/implementation/Nurse-Family%20Partnership%20(NFP)%C2%AE/Model%20Overview.

[7] U.S. Department of Health & Human Services, Home Visiting Evidence of Effectiveness, *Implementing Nurse-Family Partnership (NFP), available at*: https://homvee.acf.hhs.gov/implementation/Nurse-Family%20Partnership%20(NFP)%C2%AE/Model%20Overview; Miller TR. Projected Outcomes of Nurse-Family Partnership Home Visitation During 1996-2013, USA. Prev Sci. 2015 Aug;16(6):765-77. doi: 10.1007/s11121-015-0572-9. PMID: 26076883; PMCID: PMC4512284; Nurse-Family Partnership, *Proven Effective Through Extensive Research, available at*: https://www.nursefamilypartnership.org/about/proven-results/; RESEARCH FOLLOW-UP HIGHLIGHTS NURSE-FAMILY PARTNERSHIP'S SUBSTANTIAL IMPACT ON LOWERING HYPERTENSION RATES IN MOTHERS AND REDUCING OBESITY AMONG THEIR DAUGHTERS, Nurse-Family Partnership, (January 25, 2024), *available at*: https://www.nursefamilypartnership.org/in-the-news/research-follow-up-highlights-nurse-family-partnerships-substantial-impact-on-lowering-hypertension-rates-in-mothers-and-reducing-obesity-among-their-daughters/.

[8] Data on Nurse-Family Partnership in calendar year 22 and calendar year 23 on file with Children's Law Center.
[9] FY2021 DC Health Performance Oversight Responses, response to Q41 and page 199, *available at*: https://dccouncil.gov/wp-content/uploads/2022/02/dohpoh.pdf.
[10] FY2024, Department of Health Care Finance Budget, District's Approved Budget Enhance, E-62.
[11] Council of the District of Columbia Office of the Budget Director, Certification of the Draft Report and Recommendations of the Committee on Health on the Fiscal Year 2024 Budget and Financial Plan for Agencies Under Its Purview, (April 26, 2023), p. 96, *available at*: https://lims.dccouncil.gov/downloads/LIMS/52615/Committee_Report/B25-0203-Committee_Report7.pdf?Id=162585.
[12] FY2023 Department of Health Care Finance Performance Oversight Responses, response to Q80, *available at*: https://lims.dccouncil.gov/Hearings/hearings/282.
[13] Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-63.
[14] Per Mary's Center, please reach out to Fernanda Ruiz, Home Visiting Director at Mary's Center, fruiz@maryscenter.org.
[15] FY2023 DC Health Performance Oversight Responses, response to Q43, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232; Perinatal Mental Health Task Force: Recommendations to Improve Mental Health in the District, January 9, 2024, p. 38, *available at*: https://lims.dccouncil.gov/downloads/LIMS/54594/Introduction/RC250123-Introduction.pdf?Id=183298; District of Columbia's Maternal Mortality Review Committee Annual Report, 2021, published September 2023, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/MMRC2021Annual%20ReportFinal.pdf; Ayan Sheikh and Chris Remington, *Why do so many Black infants in D.C. die before their first birthday*, January 30, 2024, *available at*: https://wamu.org/story/24/01/30/listen-why-do-so-many-black-infants-in-d-c-die-before-their-firstbirthday/; Rachel Metz, *DC Must Continue Tackling Youth Mental Health Crisis*, DC Action, August 21, 2023, *available at*: https://www.wearedcaction.org/blog/dc-must-continue-tackling-youth-mental-healthcrisis.
[16] Programs like HealthySteps, home visiting, doula Medicaid reimbursement. *See* Leah Castelaz, Testimony Before the DC Council Committee on Health, (December 14, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/12/L.-Castelaz_Maternal-Health-Roundtable_Committee-on-Health_December-14-2023_final.pdf.
[17] Nurse-Family Partnership, *available at*: https://www.nursefamilypartnership.org/; U.S. Department of Health & Human Services, Home Visiting Evidence of Effectiveness, *Implementing Nurse-Family Partnership (NFP), available at*: https://homvee.acf.hhs.gov/implementation/Nurse-Family%20Partnership%20(NFP)%C2%AE/Model%20Overview.
[18] *Id.*
[19] *Id.*
[20] FY2024 DC Health Budget Oversight Responses, response to Q14(c), *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAIiPdhYtacABxBTKEvacWWa/FY%202024%20Budget/DOH/Agency%20Responses?dl=0&preview=FY24+DC+Health+Budget+Oversight+Questions_final040723.docx&subfolder_nav_tracking=1.
[21] FY2021 DC Health Performance Oversight Responses, response to Q41 and page 199, *available at*: https://dccouncil.gov/wp-content/uploads/2022/02/dohpoh.pdf.

[22] Data on Nurse-Family Partnership in calendar year 22 and calendar year 23 on file with Children's Law Center.
[23] FY2023 DC Health Performance Oversight Responses, response to Q43, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.
[24] District of Columbia Home Visiting Council, Home Page, *available at*: http://www.dchomevisiting.org/; District of Columbia Home Visiting Council, 2023 Annual Report, *available at*: https://wearedcaction.org/wp-content/uploads/2023-Home-Visiting-Council-Annual-Report.pdf; Leah Castelaz, Testimony Before the DC Council Committee on Health, (October 4, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-home-visiting-services-reimbursement-and-childhood-continuous-coverage-acts-of-2023/; Leah Castelaz, Testimony Before the DC Council Committee on Health, (April 10, 2023), *available at*: https://childrenslawcenter.org/resources/fy24-budget-testimony-dc-health/; Leah Castelaz, Testimony Before the DC Council Committee on Health, (March 2, 2023), *available at*: https://childrenslawcenter.org/resources/fy23-oversight-testimony-dc-health/.
[25] Mayor's Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part III, Human Support Services, Operations and Infrastructure, Financing and Other, and Enterprise and Other, p. E-63.
[26] Notes from Department of Health Care Finance Budget Briefing on Thursday, April 11, 2024, on file with Children's Law Center.
[27] D.C. Law L25-0142. Home Visiting Services Reimbursement Act of 2023.
[28] HRSA, Managing Multiple Funding Sources to Supporting Home Visiting Programs, *available at*: https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/managing-multiple-funding.pdf; Elisabeth Burak and Vikki Wachino, Promoting the Mental Health of Parents and Children by Strengthening Medicaid Support for Home Visiting, Think Bigger Do Good, May 9, 2023, *available at*: https://thinkbiggerdogood.org/promoting-the-mental-health-of-parents-and-children-by-strengtheningmedicaid-support-for-home-visiting/; and National Academy for State Health Policy, Medicaid Reimbursement for Home Visiting: Findings from a 50-State Analysis, May 1, 2023, *available at*: https://nashp.org/state-medicaid-reimbursement-for-home-visiting-findings-from-a-50-state-analysis/.
[29] D.C. Law L25-0142. Home Visiting Services Reimbursement Act of 2023; National Academy for State Health Policy, Medicaid Reimbursement for Home Visiting: Findings from a 50State Analysis, May 1, 2023, *available at*: https://nashp.org/state-medicaid-reimbursement-for-homevisiting-findings-from-a-50-state-analysis/.
[30] At least 19 states cover some form of skill building provided by home visiting, including Maryland. *See* National Academy for State Health Policy, Medicaid Reimbursement for Home Visiting: Findings from a 50 State Analysis, May 1, 2023,*available at*: https://nashp.org/state-medicaid-reimbursement-for-homevisiting-findings-from-a-50-state-analysis/.
[31] For further calculations please reach out to Leah Castelaz, LCastelaz@childrenslawcenter.org to access excel document associated with Attachment A.
[32] D.C. Law L25-0142. Home Visiting Services Reimbursement Act of 2023.
[33] The Maternal Health Advisory Group (MHAG) launched in December 2021, the MAHG met from December through June to inform the State Plan Amendment (SPA), DHCF submitted the SPA in July 2022, DC received approval of doula services from Centers for Medicare and Medicaid (CMS) on September 28, 2022, and services began October 1, 2022. *See* Department of Health Care Finance, Maternal Health Projects, *available at*: https://dhcf.dc.gov/maternalhealthprojects.
[34] Government of the District of Columbia Office of the Chief Financial Officer, Fiscal Impact Statement – Home Visiting Services Reimbursement Amendment Act of 2023, (December 11, 2023), *available at*:

https://lims.dccouncil.gov/downloads/LIMS/53251/Committee_Report/B25-0321-Committee_Report1.pdf?Id=181986.

[35] "The District, through Mayor Bowser's leadership and commitment to improving maternal health, is undertaking efforts to improve health outcomes and expand options for families to be successful. Bill 25-0321 builds an existing program and encourages expanding access to home visiting by leveraging federal Medicaid funding." Director, Byrd, Hearing on Home Visiting Reimbursement Act of 2023, October 4, 2023, *available at*: https://www.youtube.com/watch?v=K8JH7OoxfJw&t=550s. *See also* Doctor Doe, Roundtable: Maternal and Infant Health: Addressing Coverage, Care, and Challenges in the District, December 14, 2023, *available at*: https://www.youtube.com/watch?v=NsQaTDG7_jc.

[36] Government of the District of Columbia, Muriel Bowser, Mayor, #DCValues Playbook, *available at*: https://mayor.dc.gov/sites/default/files/dc/sites/mayormb/publication/attachments/DC%20Values%20Playbook.pdf.

[37] Mayor Muriel Bowser, Mayor's Healthcare Workforce Task Force, Report and Recommendations, *available at*: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2023-09-Healthcare-Workforce-Report-web.pdf; Mike Murillo, DC task Force to tackle health care worker shortage in the city, wtop news, May 5, 2022, *available at*: https://wtop.com/dc/2022/05/dc-task-force-to-tackle-health-care-worker-shortage-in-the-city/; D.C. Policy Center, Workforce and Labor Markets, *available at*: https://www.dcpolicycenter.org/workforce/.

ATTACHMENT A

February 20, 2024

Updated: March 21, 2024

Honorable Christina Henderson
Chair, Committee on Health
Council of the District of Columbia
1350 Pennsylvania Avenue, N.W.
Washington, DC 20004

Re: Fiscal Impact Statement for the Home Visiting Reimbursement Act of 2023

Dear Chairperson Henderson:

During the Department of Health Care Finance's Performance Oversight Hearing, you indicated you would welcome additional information regarding the OCFO's cost estimate for implementing the Evidence-based Home Visiting Program. As you heard from Fernanda Ruiz of Mary's Center, home visiting programs and advocacy organizations believe the OCFO grossly overestimated the cost to the District to provide Medicaid coverage of Home Visiting based upon multiple factors. Our rationale and analysis are set forth below. In addition, we have provided a spreadsheet that includes revised calculations that substantially reduce the local cost of implementing the Home Visiting Reimbursement Amendment Act.

I. The OCFO failed to account for other federal program dollars that currently support Home Visiting programs serving District Residents.

The OCFO's estimate of costs fails to account for other federal funding that currently supports Home Visiting Programs in the District. Early Head Start, for example, is funded by other Federal grants.[11] HIPPY is federal funding via Community-based Child Abuse and Prevention funds, while Mary's Center receives $1.2 million from DC Health through Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program funding to support Healthy Families America (HFA) and Parents as Teachers (PAT).[2] Medicaid (including the use of local Medicaid dollars) should not be used to supplant other Federal grant funding, particular grant funding that is formula based. The OCFO's failure to factor in existing federal funding erroneously inflates the cost of financing remaining costs through Medicaid. Removing the number of families currently being served by federal funding brings the total number of families for FY2025 down to 248. (see table 1 on excel tab "Financing _ PP + MV").

II. The OCFO overestimated the cost of covering Alliance beneficiaries.

The OCFO estimates that the yearly cost of serving one family in a home visiting program is $7,560. For a Medicaid beneficiary, the OCFO calculated the local cost to be $2,268. However, for an Alliance family, the OCFO concluded that the District would be responsible for the full cost of the program, or $7,560. In so doing, the OCFO failed to consider:

[1] While Medicaid covers Medical costs for many children in Head Start, as a general rule, other States are not using Medicaid coverage for home visiting to pay for Head Start.

[2] DC Home Visiting Council, Annual Report for FY2023, *available at*: https://www.wearedcaction.org/sites/default/files/2023%20HV%20Annual%20Report%20.pdf; FY2023 DC Health Performance Oversight Responses, response to Q45, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

A. Last year, following guidance published by CMS in State Health Official Letter 02-004, DHCF published a Notice of Intent to change its CHIP State Plan to establish CHIP eligibility for pregnant District residents with incomes at or below 319% of FPL who are not eligible for or enrolled in Medicare, Medicaid, or other third-party medical insurance. (See attached). The stated purpose of this SPA is to promote healthy pregnancies and healthy children regardless of the pregnant mother's eligibility status and the proposed effective date was October 1, 2023. Although the SPA has not yet been approved, DHCF has shared that they anticipate it will be in effect prior to FY 25. In sum, by the time Medicaid coverage for home visiting is effective, Alliance members who are pregnant will be eligible for CHIP coverage. In FY 25, DC's federal match rate for CHIP is 79%. Thus, extending CHIP coverage to Alliance members during pregnancy substantially reduces the local share of cost in FY2025 for Alliance members to $25,805 and for all program participants (Medicaid and Alliance) to $410,798, which is ten times less than the OCFO's estimate (see tables 2,3,4 and 6 on excel tab "Financing _ PP + MV").

B. Assuming Medicaid coverage for pregnant Alliance members is not established by January 1, 2025, the OCFO still overestimated the local cost of covering an Alliance member because once a child is born, home visiting program costs can be shifted to Medicaid (this is what Maryland does). According to Mary's Center, the average gestational age at which participants enroll for both Medicaid and Alliance families is 18 weeks or about four months, leaving a maximum of five months during which Medicaid would not be available.

C. DC also has the option to use MIECHV dollars to fund non-Medicaid eligible women during pregnancy. Under the new funding formula, MIECHV could cover 75% of the cost to cover immigrant women during pregnancy. Thus, lowering the average cost.

III. The OCFO overestimated the growth rate of programs.

The OCFO estimates that each program would grow by 50 families (40 Medicaid families and 10 Alliance families) each year. However, historically, the growth rate of programs has been much lower. For all currently eligible programs, the average growth rate for increased capacity is negative 1.30. Even factoring in Mamatoto Village and Georgetown, the average growth is only 2.7 families per year amongst all programs (please see "Average Growth Rate Tab" on Excel).

While we are hopeful that Medicaid will help increase the availability of programs, we do not believe that it will exponentially increase demand for the programs and thus increase capacity. Medicaid provides an opportunity to stabilize programs as they are.

IV. The OCFO's conclusion that 13 Home Visiting programs would be eligible for Medicaid coverage is incorrect.

Under the Home Visiting Reimbursement Act of 2023, to qualify as an eligible evidence-based home visiting program, the program must:

(1) Conforms to a home visitation model that has been in existence for at least 3 years and
(2) Is research-based and grounded in relevant empirically based knowledge;
(3) Has demonstrated program-determined outcomes;
(4) *Is associated with a national organization, institution of higher education, or other organization that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement*; and
(5) Meets the U.S. Department of Health and Human Services' criteria for evidence of effectiveness as determined by a Home Visiting Evidence of Effectiveness review or meets substantially equivalent criteria for evidence of effectiveness as determined by a credible, independent academic or research organization.

While the OCFO correctly notes there are currently 17 different home visiting programs operating in DC, the OCFO'S conclusion that 13 programs have the required certifications and would qualify for Medicaid coverage and funding using the criteria in the Home Visiting Reimbursement Act is incorrect.

Based upon our analysis, including checking the websites of the national organizations that ensure fidelity to specific home visiting models, and excluding Early Head Start and Nurturing Parent which are funded through other federal programs, we count only six programs operated by three organizations in DC that currently have the required certifications to qualify as an evidence-based program under the legislation.[3] These are:

- At Community of Hope, Parents as Teachers and Healthy Families America,
- At Mary's Center, Parents as Teachers, Healthy Families America and the Nurse Family Partnership.
- At the Family Place, HIPPY Home Visiting

As noted in the attached spreadsheet at Table 1 on the excel tab "Financing _ PP + MV", these six programs have a contracted capacity to serve 448 families, though they are currently serving less due primarily to staffing issues.

There are two additional programs that currently are undergoing the rigorous evaluation process to become certified as evidenced-based. There are: Georgetown and Mamatoto Village. It is anticipated that Georgetown will become certified as a PAT affiliate in FY2024. However,

[3] https://www.healthyfamiliesamerica.org/sites/; https://parentsasteachers.org/program-locator/; https://homvee.acf.hhs.gov/HRSA-Models-Eligible-MIECHV-Grantees#:~:text=Statutory%20requirements%20for%20an%20evidence,to%20program%20determined%20outcomes%2C%20associated; https://www.nursefamilypartnership.org/locations/district-of-columbia/; https://www.thefamilyplacedc.org/hippy-home-visiting; https://homvee.acf.hhs.gov/implementation/Nurse-Family%20Partnership%20(NFP)%C2%AE/Model%20Overview.

Mamatoto Village's evaluation, which is being conducted by an independent entity, is on-going and likely will not be completed until FY 2026. Georgetown currently has a capacity to serve 40 families, bringing the total number of contractual capacity for eligible home visiting programs to 488 families in FY2025. Mamatoto Village is currently serving 450 families, bringing the total number of families to 938 in FY2026. Note these numbers do not account for existing available federal funds which as described above removes a significant number of families accessing Medicaid dollars. (see table 1 on excel tab "Financing _ PP + MV").

Thus, accounting for existing federal dollars (MIECHV and CBCAP), we count seven programs for FY2025 with a total capacity to enroll 248 families. In FY2026, we count eight programs with a total capacity to serve 701 families (given the average growth rate, noted above, we have added 3 families to the FY2026 calculations so what is originally 698 we have added to). It is important to note that Mamatoto Village program cost is lower than the cost of HFA, PAT, and NFP. To deliver the Mothers Rising program and ensure an equitable wage for our supervisory and frontline staff, the total cost is $1.8M.[4] This comes out to total of $4,000 per family per year as compared to $7560 for the other evidence-based home visiting programs in the District. For more information on calculating Mamatoto Village inclusion in FY2026 please reference "Financing _ PP + MV" tables 3, 4, and 8.

Based on the corrected capacity, existing federal funding for home visiting, and the reduction of local funding for Alliance members, we have calculated the max local funds needed for FY2025 is $410,798.[5] For FY2026 and FY2027 calculations please see excel tab "Financing _ PP + MV" tables 2-4, 6, and 7.

Additionally, the start date of state plan amendment in the legislation, currently January 1, 2025, could be amended and postponed to lower the cost of Medicaid reimbursement in FY2025 even further. Please see tabs "7.1.25 start_Financing_PP+MV" and "4.1.25 start_Financing_PP+MV." **If amended to have the SPA by start July 1, 2025, the cost in FY2025 could be as low as $136,933.**

Please let us know if we can answer any questions or provide you with any additional information. Given the current state of maternal health in DC, we believe it is vital that the Mayor and Council identify funding to support these critical programs. Incorporating them into Medicaid also provides the opportunity to strengthen the ability of our Medicaid MCOS to reach and engage pregnant women and ultimately improve maternal health outcomes.

Finally, as you are aware, the Nurse Family Partnership (NFP) was established with the Council's support as a pilot program. NFP, as with other District home visiting programs, has seen many successes including significant increases in pregnant participants attending all recommended prenatal visits, receiving perinatal depression screenings, and no low birth weights for infants. (See Tab 3 in attached spreadsheet, "Nurse Family Partnership Data"). Unfortunately, NFP is at risk of ending. Although Mary's Center is working to secure continued philanthropic support, there is a possibility that without additional District support the program could fold in October 2024. We, therefore, hope we can work together to ensure enough funding to sustain NFP and fund Medicaid reimbursement for home visiting in the District.

We look forward to working with you and your staff to develop a more realistic estimate of the

[4] Mamatoto Village, Testimony before Committee of Health, (October 4, 2023), *available at*: https://lims.dccouncil.gov/downloads/LIMS/53251/Committee_Report/B25-0321-Committee_Report1.pdf?Id=181986.
[5] This assumes DHCF's CHIP SPA to provide prenatal care to immigrant women is approved and implemented.

fiscal impact of the Home Visiting Reimbursement Act of 2023.

Best regards,

Claudia Schlosberg, consultant for Nurse Family Partnership National Service Office
Leah Castelaz, Children's Law Center and Under 3 DC Coalition
Dara Koppelman, Executive Vice President of Health Services and Programs, Mary's Center
Felix Hernandez, Mary's Center and DC Home Visiting Council
Mary Katherine West, DC Action and DC Home Visiting Council

Copies to:

Hon. Brianne Nadeau
Hon. Vincent Gary
Hon. Charles Allen
Hon. Zachery Parker

Testimony for

FY 2023 Performance Oversight of the Department of Health Care Finance

April 29, 2024

Submitted By

Fernanda Ruiz

Home Visiting Director

Mary's Center for Maternal and Child Care, Inc.

To

Councilmember Christina Henderson, Chair,

Committee on Health

Testimony for FY2025 Budget Hearing of the Department of Healthcare Finance
Committee on Health
Department of Health Care Finance
April 29, 2024

Fernanda Ruiz
Home Visiting Director
Mary's Center for Maternal and Child Care, Inc
2333 Ontario Rd NW

Good morning, Chairwoman Henderson, and Members of the Committee,

Thank you for the opportunity to testify today. My name is Fernanda Ruiz, and I am the Home Visiting Director at Mary's Center, a member of Under 3DC and a District resident from Ward 4.

I am here today to provide testimony regarding Mary's Center's new partnership with DHCF to implement the Nurse Family Partnership program and the sustainability of the program.

As you are aware, Mary's Center was awarded this fiscal year $225,000 dollars from DHCF for the 2024 First-Time Birthing Person Home Visiting Grant. We are grateful for this investment in the Nurse Family Partnership (NFP) program, and we are glad to see this funding as recurrent in fiscal year 2025. As stated previously, NFP is a widely researched and proven evidence-based home visiting model, that supports first-time mothers facing financial barriers. Piloting NFP in the District was made possible through seed funding from DC Council and DC Health in FY22 with a funding award of $150,000 dollars and Mary's Center securing an additional $2.2 million dollars through private foundations. The community has received well the NFP program, and we are happy to report that NFP has supported 146 mothers and welcomed more than 106 healthy births in the three years of being piloted. We are excited to continue to partner with the District in offering NFP to more mothers and their children in the District.

However, despite the success of the program, NFP is at risk of not being funded. As stated during the Oversight Performance Hearing for DHCF, all private funding for NFP ends with the fiscal year. Mary's Center is raising funds and pursuing other grant opportunities, both federal and private. Yet, the only secured funding for FY25 is the $225,000 dollars from DHCF which is 30% of the operating budget. For this reason, it is imperative that the District invests in long term sustainability strategies such as leveraging Medicaid and continues to support NFP. As we have discussed, The Home Visiting Reimbursement Amendment Act of 2023 provides a clear pathway for long term sustainability. We appreciate the unwavering support DC Council has demonstrated for the bill. However, without funding attached, the bill will not be implemented.

On this note, we appreciate the involvement and support the Council and DCHF have demonstrated in working with the Office of the Chief Financial Officer to review the Fiscal Impact Statement they provided for the implementation of the bill. In the most recent version shared with us last week, the FIS estimations have been revised, however, they continue to include programs that the advocates do not anticipate participating in the Medicaid reimbursement and the projections remain higher in comparison from the ones provided by the Home Visiting Council and Under 3DC.

Last year, Mary's Center incorporated Medicaid reimbursement for our home visiting programming in Maryland. From experience, we know it takes time to roll out Medicaid reimbursement and to incorporate billing. We are concerned Medicaid reimbursement will not come soon enough to save the NFP program.

Funding NFP and other evidenced based home visiting programs through Medicaid is not only cost-effective it also promotes better coordination of care and services for pregnant persons and

babies who are enrolled in Managed Care. Mary's Center continues through our social change model to be committed to the health, education and safety of families in the District. We hope we can build from here to continue our shared commitment to serve families in the District with the goal of improving maternal and child health outcomes.

Thank you for the opportunity to testify.

COUNCIL OF THE DISTRICT OF COLUMBIA

Committee on Health
Christina Henderson
FY 2025 Budget Hearing
Department of Healthcare Finance (DHCF)

April 29, 2024

Testimony of Veronica Sharpe
President
District of Columbia Health Care Association

My name is Veronica Sharpe. I am the President of the District of Columbia Health Care Association (DCHCA), representing all the licensed nursing facilities and assisted living communities in the District.

On behalf of the DCHCA facility members and the over three thousand District residents who rely on them for essential care and services, I must say that we are extremely grateful to the Mayor, her budget team, Deputy Mayor Wayne Turnage and Senior Deputy Budget Director, Angelique Martin for recognizing the need and funding increased rates for skilled nursing providers in the extremely difficult budget position that the District of Columbia is facing. When presented with the data that unfunded post- COVID cost were destabilizing the industry, action was taken. We are grateful for what is being done. I think it's important for Council to know that increasing the rates does not come without a price- tag to the industry, in order to support the increased rates the Nursing Home Provider Tax will be raised 0.5% to reach 6.0% the highest allowed by CMS. We are happy to do our part to make this happen.

As I reviewed my FY 2024 budget testimony, I was not surprised to be reminded that my testimony focused on the healthcare workforce crisis that we are facing in the District of Columbia. The majority of the costs being funded by our rate increase are due to the ever increasing wages that direct care workers and nurses are demanding providers to pay to stay competitive in the market place.

In Deputy Mayor Turnage's presentation of the DHCF budget there is a slide that shows that DC pays direct care workers the highest rates in the Region. He would be correct in saying that, but that is not who we are competing with, we are competing with employers that can offer similar or often better wages, better benefits, free training and safer and less stressful jobs. Direct care workers are leaving the industry and there is proof of that in last year's Board of Nursing renewal numbers. The direct care workforce shrunk by 4,489 workers or 30%.

In Mayor Bowser's testimony before the Committee of the Whole, the Mayor noted that the District had not made a similar investment in the direct care workers that care for older adults. The time to at least start moving toward comparable wages found under the Pay Equity Act for Child Development Associates is now.

We agree with Chairman Mendelson and the Council's methodology and commitment to restore and fully fund the Pay Equity Act and ask that Council look at similar solutions to fund the direct care workforce and establish pipelines to engage individuals in seeking this type of work.

The other area of the DHCF budget that I will comment on is that DHCF needs to fund improvements to the DCAS system that makes it more transparent and easier to track actions taken or requested on the provider side in their improvements to that system.

Thank you for the opportunity to testify. I'm happy to answer any questions.

Good morning, Councilmember Henderson, and members of the Committee on Health. Thank you for the opportunity to address the Council today. My name is Abby Goldstein, I am the Nursing Supervisor for Mary's Center's Nurse Family Partnership Program (NFP) and a resident of Ward 4. I want to thank you for the support you have given to DC's nascent Nurse Family Partnership program. It was instrumental to our initiation just 3 years ago and continued growth and success to date in building our program. I am testifying today about the extremely time sensitive need to provide one-time gap funding of $475,000 to ensure the program continues. Additionally, we can secure long-term sustainable funding by lowering the Fiscal Impact Statement in order to implement and fund the already, unanimously passed Home Visiting Medicaid Reimbursement Act of 2023. At a 70% federal dollar match to just 30% of local funding we can bring in significant outside funding to benefit our families in DC with only a small investment from our limited budget.

One of the most striking things we see with clients is a lack of social support. Just to provide a glimpse of the numbers, in just 3 years NFP has worked with 146 families including 105 children. Of those clients our assessments have shown that 1 in 3 report loneliness, isolation, depression, anxiety and/or mental health issues. The saying that "it takes a village" is not a luxury the majority or our clients have the benefit of harnessing right as they are entering a critical time for themselves and their new families. Unfortunately, most come with a history of significant challenges, lack of support, and repeatedly fractured relationships with those they should be able to depend on. A Nurse Home Visitor (NHV) comes alongside families to provide non-judgmental support when they are looking to be a secure base of safety and attachment for their newborns. As they navigate this unique time period and work to set a new pattern for their children, families benefit from the nursing expertise in not only physical and mental health assessments and medical education but also in all areas that touch on social determinants of health. However, with our work at risk of funding cuts, not only would we not be able to support future families in the manner that has proven to improve outcomes for both parents and children but we would be forced to terminate services to those families we are currently working with. This means that it would be just one more broken relationship in their lives, one more person or system to allow them to fall through the cracks after offering the promise of something different. Simultaneously it would lay waste to all of the resources we have invested in training the excellent team of RNs over the past 3 years that are now experienced in the NFP model and consistently practicing at such a nuanced and high level of implementation. This cannot be easily replaced.

With this connection to their NHV families are able to gain increased self-sufficiency to bridge the gap in pre-existing lack of access, knowledge, skills and information to be

able to address the needs of their families in a way that not only encourages their progress but also prevents greater deterioration of their social, emotional and physical needs.

I am thrilled to share a recent update from my experience as a NHV with NFP in New York City prior to coming to DC to build the new program here.. At 18 years old and pregnant with her first child this NFP participant was in a group home after being in and out of foster care throughout her childhood. She moved back in with her mother, who struggled with severe mental health illness. Her relationship with the father of the baby included past and current IPV, including instances of choking her until she passed out and numerous calls to law enforcement. Despite that, he and his family continually threatened to take her child away from her and call CFSA. With pre-eclampsia and post-partum depression she also found herself parenting a colicky newborn who turned out to have a protein milk allergy causing blood in her stool and poor weight gain. Together we called the pharmacy to obtain her medication to control her blood pressure, connected her with a therapist, and tracked her daughter's weight and intake with numerous follow-up calls and appointments with her pediatrician in order to identify the allergy and the appropriate formula. I will never forget waiting in my car for 2 hours from 5:30 – 7:30pm on a Monday night to meet her and her new baby, as we had planned, when they were initially discharged from the hospital to return home for the first time. The client called and texted me to say that she really wanted to have our visit and would I please wait for her. The client's mother had picked her and her 3-day old baby up from the hospital and took them to the courthouse for a hearing while they waited for 4 hours before they could go home. Just 2 weeks ago this mother reached out to me to let me know that she had moved away from NYC. She was no longer in touch with the father of the child but was married, in a safe and supportive relationship. She is now working at a VA hospital near her and completed her GED. She is currently enrolled in Nursing School. Her child, that I met that first night after a 2 hour wait in my car, is in 1st grade and doing wonderfully. All of this progress did not happen overnight or even within the 2.5 years I was completing home visits with her. It happened step-by-step by laying the foundation for this progress that continues to develop over this now 26-year old and her daughter's life. She reached out to me to share her success and express how meaningful her participation in NFP was to her journey. I share this story with you not because it is unique. It is merely the most recent example reminding me of the immense value this program offers to those that have the opportunity to participate in Nurse Family Partnership.

With a significant yet relatively small investment from DC government we can not only continue to provide these evidence-based programs like Nurse Family Partnership to current families but also ensure it is available for families of our newest DC residents.

Thank you so much for taking the time to learn more about home visiting and Nurse Family Partnership today. I hope that we will have the opportunity to continue to serve as a crucial support system for families throughout DC while building a stronger base for their future.

Date: April 29, 2024

To: Committee on Health, Council of DC

From: Makeda Vanderpuije, Executive Director, LeadingAge DC

Re: Proposed FY 25 Budget for the Department of Health Care Finance (DHCF)

Good afternoon, Chairperson Henderson and members of the Committee on Health, and thank you for the opportunity to testify today. My name is Makeda Vanderpuije and I am the Executive Director of LeadingAge DC, representing mission-driven organizations serving older adults across the District, including nursing homes, assisted living, affordable housing, Senior Villages, home and community-based services, and Life Plan Communities (CCRCs). I am also a District resident and an active member of the District of Columbia Coalition on Long Term Care's Workforce Development Committee.

I am testifying in support of funding in the proposed FY 25 budget to address the direct care workforce crisis.

Mayor Bowser's proposed fiscal year 2025 budget reflects tight budget constraints and difficult decisions about where to direct finite resources. Unfortunately, it falls short of expectations that the District will make critical investments to the aging services continuum of care.

We applaud the commitment of DHCF to make targeted investments in provider rates in the proposed FY25 budget, especially for our mission-driven nursing home providers who are facing surging costs and increasing demands.

I commend Chairperson Henderson and the seven co-sponsors of the groundbreaking Direct Care Workforce Amendment Act addressing the direct care workforce crisis and thank you for your leadership. The LeadingAge DC provider members who have collectively served many thousands of older adults in our community across hundreds of years, are depending on this effort to support and rebuild this essential healthcare workforce and remain committed to providing high quality care to some of our most vulnerable residents. When enacted, which we urge Council to do as soon as possible, this Act has the potential to enrich the lives not only of direct care workers, but also of our elders and the community at large.

The necessity of this legislation is highlighted by the rapidly growing population of older adults in the District – the Office of the Budget Director estimates that over the next five years approximately 44,200 residents will turn 65 years old and increasingly, residents will require support with tasks of daily living at home or in a facility setting. It is especially troubling then, that the professional caregivers who make it possible for family members to work in a fulfilling profession, and for elders to be cared for and age with dignity, are leaving the field for jobs that are less difficult, require less training and pay more money.

While we recognize that finding or creating revenue to fund needed pay increases and workforce training is challenging, this is an investment in the health of our residents that we cannot afford to overlook. The decision by Chairperson Mendelson to redirect $217 million from the reserve fund to restore cuts to the Pay Equity Fund highlights the importance of equitable wages for child development workers who care for our youngest residents. In an equitable District, this prioritization

naturally applies to the workers caring for our eldest residents and their families. The estimated cost for an increase in wages for 7,723 direct care workers - Home Health Aides and Trained Medication Aides currently certified/registered to work in DC – is $17.58 Million (see Table 1 below).

Direct care workers deserve a living wage that supports their families without needing to rely on overtime and public benefits to make ends meet. Older adults need access to timely, quality care to support good health and manage health challenges before they become more costly. Mission-driven providers ought to be able serve those in the community who need care, while keeping their employees paid well and their facilities safe and open. Young people and those looking for a career change should see professional caregiving as a fulfilling career with potential for wage growth and professional advancement[1].

Our elders have so much to contribute to our communities, sharing hard-earned wisdoms, providing childcare and mentorship, volunteering and so much more. LeadingAge DC members, largely not-for-profit organizations, and the direct care workers that they employ, are committed to providing high-quality care, services, and supports that empower aging residents to live with meaning, purpose and dignity.

To do so, they need your continued support and *a coordinated all-of-government approach to finding long-term solutions for this workforce crisis*, as well as *reimbursement at a level that allows them to*

[1] *DC would need to raise the hourly wages of Direct Care Workers to a minimum of $23.13 cents to be eligible for OSSE's CTE Training program. See District of Columbia Career and Technical Education State Plan (draft) 2024-2025, page 32-33. Accessed at: https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/State%20Draft%20Plan_v3.2.29.24_Appendix.pdf.

cover costs and pay a fair, living wage to direct care workers and other licensed professionals.

LeadingAge DC is ready and willing to support the Committee and partners in realizing a future where all District residents can age well and thrive.

I welcome any questions that you may have.

Table 1 Developed by DC Coalition on Long Term Care

Incremental Local Cost of Raising the Average Wage of DSPs

Percent of Living Wage (1)	TOTAL Average Annual Wage per FTE (2)	Average Hourly Wage	Incremental Cost Increases Per Hour	Local Share of Hourly Increases @ 30%	Total Local Share of Annual Increase for 1 FTE	Total Annual Unfunded Increase in Local Cost for 7,723 Direct Care Workers (3)
117.6%	$42,806	$ 20.58				
120%	$43,680	$ 21.00	$ 0.42	$ 0.13	$ 314	$ 2,428,853
122%	$44,408	$ 21.35	$ 0.77	$ 0.23	$ 577	$ 4,452,896
125%	$45,510	$ 21.88	$ 1.30	$ 0.39	$ 973	$ 7,517,877
130%	$47,370	$ 22.75	$ 2.17	$ 0.65	$ 1,625	$ 12,549,072
135% (4)	$49,130	$ 23.62	$ 3.04	$ 0.91	$ 2,276	$ 17,580,266

NOTES:

(1) The Living Wage rate used to calculate the average wage is $17.50. According to MIT"s Living Wage Caculator, a Living Wage in DC for a single adult in 2023 is $23.90. See: https://livingwage.mit.edu/states/11

(2) FTE = 2080 hours

(3) As reported by the Board of Nursing on January, 3, 2024, 7,723 represents the number of direct care workers (Home Health Aides and Trained Medication Aides) that are currently certified/registered to work in DC). We have excluded Certified Nursing Assistants from this calculation because DHCF has already included a $7.9 million increase for Nursing Facility reimbursement rates in the FY 25 proposed budget. The increase in Nursing Facility reimbursement rates primarily funds increased labor costs including costs for direct care workers.

(4) DC would need to raise the hourly wages of Direct Care Workers to a minimum of $23.13 cents to be eligible for OSSE's CTE Training program. See District of Columbia Career and Technical Education State Plan (draft) 2024-2025, page 32-33. Accessed at: https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/State%20Draft%20Plan_v3.2.29.24_Appendix.pdf.

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Testimony Before the District of Columbia Council
Committee on Health
April 29, 2024

Public Hearing:
Budget Oversight Hearing
Department of Health Care Finance

Amber Rieke
Policy Lead, *A Path Forward*
Children's Law Center

Introduction

Good Morning, Chairperson Henderson, and members of the Committee on Health. My name is Amber Rieke, and I lead the *Path Forward* project at Children's Law Center.[1] Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism, and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify about the proposed Fiscal Year 2025 (FY25) budget for the Department of Health Care Finance (DHCF). Our clients often have significant behavioral health needs – whether they are involved in the child welfare system or navigating other upheavals – yet are frequently unable to find the services they need. Their greatest obstacles are a) the lack of behavioral health care professionals practicing in public programs, and b) the challenges of navigating between and through services and across agencies.[2] According to the American Academy of Pediatrics, behavioral health is the largest unmet health need for children and youth in foster care nationally.[3] This is why we have supported DHCF's recent projects to better integrate

behavioral health care with physical health, and to broaden the network of providers with whom it contracts.

We are glad DC is a jurisdiction that strives to expand access to services. However, our public healthcare system still needs significant work in many areas to provide timely, accessible, high quality, culturally appropriate, or affordable care to thousands of children who need it. This is why Children's Law Center joined with partners and community members to write *A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, which details the many needs and recommends 94 actions to improve the system.[4] The behavioral health system envisioned in *A Path Forward* would deliver high-quality mental health and substance use services along the full continuum of care (early identification, treatment, recovery and rehabilitation services, and long-term supports) that meets the evolving needs of children in DC. Service networks would be actively coordinated with accountability and efficiency, and care would be integrated for ease of access.

As you know, DHCF has recently halted integration of behavioral health services into Managed Care Organizations (MCOs) which was in the works for years – also referred to as the behavioral health "transformation" or "carve-in." While we understand the revenue constraints driving this decision, our testimony today will: 1) underscore why the District's goal of integration should not be abandoned, 2) call for more meaningful stakeholder engagement in this and DHCF's other ongoing system

improvement projects, and 3) re-iterate the imperative for network adequacy and higher payment in the Medicaid provider network. We also ask the Committee to maintain its oversight and hold public hearings for the sake of transparency and community engagement.

The District's Goal of Behavioral Health Integration Has Been Years in the Planning and Should Not be Abandoned.

DHCF has undertaken multiple projects in recent years to expand services in Medicaid and implement models that incentivize better whole-person care. First, DHCF started moving most Medicaid beneficiaries from a fee-for-service model to a managed care model in 2019.[5] With built-in care coordination and value-based purchasing requirements, managed care rewards good patient outcomes instead of high volume,[6] helping the District move toward the "triple aim" of better care, better health outcomes and reduced costs.[7]

In 2020, through the District's Section 1115 Medicaid Behavioral Health Transformation Demonstration Waiver, DHCF began preparing to integrate[8] a "broader continuum of behavioral health treatment" into its managed care contracts.[9] "Carving in" behavioral health services to Medicaid would allow the District to pull in federal matching dollars for the carved-in services, as opposed to only using local dollars through the Department of Behavioral Health (DBH), as well as improve system navigation for patients.[10]

We shared DHCF's goals to expand Medicaid services and better integrate care for the District's low-income residents and children. The World Health Organization defines integrated care as "health services organized and managed so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."[11] Research has linked pediatric integration models to improved behavioral health outcomes in children.[12] Integrated behavioral health services also help to reduce stigma for individuals who may not have otherwise sought services in a behavioral health clinic.[13] For children, care integration ensures access to behavioral health services in settings they already are, such as child care centers, K–12 schools, and pediatric primary care practices.[14] We were optimistic that the carve-in would facilitate this access and improve outcomes. However, there have been significant challenges for the provider network in this transition, as well as protracted delays.

In part due to the disruptions of the COVID-19 Public Health Emergency, the integration was delayed from 2022 to October 2023, and again to April 2024. Despite the longer ramp-up, at the January and February 2024 performance oversight hearings for DBH and DHCF respectively, the Committee heard testimony from several providers and advocates expressing pessimism about the system's readiness for – and communication about – the imminent change.[15] The mechanics were still not ready, nor were all the payment rates set.[16] If unable to transition seamlessly from DBH contracts to

their new MCO payors, providers stood to lose revenue, potentially displace their patients, and undermine the intentions of the transformation.[17]

Then, on February 28, less than five weeks before the carve-in date, DHCF officially announced to stakeholders that the MCO carve-in was "paused."[18] At that time, they did not share details, other than generally citing budgetary reasons. Questions about the future timeline went unanswered. At DHCF's budget presentation on April 11, Deputy Mayor Wayne Turnage stated that the FY25 budget maintained behavioral health services in Fee-for-Service and walking back the carve-in created $13.7 million is "savings" for the year.[19] He explained that the carve-in would only move forward if future revenue increased significantly enough.[20]

We understand that this decision came in the middle of a difficult juncture in budget formulation for FY25. However, we are frustrated that the years-long cooperation of providers and advocates has not been honored with clear answers about the future. Community-based organizations (CBOs) were required to make significant administrative changes to participate in the Medicaid infrastructure, certify and contract with the new insurance companies, and adjust to new billing procedures, timelines, and methodologies.[21] Ultimately, we are most disappointed that the systemic barriers keeping our clients and other residents from care will no longer see a remedy. We hoped that the carve-in – though not a panacea – would more effectively align services, expand access, ease navigation, and better support children and their families by integrating all care

through one case management hub. It is not clear how these goals will now be pursued, or how else the District's systems will be reformed to produce better behavioral health outcomes than the status quo.

The indefinite delay of the carve-in will also impact other notable projects across government. As just one example, DBH has publicly committed to create a strategic plan for Children's behavioral health, beginning this year.[22] We have called for such a plan, specifically one that is developed through interagency collaboration, with input from relevant stakeholders, including families, youth, service providers, and education agencies, to outline the long-term goals for children's behavioral health in DC. We are concerned that without clarity on DHCF's short- and long-term plans for a carve-in, it will be very difficult to create this plan. District families who rely on the public behavioral health system for critical services – as well as the Council – deserve more clarity about how integration will be pursued and achieved in the immediate future.

More Meaningful Stakeholder Engagement in DHCF's Ongoing System Improvement Projects is Necessary

DHCF has the responsibility to not only effectively communicate changes to processes, procedures, and payments to providers and patients – with enough time for them to respond and adjust – but to better support these community-based businesses and their thousands of patients every step of the way. We do not believe that DHCF or DBH put sufficient technical assistance in place to support providers through the lead up

to the carve-in – or enough communication about the decision to pause.[23] In fact, as of this hearing date, DHCF's website still heralded April 1 as the effective date for the carve-in.[24]

The issues with communication go beyond the technical assistance or the budget shortfalls for the carve-in, extending to other components of the original (2019) 1115 Waiver.[25] According to an evaluation by American Institute for Research (AIR), the District has met only two of the 11 goals of the original 1115 Waiver.[26] We only saw these evaluation results this month when DHCF released its proposed application for its upcoming 2024 waiver. We are concerned that DHCF has not been transparent enough – with this Committee or the community – about the costs, delays, capacity issues, and success of its system improvement projects. In this light, we were troubled that along with the carve-in pause, future meetings of the Public Forum on Integrated Care – where stakeholders received updates and provided input on the carve-in project – have been cancelled.

Separately, but related, the community engagement processes for the new 1115 Waiver application has been constrained because DHCF has created tight deadlines for input during busy times of year. Specifically, it published a survey to collect stakeholder suggestions right before the November holiday and announced the public comment period on the proposed application for one month in the middle of the District's contentious budget process.

Diverse, inclusive collaborations with community stakeholders, especially families and youth, should be actively sought in all of DHCF's activities, not just to satisfy legal requirements but to lead to better results. In regard to managed care behavioral health integration, a Center of Health Care Strategies report states, "there is no such thing as too much stakeholder outreach, education, and communication."[27] We call on DHCF to more clearly communicate about the future of the entire integration project – from the 2019 1115 Waiver activities to plans for the 2024 application – beginning with resuming monthly meetings of the Public Forum on Integrated Care.

DHCF Must Dedicate More Attention to Building Network Adequacy

A Path Forward highlights "network adequacy" as a key goal to improving the public behavioral health system, as Children's Law Center has testified at several hearings over the last year.[28] Network adequacy refers to the mandate in federal Medicaid regulations that participating states must maintain an adequate network of providers "to achieve greater equity in health care and enhance consumer access to quality, affordable care."[29] The MCOs are also required to comply with network adequacy standards and "availability of services standards,"[30] as well as the Mental Health Parity and Addiction Equity Act of 2008[31] and the District of Columbia Behavioral Health Parity Act of 2018.[32] As the government agency tasked with both implementing the District's Medicaid program and administering the MCO contracts, DHCF is principally responsible for ensuring the District's Medicaid program has an adequate network of providers.

Despite these requirements, DC has an insufficient number of behavioral health providers and facilities, especially for perinatal and pediatric populations.[33] In our work at Children's Law Center, we see a need for more child psychiatrists, specialists, child psychologists, and social workers, especially for very young children (under five years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays.[34] Similar needs for increases to the perinatal mental health workforce are reported by the Perinatal Mental Health Task Force, which also recommends improving cultural and linguistical representation in providers, expansion training of perinatal mental health screening.[35] We also need more providers with training in family therapy and specific evidence-based treatments (e.g., parent-child interaction therapy).[36] Networks should include all needed facilities for populations like parents suffering from significant perinatal mental health conditions or children with high behavioral health needs, like inpatient psychiatric units, residential treatment facilities, partial hospitalization and intensive outpatient programs, and coordination and case management service providers.[37]

Network adequacy is one of the myriad areas we hoped the carve-in could improve, by sharing the imperative with MCOs. If the carve-in is indefinitely delayed, it becomes even more critical for DHCF to intentionally cultivate and enforce network adequacy. Meaningful measures of access should be tied to accountability mechanisms that are regularly and transparently enforced, but we are not aware of any enforcement

measures being levied to date, despite external reviews documenting inadequacies.[38] Going forward, we want to learn more from DHCF about how it plans to improve its provider network. We encourage the Committee on Health to continue to hold our government partners accountable in this area.

The foundation of an adequate network of community-based behavioral health service providers in public programs is to pay adequate rates. There is high demand for services and a limited pool to provide them. It is imperative in this market for the District to sufficiently pay professionals in hospitals, health centers, primary care, and private practice offices to serve Medicaid beneficiaries. Mayor Bowser's own Healthcare Workforce Task Force recommended in 2023 to "address current supply and demand challenges in the healthcare workforce" by, among other strategies, increasing provider compensation.[39]

Through a combination of a carve-in and last year's rate study, DHCF could have leveraged federal Medicaid dollars to enhance provider payments, but this is another area where progress has stalled. As of this month, reimbursement rates for nearly two-thirds of DBH provider network services (Community Support Services[40]) are still lagging 17.3% behind inflation.[41] Review of these rates is not scheduled to begin any earlier than July 2024, and the FY25 budget does not include changes to Community Support Services payment rates at all.[42] If the District were to bridge this inflationary gap, it would require $4.9 million additional dollars.[43]

In this budget environment, there may be no easy solution to fix provider rates. However, we know it is ultimately less expensive to connect patients to community-based care before their needs become costly crises. By paying providers competitively to deliver upstream therapies and support, DHCF can reduce the need for patients to endure – or the system to pay for – hospitalization or other catastrophic outcomes of under-treated behavioral health needs. Therefore, we ask DHCF – and this Committee – to stay devoted to the goal of an integrated, efficient, and adequately staffed behavioral healthcare system.

If the District cannot dedicate all the local dollars needed in this budget, it must sustain its investments of time and creativity to the task. Success can only be achieved by working with the providers, consumers and advocates, honoring the resources that have already been dedicated to integration projects, and adequately sustaining the provider network with technical and financial resources. We believe it would be helpful for the Committee on Health to facilitate public hearings related to system integration and network adequacy, to ensure these investments are made.

Conclusion

We hope to see the District continue its ambitious – and desperately needed – projects to improve the public behavioral health care system. Unfortunately, we have significant concerns that this work is being abandoned. We are disappointed about the indefinite pause on the "carve-in" of behavioral health into managed care contracts, and

the communication and transparency from the agency about its plans. We call on DHCF to be more forthcoming and publicly, transparently respond to this important question: What will the fate be of our community's work to integrate behavioral health care as a part of whole-person health? We appreciate the Committee's oversight to ensure this is answered.

Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

[1] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org. This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition. A Path Forward is a blueprint for creating a successful public behavioral health system, one that supports children and families and, in doing so, strengthens our entire community. The recommendations in this report build on the commitment shown by DC government leaders and is informed by the expertise and experiences of youth, parents, experts, and best practices from across the country.

[2] Megan Conway, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Megan-Conway-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf;
William Cox, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Wil-Cox-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf;
Rachel Ungar, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/RU-Draft-Testimony-EM-updated_-narrative_final.pdf.

[3] American Academy of Pediatrics, *Mental and Behavioral Health Needs of Children in Foster Care,* (2021), *available at*: https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/*; see also* Children's Law Center, Testimony before DC Council Committee on Health and Committee on Facilities and Family Services, (December 6, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-behavioral-health-for-children-and-youth-in-foster-care/.

[4] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org.

[5] DHCF, DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts, (September 11, 2019), available at: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts.

[6] *Id.*

[7] Donald Berwick, *The Triple Aim: Why We Still Have a Long Way to Go*, Institute for Healthcare Improvement (February 14, 2019), *available at:* https://www.ihi.org/insights/triple-aim-why-we-still-have-long-way-go.

[8] Integrated care can take many forms, but the focus in DC has been to better incorporate behavioral health care and coordination into existing conventional healthcare systems. A team approach to healthcare allows professionals specializing in different areas to working together to enhance a patient's overall wellbeing. We have seen success across numerous programs from integrating healthcare. For example, through the HealthySteps program, embedding a behavioral health professional in the primary care setting has increased earlier identification of behavioral health issues for both child and caregiver, as well as greater connection to community supports and resources. Integrated care allows for children and families to access care more seamlessly, as well. Patients after giving birth, for example, are more likely to keep a well-child visit than their own postpartum visit. Pediatric care offers parents six or more interactions with their child's pediatrician within the first year following delivery. Therefore,

pediatrician offices, when integrated with professionals who can care for parents as well, can offer a safe and consistent space for parents to access the support and resources they need for a successful first year.

[9] DC Department of Health Care Finance, *1115 Demonstration Waiver, available at:* https://dhcf.dc.gov/1115-waiver-initiative.

[10] KFF State Health Facts Data, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier: FY 2025, available at:* https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[11] World Health Organization, I*ntegrated Health Services: What and Why?* (2008), *available at:* https://www.who.int/healthsystems/service_delivery_techbrief1.pdf.

[12] Burkhart K, Asogwa K, Muzaffar N, et al, *Pediatric Integrated Care Models: A Systematic Review*, Clin Pediatr (Phila). 2020;59(2):148-153. doi:10.1177/0009922819890004.

[13] Miller-Matero LR, Khan S, Thiem R, et al, *Integrated Primary Care: Patient Perceptions and The Role of Mental Health Stigma*, Prim Health Care Res Dev. June 19, 2018:1-4. doi:10.1017/S1463423618000403.

[14] SAMHSA, *The Integration of Behavioral Health into Pediatric Primary Care Settings* (2017), *available at:* https://www.nashp.org/wp-content/uploads/2019/09/The-Integration-of-Behavioral-Health-into-Pediatric-Primary-Care-Settings.pdf.

[15] FY 2023 Performance Oversight Hearing on the Department of Behavioral Health, *District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://dc.granicus.com/MediaPlayer.php?view_id=9&clip_id=8636

[16] Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://childrenslawcenter.org/resources/2023-24-oversight-testimony-department-of-behavioral-health/.

[17] *Id.*

[18] DHCF, Behavioral Health Integration, *available at:* https://dhcf.dc.gov/page/behavioral-health-integration

[19] Notes from Department of Health Care Finance Budget Briefing on Thursday, April 11, 2024, on file with Children's Law Center.

[20] *Id.*

[21] Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://childrenslawcenter.org/resources/2023-24-oversight-testimony-department-of-behavioral-health/.

[22] DBH, FY 2023 Performance Oversight Responses, responses to Q66, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[23] Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://childrenslawcenter.org/resources/2023-24-oversight-testimony-department-of-behavioral-health/.

[24] DC Department of Health Care Finance, *Behavioral Health Integration, available at:* https://dhcf.dc.gov/page/behavioral-health-integration.

[25] DC Department of Health Care Finance, District of Columbia Section 1115 Medicaid Demonstration Renewal Request: Draft 1115 Renewal Application for Public Comment (April 1, 2024), page 7-8, *available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DRAFT%201115%20Renewal%20Application_For%20public%20comment_V2.pdf.

[26] *Id.*

[27] Soper MH, *Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators*, Cent Health Care Strateg. April 2016:13.
[28] Sharra Greer, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (February 1, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Sharra-Greer_CLC_Performance-Oversight_DBH_General_February-1-2023_final-1.pdf; Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (February 16, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_DHCF-Performance-Oversight_FINAL-2.16-and-2.17.pdf
Leah Castelaz, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (April 3, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/04/L-Castelaz_Testimony-before-DC-Council-Committee-on-Health_DHCF_4.5.23_FINAL.pdf;
Amber Rieke, *Testimony before the District of Columbia Council Committees on Health, Judiciary and Public Safety, and Recreation, Libraries and Youth Affairs*, (December 13, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Amber-Rieke-CLC_Public-Safety-BH-Roundtable-Testimony_Dec-13-2023.pdf.
[29] "A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section." *See* Centers for Medicare & Medicaid Service, Department of Health and Human Services, 42 Fed. Reg. § 438.68 (June 19, 2020). *See also* Andy Schneider & Alexandra Corcoran, *Standards for Provider Network Adequacy in Medicaid and the Marketplaces*, Georgetown University Health Policy Institute Center for Children & Families, May 16, 2022, *available at*: https://ccf.georgetown.edu/2022/05/16/standards-for-provider-network-adequacy-in-medicaid-and-the-marketplaces/. National Conference of State Legislatures, *Health Insurance Network Adequacy Requirements*, June 1, 2023, *available at*: https://www.ncsl.org/health/health-insurance-network-adequacy-requirements; Karen Pollitz, *Network Adequacy Standards and Enforcement,* KFF, February 4, 20233, *available at*: https://www.kff.org/affordable-care-act/issue-brief/network-adequacy-standards-and-enforcement/#:~:text=The%20Affordable%20Care%20Act%20(ACA,out%2Dof%2Dnetwork%20providers.
[30] "Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with § 438.68." *See* Centers for Medicare & Medicaid Service, Department of Health and Human Services, 42 Fed. Reg. § 438.206(a), (June 19, 2020).
[31] The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* amended ERISA to require U.S. if health insurance companies provide coverage for mental health and substance abuse, the coverage must be equal for conditions such as psychological disorders, alcoholism, and drug addiction. *See* Labor, EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM, 29 U.S. Code § 1185a - Parity in mental health and substance use disorder benefits.
[32] "To require health insurers offering health benefits plans in the District to comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any guidance or regulations implementing the act…" *See* D.C. Law 22-242. Behavioral Health Parity Act of 2018. https://code.dccouncil.gov/us/dc/council/laws/22-242.
[33] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org.
[34] *Id.*
[35] Department of Health Care Finance, Perinatal Mental Health Task Force Report, (January 2024), p. 27-29, *available at*:

https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf.

[36] Tami Weerasingha-Cote, Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Childrens-Law-Center-Testimony-for-Dec-6-2023-Hearing-on-B25-0500-and-Foster-Youth-Behavioral-Health_FINAL.pdf.

[37] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org.

[38] Mark Hall & Paul B. Ginsburg, A Better Approach to Regulating Provider Network Adequacy, Brookings Institute, p. 23 (2017), available at: https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy/.

[39] *Report and Recommendations of the Mayor's Healthcare Workforce Task Force* (September 2023), *available at:* https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2023-09-Healthcare-Workforce-Report-web.pdf.

[40] DHCF's recent rate study has provided justification to increase rates for over 20 behavioral health billing codes. *See: Angelique Martin, DHCF Performance Oversight response to question from CM Henderson, February 8, 2024.* Those rates do not include H0036, the billing code used for Community Support Services. *See: DHCF Providers and Associations Presentation, Slide 31 "88% of FFS Behavioral Health Expenditures were for MHRS and 63% were for Community Support Services in FY23," (April 16, 2024), on file with Children's Law Center.*

[41] CMS Medicare Economic Index, 2023Q2-2016Q2, adjusted by 6.2% for cumulative intervening adjustments.

[42] DCHF Medicaid Care Advisory Committee Budget Presentation, Slide 22, "Behavioral Health Cost Drivers: FY23 and FY24 Implementation of Comprehensive BH Rate Study Recommendations," (April 24, 2024), *available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/April%202024%20MCAC%20Presentation.pdf.

[43] DBH is budgeted to spend $44.638M for behavioral health rehab services (Medicaid local match) in FY 25. Given 63% of $44.6M needs to be increased by 17.3%, $4.9M is needed to increase Community Support Services payment rates to meet inflation-adjusted expected costs. *See:* RM0-4 expenditure code H04317, Budget Vol. 4, p. E-25.

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The Deputy Mayor for Health and Human Services
Budget Oversight Hearing
Written Testimony
Submitted DATE, 2024

Committee on Health
Councilmember Christina Henderson, Chairperson

Written Testimony of Swapna Yeluri, Esq.
Senior Attorney, Legal Counsel for the Elderly

Legal Counsel for the Elderly ("LCE") submits this written testimony to help the District Council ("Council") evaluate the Deputy Mayor for Health and Human Services' budget for FY 2025.

LCE provides free legal representation and social work services to low-income residents of the district who are 60 years of age and older. Through LCE's Economic and Healthcare Security ("EHS") practice, LCE assists older DC residents with their initial claims and appeals to obtain and preserve public benefits, including Supplemental Nutrition Assistance Program ("SNAP") benefits managed through the D.C. Department of Human Services' ("DHS") Economic Security Administration ("ESA"), which is under the Deputy Mayor for Health and Human Services ("DMHHS"). Through the integration of social work support and legal advocacy, LCE's Tenant Advocacy and Support Practice ("TAS") prevents the eviction of the District's lower income seniors, securing affordable, habitable, and accessible rental opportunities. Although the District is facing a difficult budget year, the Council needs to fund DHS to help ensure that DC Seniors have access to the support systems that help ensure their health and home. This written testimony will focus on inadequate funding for SNAP and the Emergency Rental Assistance Program ("ERAP"). This testimony highlights significant inefficiencies in the application process for both SNAP and ERAP. These inefficiencies create barriers to access for many District residents who need housing or food assistance. LCE's testimony will break down inefficiencies in both ERAP and SNAP, make recommendations to remedy those inefficiencies, and further recommend that the Council and the DMHHS ensure that District residents can access their public benefits without the assistance of counsel. LCE noted throughout budget and performance oversight, greater efficiency will result in less waste from notice, appeal, and emergency benefits.

I. ERAP Misconceptions

LCE shares the Council's frustration with the rhetoric coming from the Mayor's office regarding unsubstantiated claims of fraud with ERAP. DHS Director Laura Zeilinger's ("Dir. Zeilinger") testimony during DHS oversight hearings did nothing to assuage these concerns. Dir. Zeilinger doubled down on the claim that some people are "abusing the system" without providing proof and she played down the critical role ERAP plays in reducing homelessness. Based on these unproven premises, Dir. Zeilinger recommended three changes to the system. First, she suggested that ERAP be unavailable to those that attest they cannot pay rent. This is already largely the practice of ERAP services. A tenant with an income lower than rent is generally not able to access ERAP. Second, Dir. Zeilinger suggested that the ERAP's definition of emergency should be changed. The current definition of emergency is "a situation in which immediate action is necessary to avoid homelessness or eviction, to re-establish a home, or prevent displacement from a home." This definition is targeted to address homelessness at any stage of the

eviction process. Any alteration to this definition should be carefully considered so that landlords and tenants are not incentivized to wait until there is a crisis. Third, Dir. Zeilinger suggested that ERAP should not always be available to tenants in subsidized housing. Again, any such changes should be carefully considered. Not all subsidized housing operates under the same rules and each tenant's situation should be considered individually.

ERAP processes should be revised to make the program more efficient. But first, LCE recommends that DHS collect and study data to determine what the need is. Dir. Zeilinger admitted that the District has no idea who is unable to access ERAP. This is crucial information that will help the District determine how much additional funding is needed for ERAP. LCE further recommends that the Council and DMHHS require DHS to improve the application process and provide an efficient system for customers.

II. ERAP and SNAP Demand

The Mayor's proposed budget cuts nearly $22.3 million from ERAP funding. Despite the Mayor's portrayal of ERAP as fraught with fraud, ERAP is a vital program that is half spent despite the fiscal year being just past the halfway point. Of the $51 million available for rental assistance appropriated for FY 24, as of this testimony $21 million in benefits have been dispersed to those who need assistance. Current demand is likely to outpace the FY 24 ERAP funds; between the portal's opening on April 1, 2024, at noon and 4:30PM that afternoon, approximately 4,815 DC residents submitted applications for assistance. The drastic cut, during times of rapidly rising rent, is a direct assault on low-income residents of DC. LCE's clients, many of whom live on fixed incomes, rely on every subsidy available to them to make ends meet. And with the significant cuts in the Mayor's proposed budget, they will likely have one less benefit to rely on. Therefore, LCE recommends funding ERAP at the FY 24 levels.

Many LCE clients rely on SNAP benefits to purchase groceries for the month. Due to transportation costs, physical or mental health issues, or other limitations many clients are unable to make long trips to food banks or soup kitchens, therefore SNAP benefits are their sole source of nutrition. Interruptions to SNAP benefits have a profound impact on their lives curtailing access to food which leads to an inadequate diet. Without access to nutrition, many of these clients will experience exacerbated health conditions, and increased feelings of insecurity and vulnerability. DHS must improve their customer services and processes to ensure that interruptions do not jeopardize the health of District seniors.

III. DHS's Notices, District Direct App, DHS technology, and DHS Processes

Despite LCE's efforts to highlight the problem of improper notices in our written testimony last year DHS has yet to remedy the problem. DHS still frequently sends multiple notices simultaneously, often with conflicting information. Furthermore, DHS continues to send beneficiaries notices with incorrect deadlines for recertification and incorrect documents required for recertification and benefit approval. DHS mistakes and incorrect information make figuring out SNAP benefits nearly impossible for beneficiaries who do not have legal representation. Beneficiaries and advocates must guess when SNAP benefits are going to expire, what DHS requires of beneficiaries to reenroll, or to understand what steps DHS needs for reenrollment. Beneficiary recipients are going months without access to their desperately needed services while the issues work through the system. LCE reiterates testimony from our performance oversight hearings that District residents should not require legal representation to secure benefits.

DHS disorganization goes beyond the application process. After an applicant applies for support, DHS will sometimes approve or deny applicants for benefits beyond those applied for, instruct beneficiaries to renew benefits shortly after DHS approval, or give "corrected benefits" with incorrect calculations. The frequency of these mistakes costs time and money to fix, and impacts the beneficiary's support.

DHS disorganization and error creates a burdensome process for clients and consumes a significant amount of time as we attempt to determine whether there is a legitimate issue to address or if DHS sent the notification in error. We allocate numerous hours and resources each week to resolving which of the DHS notices are accurate, resources that could otherwise provide other essential services. Again, District residents should not need legal representation to secure benefits.

Like the issues expressed above, LCE testified several times about the chaotic and limited Emergency Rental Assistance Program ("ERAP") applications. In FY23, DHS accepted ERAP applications between October 1, 2022, through March 2023 (when DHS estimated it had run out of money). DHS shut down the ERAP portal in early FY24 shortly after it opened accepting only 3500 applications. DHS reopened the portal again on January 2, 2024, but closed the portal after only half a day.

Like the application process for SNAP, DHS created an inequitable application process for ERAP. The DHS application process discriminates against working individuals and those without reliable access to technology. Inequity is only the beginning of the DHS application process, an unforeseen consequence of this new process is that very few, if any, tenants can apply for ERAP for their security deposit. If a tenant finds a suitable apartment today, the DHS process would force them to wait until April 1 to apply for ERAP. If the landlord accepts the rental application DHS is unlikely to process the application for another 30 to 60 days. It is unreasonable to expect a tenant or a landlord to wait that long to lease-up. However, DHS could reduce the wait time by keeping the portal open throughout the year, potentially increasing access to affordable rental housing. LCE recommends that DHS set up a lottery system that creates a very low barrier to entry. This will allow the portal to remain open through the fiscal year and allow DHS to equitably distribute the limited resources.

IV. DHS Lack of Timely Action

DHS failed to respond promptly and, at times, has shown complete inaction. Slow or no response leads to detrimental outcomes for clients including periods of months or even years without receiving essential benefits while DHS works to address their issues. For example, an elderly client sought assistance from LCE after facing multiple unsuccessful attempts to correct her household size for SNAP benefits. Despite diligently submitting all required forms and consistently following up with various DHS supervisors and managers, DHS did not make any progress updating the client's household size. Despite DHS assuring that they would resolve the matter, the client had to wait three years for a Fair Hearing. The client could not access her benefits during the extended period, which significantly impacted her financial stability and exacerbated her mental health challenges.

V. Impact of Improper DHS SNAP Terminations

DHS improperly terminating SNAP benefits causes significant financial, mental, and physical harm for beneficiaries. Pro se beneficiaries feel a greater impact because they do not have direct contact with ESA's upper administration to push for quicker remedies or have access to advocates to spend hours trying to correct these errors, unlike LCE's clients. DHS errors and improper terminations result in a waste of

valuable resources and time expended by the Courts, attorneys, and clients to correct these errors caused solely by DHS. LCE repeats that District residents should not have to retain legal counsel to secure public benefits.

VI. DHS Application Recommendations

In addition to more funding, LCE recommends that the Council require DHS to make considerable progress toward efficiency for the application process. As with SNAP, programmatic efficiencies will open funds to help more folks with assistance. For example, when the portal opened on April 1, 2024, DHS hosted an application fair at the MLK Library. For an event that DHS did not advertise widely, between 200 and 300 people, DHS forced many seniors who attended to stand in line for hours. After waiting DHS told those in line to apply online if they had a phone or computer. Furthermore, all DHS staff were at the in-person event, leaving nobody to trouble shoot or answer questions for those applying online. LCE recommends that DHS:

1. Provide administrative funds to allow ERAP adequately so that the application portal can remain open year-round. In FY23, DHS opened the application portal for only 7 days. The District needs to establish a system that allows applicants to submit documents 24 hours a day 7 days a week. This would lower the current barriers to ERAP.
2. Increase technical and programmatic training for staff and improve technology to better deliver service to District residents.
3. Improve DC's social service net across the board so that ERAP does not become the sole housing subsidy available to DC residents. The District is not creating enough new affordable housing.

All these recommendations will require funds; however, they are an investment in the efficiency of the DHS application process. These efficiencies will result in programmatic savings that the Council can pass along to applicants.

DHS, the Mayor, DMHHS, and the Council must take this opportunity to expand access to SNAP and ERAP through efficient application processes that will ultimately provide more benefits to applicants. I trust the Council will work equally hard to find funding for SNAP and ERAP to help DC residents stay in their homes, as it did to keep the Wizards and Capitals home in D.C.

Sincerely,

Swapna Yeluri, ESQ.
Senior Staff Attorney, Economic and Healthcare Security Practice
Legal Counsel for the Elderly

Neils Ribeiro-Yemofio,

Executive Director, LIFT-DC

Written testimony for the FY 25 Budget Oversight Hearing for

the Deputy Mayor for Health and Human Services

D.C. Council, Committee on Health

Monday, April 29, 2024 at 9:30 a.m.

Hello Chairperson Henderson and members of the Committee on Health. My name is Neils Ribeiro-Yemofio, and I am the Executive Director of LIFT-DC, an arm of the national organization working to break the cycle of poverty by investing in parents. I am submitting this testimony for the record on behalf of LIFT-DC and the 140+ families that we serve in the District, regarding the Mayor's proposed budget for the Office of the Deputy Mayor for Health and Human Services (DMHHS).

Operating in the anti-poverty space in the D.C. area for over 20 years, and at the forefront of distributing direct cash to low-income families for nearly a decade, LIFT is the two-generation non-profit that partners with families to provide cash and transformational coaching to empower parents in their goals towards economic mobility and break cycles of poverty. We are disheartened by the proposed budget cuts to critical human services within the Office of DMHHS, which threaten to further entrench families in this cycle by eliminating access to basic needs.

Despite the housing crisis that many in the District are facing, the proposed budget cuts Emergency Rental Assistance Program (ERAP) by over half from FY24 levels and restricts funding for housing vouchers. The budget also fails to set aside funding for "Give SNAP a Raise," a necessary support which this Council, led by Chairperson Henderson, fought so diligently to implement for 2024. These cuts—among others—will primarily impact Black and Brown families in the District and, at LIFT-DC, where 88.5% of our parents are Black/African American, we urge the Council to invest in these services that provide the basic supports our communities need to prosper.

LIFT has proven the impact of investing directly in the prosperity of families for economic mobility and is one of the leading organizations in this work. Nearly all of LIFT parents are people of color who are trying to find success within a system rooted in a long and painful history of racial and systemic injustices. We aim to reduce barriers to success for families and address these root causes of structural racism and the growing wealth gap.

Of the 145 members – what we call participants in our program— LIFT-DC reached in the last year, a majority were able to increase their savings, decrease their debt, increase their credit, and reported an improvement in their well-being as a result of our cash plus coaching model. Ninety-six percent of members progressed in their finances, and 95% of members progressed in income or education. Members also increased their annual income by more than $20,000 on average. At LIFT, we believe that parents are the CEOs of their family; and just as CEOs have access to coaching and holistic support, parents should also be afforded the same opportunities to achieve economic success.

However, we at LIFT also recognize that stability in basic needs, like housing, is fundamental to economic mobility. In emergencies like the pandemic, when LIFT distributed more than $1 million in emergency cash to all families nationally, we saw an increase in employment and education rates among our members. This, coupled with the 46% decrease in child poverty the nation saw with the 2021 Child Tax Credit, demonstrates that investing in D.C. families is the path forward to helping families not only survive, but thrive.

While we understand the difficult financial position facing the District, the proposed budget cuts do not speak to a "shared sacrifice" and threaten the stability of families throughout D.C., which will perpetuate the cycle of poverty for years to come. As you review the budget, we urge the Council to prioritize funding for critical human service programs. The District must empower its residents and seek ways to maintain access to housing and other basic needs services, to ensure that we do not communicate a willingness to sacrifice our residents most in need during times of bureaucratic hardship. Most importantly, investing in these programs ensures that all families—no matter their Ward, race, or income—have access to the resources and support they need to thrive.

Thank you.

Appendix

LIFT DC Overview

In FY23, LIFT DC served 145 families throughout the DC-Maryland-VA Metropolitan area, with the majority of our DC members residing in Wards 6, 7, and 8.

Of these DC members:

- 88.5% are Black or African American
- 72% are single parents
- 65% have two or more dependents

In 2023, LIFT DC successfully saw families in our programs progress in the following ways:

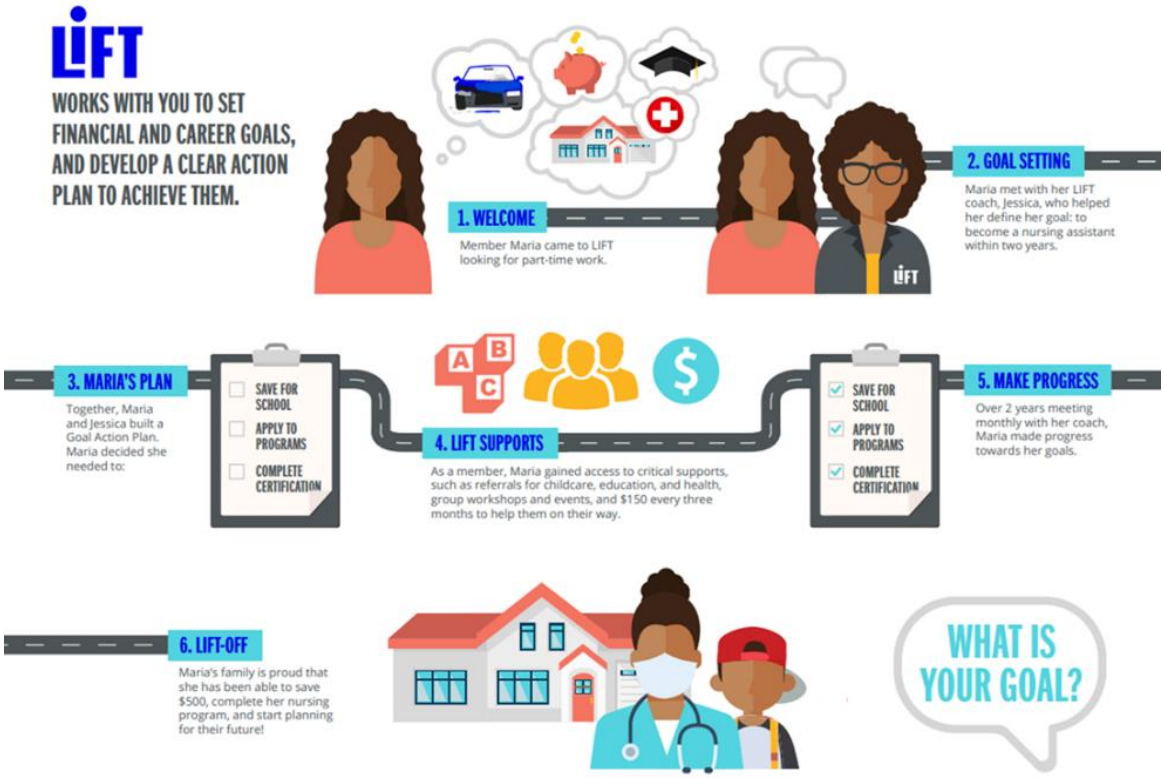
- 97% in finance
- 79% in education
- 78% in income
- 47% in well-being

LIFT National Overview

LIFT is a national nonprofit breaking the cycle of poverty by investing in parents, because all families deserve a better future—no matter their race, ethnicity, or zip code. Centered in *Hope*, *Money*, and *Love*, LIFT's approach provides immediate relief for families in poverty, while creating the conditions for their long-term success. Our cash-meets-coaching model gives families direct cash infusions to create an immediate safety net and our expert coaching program empowers parents to set and achieve goals that put families on the path towards economic mobility—such as going back to school, improving credit, eliminating debt, or securing a living wage. LIFT advocates for policies that humanize the experience of poverty and break the systems that trap generations in their cycles. We also partner with community institutions to ensure LIFT can meet parents where they are in their daily lives. LIFT operates sites in Chicago, Los Angeles, New York, and Washington, D.C. Learn more at whywelift.org, and on social media at Instagram and X/Twitter @liftcommunities. For more information on LIFT's FY22 impact, please review our Annual Report.

LIFT Coaching Model

LIFT employs a holistic and humanistic approach to breaking the cycle of poverty that is rooted in dignity, partnership, and trust. As part of this approach, LIFT offers executive coaching for parents with a 2-gen solution to ending poverty, while providing cash, connections, and community to decrease stress and enliven hope. Parents, or "members", are paired with trained coaches who partner with them on their short and long-term goals in core economic mobility areas of income, education, and finances, as well as well-being. The following graphic illustrates how we do this:



As part of the coaching program, LIFT also provides direct, unrestricted payments of $150 every three months—or what's known as the Goal Fund—to support members in their progress and basic needs. Since 2018, LIFT has distributed over $1 million in funds. For more information on the Goal Fund, please follow **this link**.

Technical Assistance (TA) Overview

LIFT partners with mission- and values-aligned organizations, nationally and locally, to amplify their impact by integrating transformational coaching services directly into their programming. We have successfully partnered with community colleges, social service agencies, early childhood education programs, and healthcare institutions with 100% agreeing LIFT's coaching model is effective within their organizations. For more information on our technical assistance programming, please follow **this link**. Our TA Area Partnerships include: Martha's Table, DC Department of Human Services Office of Work Opportunity, and Richmond Office of Community Wealth Building. For more information on our DC partnerships, please follow **this link**.

Felix Hernandez

DC Council Budget Hearing for the Department of Health Care Finance.

Good morning members of the committee. My name is Felix Hernandez, and I am here on behalf of Home Visiting Programs to urge this council to fund the Medicaid Reimbursement Bill at the adjusted FIS rate so that NFP and other similar programs can begin to draw down Medicaid funds to support implementation of programs. Static and constrained investments in Home Visiting that do not adjust with inflation are effectively pay cuts to staff and weaken the potential of Home Visiting. Relying on the Mayor's good graces to allocate the necessary investments into Home Visiting is not sustainable for programs who support parents over years at a time depending on need. Home Visiting should rely on braided funding streams as other states have exemplified so that programs like NFP can keep their commitments and promises and other programs can receive the funding that will allow them to implement the program to their maximum potential. Funding the Medicaid Reimbursement Bill for implementation in FY25 is necessary to make sure Participants can continue to thrive in a city where gentrification has displaced much of its impoverished residents to the fringes; invests in policing over prevention and revitalizing an underutilized downtown region as opposed to funding Rental Assistance for families navigating hardships.

As of 2022, 28 other states have already implemented Medicaid Reimbursements for Home Visiting. Delaying the funding of this bill at the correct FIS adjusted rates means that the commitments our program make with participants will be severed. Home Visiting is a unique strategy that has wide reaching impacts to health and achievement outcomes, and many are tailored to the varied contexts of the population. NFP is one such program that targets first time mothers and provides key support and resources to make health outcomes better in a city who's 90% of pregnancy related deaths are of Black people as of 2022 despite being only about 50% of all births. Many here today will speak on the Social Determinants of Health, NFP is the kind of program that should receive immediate resound support with Medicaid Reimbursement Bill funding as it is a potential antidote to the material challenges families navigate throughout their pregnancy.

I'll share also excerpts from a participant testimony who could not be here today:

"For me to have this support in this moment is so important to my life. It was very valuable as I am a first-time mother and I did not have any experience, had tons of questions and very few answers. However, thanks to this program and my Home Visitor I began learning step by step how to care for myself and my child during and after my pregnancy.

Having a home visitor in this stage of my life has been impactful because the program is uplifted by capable, experienced, trained people equipped to support pregnant people. I can confidently rely on my home visitor and ask any questions that arise. In the future I'd like to always rely on

this program. I would appreciate DC Council in providing support to Home Visiting programs and especially Home Visitors so that families like mine can receive this vital support."

Thank you for your time. I welcome any questions.

Felix Hernandez

Hello, Chairwoman Henderson, and Members of the Committee. Thank you for your time and the opportunity to submit testimony about the importance of sustained funding for Home Visiting programs.

My name is Magali Ceballos and I'm the Community Engagement Program Manager for the Home Visiting team at Mary's Center. My role entails triaging the home visiting referrals that the program receives, which makes me the potential participant's first point of contact. When I contact them, I share details about the programs that they're eligible for and work with them to find which one fits best into their life. This is a rewarding role as I get to connect with families, hear about their needs, and let them know our teams are excited to partner with them on their pregnancy and/or parenting journey. I love being able to share this happy news, and families are usually excited and relieved that they no longer have to navigate it alone.

Unfortunately, my role also includes being the bearer of bad news when someone either isn't eligible for our program or we have caseload limitations. Last year, I had to turn away 202 of the 767 referrals we received, some due to eligibility, but more due to caseload limitations. While I try to connect them to other programs, many face the same challenge we do – staff turnover. Last FY was one full of rebuilding, which meant that most of our programs had to pause accepting referrals for different periods of time. This caused many changes for enrolled families who had to be transferred to new family support workers, discharged from their programs, or sent elsewhere in hopes they'd connect to others.

We had consistent staff turnover because home visiting is heart and hard work, and the compensation is not enough. Though the years have been filled with challenge and change, we found opportunities, like the one to complete a participant survey to learn more from participant's experience in their program. We received 174 responses out of 308, and over 90% of respondents indicated that they felt their lives improved in the following ways since working with a home visitor: their ability to set goals, problem solve, advocate for their family, access to resources, and they also indicated that they have a better understanding of their child's development, and a stronger appreciation and connection with their child. 94% also agreed that they are more confident in their parenting abilities because of the support they receive from their home visitor.

Our participant survey was a temperature check, and we received such a positive response, it reinforced what we already know - Home Visiting is a partnership that supports caregivers and is often a lifeline for families who are having to juggle so much. I'm happy to share the complete survey results upon request.

Your continued investment and partnership for Medicaid reimbursement will create more stable funding which will in turn, create more confidence in this field of work. That will undoubtedly increase program stability, reduce staff turnover, and will allow us to enroll and serve more families.

Thank you for the opportunity to share.

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Testimony before Councilmember Christina Henderson of the District of Columbia

Committee on Health – FY 2025 Budget Oversight of the Department of Health Care Finance

April 29, 2024

Good afternoon, Chairperson Henderson and members of the committee on Heath. My name is Dr. Takeisha Presson, and I'm a native Washingtonian deeply invested in the dental health of our community as the owner of Dimples Dental Suite, a proud certified small business in Ward 6. For over 15 years, I've dedicated myself to providing top-quality dental care. In 2016, I opened Dimples Dental Suite with the mission to prioritize individual attention by avoiding double or triple booking patients without prejudices of insurance.

Today, I come not just as a dental practitioner but as someone who has witnessed firsthand the evolution of Medicaid management since becoming a credentialed provider in 2009. The highs and lows of this system have not gone unnoticed, particularly in how they impact access to dental health care.

I stand in solidarity with my colleagues and local dental societies to shed light on the growing dental health care access crisis in the District. According to DC Health Care Finance, approximately 50% of DC residents rely on Medicaid, reflecting the program's goal to provide quality care on an economical scale. However, this commendable objective is hindered by a shortage of dental providers and specialists combined with low reimbursement rates.

Moreover, the current system allows Medicaid Managed Care Organizations to pay below the established Medicaid Dental Fee Schedule, which can be up to 70% lower than the usual and customary fees for the District according to the American Dental Association Survey of Fees. This further exacerbates the financial strain on dental practices like mine, making it increasingly challenging to sustain quality care for Medicaid enrollees.

During the pandemic, I made the difficult decision to continue serving Medicaid enrollees at Dimples Dental Suite, despite the financial strain it placed on my practice. The combination of low reimbursement rates, increased operating costs, and a lack of access to local grants due to our professional service status and location outside designated low-income areas dug my business into a deep financial hole. As a result, I had to suspend services to new and inactive patients. Becoming one less provider available to a growing community in need to ensure Dimples Dental Suite continuity.

The repercussions of this crisis extend beyond my practice's financial struggles AND MISSION. The lack of access to dental providers and specialists has had a profound impact on the Medicaid

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population of the District of Columbia. Many individuals face barriers to receiving timely and comprehensive dental care, leading to exacerbated oral health issues and decreased quality of life.

While I understand the budget constraints facing Medicaid for this fiscal year, it's crucial to recognize that without prompt action, we risk further loss of dental providers and specialists. Failure to address the underlying issues now could exacerbate the crisis and lead to even greater challenges in the future. In order to provide the council with additional insight into the urgency of the matter and the critical need to increase Medicaid dental reimbursement rates, I would like to refer you to the written testimony of Kurt Gallagher, Executive Director of DC Dental Society. Mr. Gallagher's testimony, supported by compelling evidence and firsthand experience of practicing Medicaid Dentists, underscores the severity of the challenges faced by dental providers in our community. His perspective will undoubtedly aid the council in assessing the seriousness of the need for immediate action to address this pressing issue.

Thank you for your time and attention to this pressing matter. I will be submitting my formal testimony for your review.

Testimony of Sarah Barclay Hoffman
Early Childhood Innovation Network

Budget Oversight Hearing: Department of Health Care Finance
Committee on Health
Council of the District of Columbia
Written Testimony Submitted for the Public Record

May 2024

My name is Sarah Barclay Hoffman, and I am the Policy Director for the Early Childhood Innovation Network (ECIN), a local collaborative of health and education providers, community-based organizations, researchers, and advocates that promote resilience in families and children from pregnancy through age 5 in Washington, DC.[1] Through close collaboration with families in the District of Columbia, ECIN aims to utilize innovative and promising strategies to support healthy physical and emotional development among infants, children and families. I would like to thank Chairwoman Henderson and members of the committee for the opportunity to submit written testimony for the DC Department of Health Care Finance FY25 Budget Oversight Hearing.

Continued Focus on Perinatal Mental Health

We commend the Department of Health Care Finance (DHCF) for continuing its focus on addressing maternal health, and specifically including perinatal mental health, under the purview of the Maternal Health Advisory Group (MHAG). As the District looks towards implementation of the robust and comprehensive recommendations included in the Perinatal Mental Health Task Force report, DHCF has proactively and explicitly included perinatal mental health as a unique focus area for the Maternal Health Advisory group which comprises a diverse array of public and private stakeholders. With intention for the MHAG to continue meeting through FY25 and beyond, ECIN is grateful for DHCF's recognition of the Task Force report recommendations that fall under DHCF purview, and the agency's interest in advancing them. ECIN stands ready to partner with DHCF, and others, to improve perinatal mental health care and outcomes for District residents, and especially those insured by Medicaid.

Expansion of Behavioral Health Services for Young Children and the Workforce

DHCF also should be commended for the Medicaid rate study it conducted (in collaboration with the Department of Behavioral Health), which included additions and/or Medicaid rate enhancements to the infant and early childhood mental health service continuum, such as Attachment and Biobehavioral Catchup, Parent Child Interaction Therapy, and Child Parent Psychotherapy. These are critical, evidence-based interventions that benefit young children and their families, and set the foundation for emotional and physical wellbeing throughout the life course. We are deeply appreciative that these services and rates will continue into and through FY25, especially amid a difficult budget environment. Furthermore, we are grateful for DHCF's acknowledgement of the critical role an adequately trained, non-clinical

[1] For more information on ECIN and its innovations, see https://www.ecin.org/.

workforce can play in the provision of infant and early childhood mental health services, which was evidenced through the inclusion of a rate for non-licensed individuals who are trained to administer the Attachment and Biobehavioral Catchup model. ECIN strongly supports the appropriate utilization of a trained, non-clinical workforce. These individuals can provide crucial services and expand the behavioral health workforce that is available to young children and families. ECIN contributes to training and skill development through the implementation, in collaboration with Georgetown University, of the Certificate in Infant, Early Childhood and Family Mental Health: Family Leadership Track for parents, caregivers, and community members.[2] ECIN looks forward to continued work in advancing and expanding a trained and skilled behavioral health workforce in the District who can effectively deliver interventions and supports for young children and their families.

Supporting DC's Behavioral Health System

ECIN recognizes the difficult budget environment that necessitated the pause on the move of behavioral health services into the auspices of DC Medicaid Managed Care Organizations. ECIN continues to hear from young children and families of their need for easily accessible, high quality, culturally attuned and timely behavioral health services for parents and young children. Even as the behavioral health carve-in is paused, we strongly support continued efforts to advance the District's behavioral health system, such as through policy and system reforms outlined in the report ECIN co-authored with many other community partners, A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia. A continued focus on actively supporting and investing in DC's public behavioral health system, including for infants and toddlers, will pay dividends now and into the future.

Thank you very much for the opportunity to submit written testimony. I am happy to answer any follow up questions.

[2] More information about the certificate program can be found here: Online Certificate in Infant & Early Childhood Mental Health Family Leadership | Georgetown SCS

Comments Submitted to the Committee on Health

By

The Office of the D.C. Long-Term Care Ombudsman

Budget Oversight Hearing for the D.C. Department of Health Care Finance

Submitted May 6, 2024

Chairperson Henderson and Members of the Committee on Health. My name is Mark Miller. I am the D.C. Long-Term Care Ombudsman with the Legal Counsel for the Elderly. Thank you for this opportunity to provide these comments to you on behalf of the approximately 9,000 District residents who receive long-term care services in nursing homes, assisted living residences, community residence facilities and in their homes through the Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program.

The Ombudsman Program is part of the Department of Aging & Community Living Service Network and is charged by federal and D.C. law with representing the interests of some of the District's most vulnerable citizens. The Ombudsman Program works to promote and ensure the highest quality of life and quality of care for these individuals.

The Ombudsman Program is Highly Effective. In FY 2023, the Ombudsman Program investigated 259 complaints, resolving 83% of those issues to the satisfaction of the care recipients or complainants.

The Ombudsman Program educates individuals about their rights, empowering them to maintain their decision-making autonomy and to self-advocate when possible. In 2023, the program provided 713 individuals with information and consultation to help them navigate the long-term care system, understand their rights, and to assist them with self-advocacy.

Our Office is one of only 13 Ombudsman programs in the country that serve persons receiving long-term care services in the community, specifically EPD waiver beneficiaries. The EPD waiver program provides critical care and support to older adults and persons with disabilities that allow them to continue living independently in their own homes. The 70 Home and Community Based Care (HCBS) complaints investigated by the Ombudsman Program in 2023 included provider response to complaints, quality of care concerns, and staffing-related issues. Approximately 40% of the complaints concerned staffing-related issues.

We support all necessary funding for the Department of Health Care Finance to provide EPD Waiver services for more individuals

Adequate funding of Home and Community-Based Services (HCBS) is more critical now than ever before. Those funds support the providers and workforce that serve the people who rely on them to remain living safely in their homes and our community. Without these services, District residents will be unnecessarily forced into nursing homes and other congregate settings. For many that will mean having to leave the District, their families, friends, and the city they love, because as we already know, there are an insufficient number of nursing home beds in the District.

The Ombudsman Program needs the support of DHCF.

Let me express my appreciation for the financial support which the Ombudsman Program receives from DHCF, which is made possible by an agreement with the Department of Aging & Community Living. This support is critical to our successful work resolving concerns on behalf of hundreds of EPD Waiver beneficiaries and nursing home residents. In addition, the Ombudsman Program is often the first to provide information to persons about Medicaid eligibility and benefits. Many times we are also be the first to identify nursing home residents who wish to return to the community and help them navigate the long-term care system so that they understand their rights and choices. **Approximately 84% of persons receiving advocacy assistance through the Ombudsman Program in 2023 were Medicaid or dual eligible recipients.**

For FY 2024 the Ombudsman Program received $200k through an MOU between the Department of Health Care Finance (DHCF) and the Department of Aging and Community Living (DACL). This was an increase of $100k over previous years' agreements. This increase allowed the program to increase our capacity for serving long-term care residents and service recipients by employing an additional ombudsman specialist. We respectfully request that this amount be continued for next year's budget.

Thank you for the opportunity to provide these comments on behalf of the Long Term Care Ombudsman Program. We commend you Chairperson Henderson, as an advocate and champion for District Medicaid beneficiaries. As always, I am available to respond to any follow-up questions you may have.

Respectfully submitted by Mark C. Miller
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Nancy Alfaro

Testimony for DC DHCF Budget Hearing

(Translated from the original Spanish submission)

Good morning members of the committee,

My name is Nancy Alfaro, and I am a resident of the Columbia Heights District in Ward 1. I am here to share my testimony regarding Home Visiting.

For me to have this support in this moment is so important to my life. It's been very valuable as I am a first-time mother and I did not have any experience, had tons of questions and very few answers. However, thanks to this program I began learning step by step how to care for myself and my child during and after my pregnancy.

A typical home visit to speak about everything regarding pregnancy, my emotions, motivation to face any challenge, help me with the most important things I'll need with the birth of my child.

Having a home visitor in this stage of my life has been impactful because the program is uplifted by capable, experienced, trained people equipped to support pregnant people. I can confidently rely on my home visitor and ask any questions that arise. In the future I'd like to always rely on this program. I would appreciate DC Council in providing support to Home Visiting programs so that families like mine can receive this vital support.

Thank you,

Nancy Alfaro

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Testimony of Andrew Patterson
Senior Staff Attorney, Public Benefits Law Unit
Legal Aid DC

Before the Committee on Health
Council of the District of Columbia

Budget Oversight Hearing Regarding the Department of Health Care Finance

April 29, 2024

Thank you for the opportunity to present this written testimony regarding the Mayor's proposed FY 2025 budget for the Department of Health Care Finance ("DHCF"). Legal Aid DC[1] represents DC residents in many types of matters involving the District's Medical Assistance programs. We assist residents who have had applications for Medical Assistance denied, or had their Medical Assistance terminated, including improper terminations due to alleged, and often incorrect, failure to timely renew coverage. We also assist beneficiaries who have experienced reductions or denials of necessary health care services or needs, including with reductions or terminations of their home health care services through regular Medicaid and the Home and Community-Based Waiver program for the Elderly and Physically-Disabled. Legal Aid DC also assists beneficiaries with billing issues, such as being improperly balance-billed for services that should be paid by their insurance.

Legal Aid presented written and live testimony at the Committee on Health's February 8, 2024 Performance Oversight Hearing for DHCF as well as the March 13, 2024 hearing in support of the Direct Care Worker Amendment Act of 2023. Legal Aid now submits this written testimony to further address our concerns and recommendations regarding the District's Medical Assistance programs.

[1] Legal Aid DC is the oldest and largest general civil legal services program in the District of Columbia. The largest part of our work is comprised of individual representation in housing, domestic violence/family, public benefits, and consumer law. We also work on immigration law matters and help individuals with the collateral consequences of their involvement with the criminal legal system. From the experiences of our clients, we identify opportunities for court and law reform, public policy advocacy, and systemic litigation. For more information, visit www.LegalAidDC.org.

Legal Aid DC continues to engage with clients facing the same issues that we raised in our above-referenced testimony earlier this year. In particular, in this written testimony, we highlight two continued areas of concern. First, we continue to encounter beneficiaries who are losing their health coverage for allegedly failing to renew their coverage, despite having timely submitted the requested renewal information. Second, we also continue to see multiple beneficiaries who are not receiving all of their approved, medically-necessary home health care hours.

Continued Low Renewal Rates for DC Medicaid Beneficiaries

The most up-to-date figures on Medicaid and Alliance renewals show that, overall, 71% of beneficiaries who were due to recertify between May and December 2023 successfully renewed their Medical Assistance coverage.[2] This represents only a very small improvement from the figures in our February testimony at the DHCF oversight hearing, showing an overall renewal rate was below 70%.[3] The January 2024 report containing these figures also continues to show that the majority of Medicaid terminations are due to problems with renewals, not due to determinations of ineligibility.[4] Indeed, only very small percentages of each eligibility group had their coverage terminated due to a finding of ineligibility. Legal Aid DC has testified for years about our concerns with DHCF and DHS's processing of renewals, including renewal notices being sent to outdated addresses; and myriad failures by DHS including losing renewals that are submitted by mail or drop box, and in some cases in-person, not adequately following up with beneficiaries when more information is needed to complete a renewal; and failing to timely process completed renewals when they are submitted.

Additionally, the Aged, Disabled and Long-Term Care population continues to have the lowest renewal rate, as compared to children, childless adults, and parents who receive Medicaid. Although the renewal rate for this population is shown to be 68%, which represents a significant increase over the September and October 2023 renewal figures, DHCF itself notes that the 68% figure includes 17,000 SSI recipients who were passively renewed. Because most of the Aged, Disabled, and Long-Term Care Population is non-

[2] Medicaid and Alliance Recertification Outcomes, January 2024, p. 18. *Available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/Redetermination%20Report%20January%202024.pdf

[3] Medicaid and Alliance Recertification Outcomes, November 2023, p. 18. *Available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Redetermination%20Report%20November%202023.pdf

[4] January 2024 Recertification Outcomes, p. 26-27.

MAGI, they are not able to passively renew, the renewal rate for this population is certainly much lower than 68% when SSI recipients are excluded.[5]

What makes this situation more alarming is the fact that beneficiaries enrolled in Long-Term Care Medicaid are supposed to receive extensive assistance with renewing Medicaid coverage from their case managers (for those enrolled in the EPD Waiver) or from their Long-Term Care Facility. In the case of EPD Waiver beneficiaries, and as Legal Aid DC has testified about in the past, we continue to encounter beneficiaries who are either threatened with termination or have actually had their Medical Assistance terminated, due to case managers who fail to timely submit the renewal materials as they are required to do.[6] It is very worrisome that renewal rates would continue to be so low among this vulnerable population who are supposed to receive assistance with the renewal process.

Recommendation

Legal Aid continues to recommend that the Administration and the Council provide sufficient funding to DHCF and DHS to allow for adequate staffing levels to ensure timely processing of all Medicaid and Alliance renewals. By fully staffing both agencies, including increases for Full-Time Employees dedicated to processing annual renewals as

[5] Note that the January 2024 Recertification Report shows that 42,096 Medicaid beneficiaries in the Aged, Disabled or Long-Term Care groups had their renewals initiated between May and December 2023. The May to September 2023 figures, before the passive renewal in October of 17,000 SSI beneficiaries are included, showed a renewal rate of only 43% for the Aged, Disabled, and Long-Term Care Groups. Additionally, the November 2023 report, from right after the October 2023 passive renewal of 17,000 SSI beneficiaries, showed a renewal rate of 73%, but that figure has decreased to 68% in just two months as the effect of the October SSI renewals on the overall Aged, Disabled and Long-Terms care renewal rate fades.

[6] As we noted in our Oversight testimony, DHCF stated in their response to pre-hearing questions that 21% of EPD waiver enrollees who were due to recertify by September 30, 2023, have been disenrolled due to failure to renew their coverage. DHCF noted that some renewals were completed during the 30-day extension period and the 90 day grace period, which shows that some people who were disenrolled from the EPD waiver likely remain financially and medically eligible. Legal Aid testified at the September roundtable about our concern with low-performing case managers, and our experience in the past with EPD waiver terminations that resulted from case managers failing to timely recertify their patients, and included recommendations below to begin addressing this issue.

necessary, the Council can start to address the problems faced by beneficiaries who seek to renew their Medical Assistance coverage.

DHCF must also address the issue of non-performing case managers (who are responsible for renewing the Medicaid benefits of individuals who receive Medicaid through the EPD waiver). Legal Aid DC also recommends granting access to the DC Direct Partner Portal to beneficiary-designated assisters and shortening/simplifying the renewal documents, which are dozens of pages long. Granting access to the DC Direct Partner Portal to beneficiary-designated assisters, in particular, will help address the problem of non-performing case managers who fail to timely process a beneficiary's renewal.

Home Health Aide Staffing Challenges

1. Legal Aid DC Supports the Direct Care Worker Amendment Act of 2023

Legal Aid DC also continues to urge that the Council pass and fund the Direct Care Worker Amendment Act of 2023. As we testified in the March hearing, data from the DC Board of Nursing shows that the number of licensed Home Health Aides declined by more than 1,700 between August 2023 and January 2024, which represents a decline of more than 20%.[7] That same survey showed a decline of 4,489 direct care workers[8] in 2023.

We continue to see the impact of these staffing shortages in our work. Legal Aid DC staff have heard directly from advocates and others who work on long-term care Medicaid and home health care issues that home health workers are leaving for jobs that pay better and/or are less demanding. We have also represented multiple clients in the past couple of years who are not receiving the full number of home health hours they have been approved for because (in large part) agencies do not have enough staff to meet the demand for approved hours. As a result of these shortages, elderly and disabled Medicaid beneficiaries are put at risk of serious injury or worse, or increased risk of institutionalization without assistance to complete their daily activities.

The Direct Care Worker Amendment Act of 2023 includes multiple changes that would begin to address this staffing shortfall.

[7] DC Board of Nursing Data, cited in the Long Term Care Coalition 2024 Direct Care Workforce Survey – available at: https://www.dclongtermcare.org/wp-content/uploads/2024/02/Final-Jan-2024_Updated.pdf

[8] Direct Care Workers include Home Health Aides, Certified Nurse Assistance, and Trained Medication Employees.

First, the Act raises compensation for Direct Care Workers to a minimum of 120% of the District's living wage. Multiple home health agencies that responded to a survey by the Long-Term Care Coalition cited insufficiently competitive wages as a major challenge in hiring and retaining home health aides.[9] Setting a minimum compensation level of 120% of the District's living wage is an overdue pay increase for these critically important workers, and should make these positions more competitive with other industries.

Second, the Act includes several commonsense measures that would simplify or eliminate administrative hurdles for Direct Care Workers' attempting to work in the District. Currently, Direct Care Workers are divided into Certified Nursing Assistants (CNAs) and Home Health Aides (HHAs), with the former working in skilled nursing facilities (SNFs) and the latter working in home settings. Each type of Direct Care Worker has its own licensing requirement, and CNAs are not allowed to work in the home without obtaining an HHA certification. The Act would eliminate these separate licensing requirements and replaces them with a single credential for "Direct Care Workers" (DCWs). This would provide for more flexibility for Direct Care Workers by allowing them to accept different jobs in a SNF and a home setting while maintaining their single DCW certification. Additionally, anyone currently licensed as a CNA or HHA would automatically be certified as a DCW, avoiding a need for yet another licensure requirement for the existing direct care workforce.

The Act would also allow CNAs and HHAs who are licensed in good standing in Maryland or Virginia to practice as DCWs in the District going forward.[10] Currently, except for a limited time during the COVID-19 Public Health Emergency, Maryland and Virginia Direct Care Workers must obtain licenses in the District in order to work here. In the Direct Care Workforce Survey, allowing health aides licensed in good standing in Maryland and Virginia to work in DC was cited by 78% of providers as a "very important" way of addressing the workforce shortage.[11]

[9] https://www.dclongtermcare.org/wp-content/uploads/2024/02/Final-Jan-2024_Updated.pdf, at Slide #13.

[10] This was allowed by waiver during the Covid-19 Public Health Emergency, but was not continued after the PHE ended.

[11] https://www.dclongtermcare.org/wp-content/uploads/2024/02/Final-Jan-2024_Updated.pdf, at Slide #27.

2. Additional Legislation and Policy are Needed, Including Addressing the Long-Standing Issue of Finding Health Aides for Shorter Shifts

While the Act would make needed improvements in the provision of in-home services, there are other improvements, not addressed by the Act, that we would encourage DHCF and the Council to consider. Legal Aid has represented multiple clients in the EPD waiver program who are approved for more than 8 hours of home health care assistance per day, but only receive 8 hours. This is a particularly common situation for people who are approved to receive 9-13 or so hours per day, which translates into a full 8 hour shift for one health aide, and then a shorter, 2-5 hour shift for a second health aide. This lack of care can be dangerous for an EPD waiver enrollee.

Home health agencies have told Legal Aid staff, as well as DHCF, that the main staffing challenge in those situations is finding aides who are willing to accept a shift of fewer than 7 or 8 hours because home health aides, understandably, prefer to work and be paid for a full 8 hour shift.

Therefore, we strongly encourage DHCF and, if necessary, the Council, to consider additional reimbursement mechanisms and the funding requires to support them – such as reimbursing workers for travel time to, from, and between shorter shifts – and other financial incentives, to encourage workers to accept shorter shifts.

Conclusion

The District's provision of Medical Assistance coverage, and home health care services through regular Medicaid and the EPD waiver program, have helped thousands of DC residents achieve healthier outcomes and stay in their homes over the years. But when there are not sufficient case workers to process annual Medical Assistance renewals, or sufficient direct care workers to meet the level of need that exists, more District residents will end up at risk of losing their insurance coverage, including their homes health services that keep many of them in their homes and communities. We encourage the Council to fully fund all necessary FTEs at DHS and DHCF to timely process Medical Assistance renewals, and to pass the Direct Care Worker Amendment Act of 2023. Thank you for the opportunity to submit this testimony.

District of Columbia
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Testimony before the Council of the District of Columbia

Committee on Health – FY25 Budget Oversight Hearing on Department of Health Care Finance

April 29, 2024

Kurt Gallagher, Executive Director
DC Dental Society

Good afternoon Chairperson Henderson and members of the Council. My name is Kurt Gallagher and I serve as Executive Director of the DC Dental Society. DCDS is the professional association representing more than 400 dentists in the Nation's Capital. DC dentists are essential partners in advancing the overall health and well-being of the DC populace. They are dedicated to improving the oral health of members of our community. To succeed in that goal, those dentists who treat patients who rely on Medicaid need the support of the Department of Health Care Finance so they can continue to provide that care.

Ultimately, I am testifying today on behalf of the public. Oral health is part of total health. Every day DC dentists support the health and well-being of the public by providing dental care, alleviating pain, and performing a range of procedures that can save lives, including the prevention of medical complications resulting from untreated oral disease conditions. In recent years the stories of Deamonte Driver, who lived in Prince George's County, Kyle Willis and Vadim Anatoliyevich Kondratyuk provide a grim reminder that untreated oral health conditions can result in tragic and avoidable loss of life[1].

In February I testified during the oversight hearing on DHCF regarding the growing crisis in DC related to access to dental care. Medicaid fees paid to dentists and other dental health providers for covered dental procedures have not increased since the adult dental benefit was established in 2007. In fact, due to the enrollment or assignment of patients into plans administered by Managed Care Organizations (MCOs), most Medicaid fees paid to dentists and other dental providers have actually been reduced over the past 17 years.

Last year the American Dental Association (ADA) published a comparative analysis of the fees paid by Medicaid versus the amounts dentist bill to insurance programs based upon data from 2022. The

[1] The tragic deaths of Deamonte Driver, Kyle Willis and Vadim Anatoliyevich Kondratyuk highlight the serious consequences that can result from neglected oral health.

"Toothache Leads to Boy's Death," ABC News, March 5, 2007,
https://abcnews.go.com/Health/Dental/story?id=2925584
"Man Dies From Toothache, Couldn't Afford Meds," ABC News, September 2, 2011,
https://abcnews.go.com/Health/insurance-24-year-dies-toothache/story?id=14438171
"Tooth infection leads to young dad's death, family says," CBS News, February 1, 2017,
https://www.cbsnews.com/news/tooth-infection-leads-to-young-dads-death-family-claims/

analysis quantified the large disparity between typical charges for dental care compared to payment rates under DC Medicaid – **DC Medicaid reimburses covered dental care on average at only 43.3% of the amount that dentists charge to private dental insurance plans for adult care.**[2] For some procedures the reimbursement rate is even lower.

The District is at the Top of the Range for Dental Practice Operating Costs

Earlier in this hearing you heard from several DC dentists about the impact that low Medicaid fees paid to dentists is having on their ability to provide care and remain economically viable. Given the current level of fees paid under DC Medicaid, some dentists who care for a significant percentage of patients on Medicaid are on the verge of closing their practices. Dental practice closures would exacerbate an already perilous health care situation for the most economically vulnerable members of our community and put more pressure on the fewer dentists who remain willing to provide care to patients who rely on Medicaid.

DC is one of the most expensive regions of the country to operate as a dentist. Attached to this testimony is a table providing a "Comparison of Medicaid Dental Fees (2007-2024) and Usual Fee-for-Service Charges in DC." The table shows fees for commonly performed dental procedures. The column for Usual Fee-for-Service Charges in DC reports data from the 2022 ADA Survey of Dental Fees.[3] DC is included in the South Atlantic Region along with Delaware, Maryland, Virginia, West Virginia, North Carolina, South Carolina, Georgia and Florida. Because the South Atlantic Region contains data from a large number of dentists practicing in suburban and rural areas, the survey responses skew significantly lower than those typically found in a high-cost urban area like the District. Due to higher staff salaries, higher rents and other operating costs in DC, the fees charged by District dentists are predominantly found around the 95th percentile of the survey data.

For example, the survey shows the typical fee charged for a comprehensive oral exam (D0150) in the District is $135.00. In contrast, Medicaid pays only $69 for an adult who has this procedure, and the reimbursement rate under the AmeriGroup and MedStar Family Choice MCOs is reduced to $55.20 for an adult.

Increases in operating costs since the pandemic put even more financial pressure on dental practices. In the development of this testimony, member dentists provided several examples of those increased costs:

	Pre-Pandemic Rate	Rate in 2024
Dental Assistant	$20-$22 per hour	$28-$30 per hour
Dental Hygienist	$50-$55 per hour	$75-$80 per hour
Monthly Lease	$500 in 2007	$12,000 per month in 2024

[2] "Medicaid Fee-For-Service Reimbursement as a Percentage of Dentist Charges for Child and Adult Dental Services, 2022", American Dental Association, August 2023

[3] Dental Fees: Results of the 2022 Survey of Dental Fees, American Dental Association

Members have attested that their malpractice insurance premiums are higher as a dentist who accepts Medicaid patients. Furthermore, they have seen the valuation of their practices decline as Medicaid providers.

Recommended Approach to Increasing Medicaid Fees for Covered Dental Procedures

DCDS is engaged in a dialogue with DHCF officials about increasing Medicaid fees for covered dental procedures. We recently received a request from DHCF to develop a list of priority dental billing codes for procedures to increase fees over the short term. We are attaching this list, which we will present to DHCF for consideration. However, this piecemeal approach to increasing fees will provide triage at best. What is needed is an overall increase in Medicaid fees paid for all covered dental services.

The approach that DHCF has suggested to prioritize Medicaid fees short term by focusing on specific Medicaid fee codes is problematic because there are numerous codes for similar procedures between which there is no meaningful differentiation related to patient need or impact on health. For example, take as a category of care:

- The Medicaid fee schedule categorizes care into separate codes based on whether the tooth is located at the front (anterior) or back (posterior) of the mouth.
- There are additional codes depending on whether multiple surfaces are treated, which is largely indicative of the type of tooth treated (e.g., incisor, canine, premolar or molar).
- The need for treatment of cavities is dependent on the size and the level of discomfort that a patient may be experiencing, not the location on a tooth.
- Medicaid fee increases for fillings should be inclusive of all teeth, not particular types of teeth or particular locations on a tooth.

We respectfully suggest that DHCF consider an alternate approach: increase fees for categories of treatment to ensure that those procedures that have the most significant impact on the health and well-being of the public—either because of their frequency or their overall impact on the health of the patient—are prioritized for an increase short term. The categories of oral health care that should be prioritized for an initial increase in Medicaid fees are listed in Table 2 below "Priority Categories of Dental Procedures for an Increase in Medicaid Fees." For non-oral health care, DC Medicaid bases its fees at 80% of the Medicare fee schedule. Because Medicare does not include dental coverage, the usual benchmark for establishing fees is not available. As an alternative, we recommend setting DC Medicaid fees for covered dental procedures at 80% of the Usual Fee-for-Service Charge in DC, examples of which are listed in Table 1. As explained above, those fees are based upon the 95th percentile for the South Atlantic Region.

Table 1 also provides data for a range of commonly performed dental procedures, including a comprehensive oral examination, x-rays, cleanings, fillings, dentures and root canals. The table is divided into groups of similar procedures (e.g., general procedures, dentures, extractions and implants). All of the procedures related to implants may be performed on a single patient to complete the implant process.

To remain economically viable, dentists need the ability to charge fees and collect revenues that are several factors greater than staffing costs and lab fees charges to fabricate dentures, crowns and other

dental devices[4]. Some procedures require multiple visits, preventing the dentists from providing care to other patients all while receiving compensation from Medicaid that is far below what is needed to maintain operations. For example, the process for fabricating dentures typically requires 4-5 visits before the single fee paid.

In some cases, the fees paid by DC Medicaid and MCOs are below the cost to produce dental materials. One member dentist shared with DCDS that the lab fee she recently paid a lab to manufacture an abutment (D6056) was $385.95, much higher than the $240 fee paid by AmeriGroup and MedStar Family Choice for an adult who has this procedure.

Complicating the situation, DCDS member dentists report that oral health appears to be on the decline among certain patient segments, including those struggling with opioid addiction whose oral care practices have diminished, which will put even more pressure on the oral health system.

Unless the Medicaid fees paid for dental procedures are raised significantly, DCDS expects that over the next 1-3 years we will see a significant number of dentists exiting the Medicaid program. Sadly, we also anticipate that other practices will close because they care for a significant percentage of patients who are covered by Medicaid and are no longer financially viable due to the outdated and below-cost fees paid by Medicaid.

We offer these comments to highlight for this committee and for DHCF the need to increase Medicaid fees for covered dental procedures. Additional issues that further complicate the ability of Medicaid dental providers to remain in operation include the following.

Efforts to Increase Provider Enrollment will Fail

Our initial discussions with DHCF regarding Medicaid involved a request for assistance to increase provider enrollment. We have been candid with DHCF officials that efforts to increase the number of dentists participating in DC Medicaid will fail until a meaningful increase in Medicaid fees for covered dental procedures is implemented.

Furthermore the situation with respect to specialist dentists enrolled in DC Medicaid is even more dire. A search of providers who are accepting new patients on the DC Medicaid website found fewer than ten providers practicing in the District for three specialties. Specialist dentists treat the most complex and severe oral health conditions that accordingly can have the most significant impact on patient health. The dearth of dentists with advanced training in specialized areas of practice is delaying access to care, worsening the complex cases that specialists treat, and forcing more DC residents to seek care from dentists practicing outside of DC.

Dental Codes Not Recognized by DC Medicaid Program

The codes for dental procedures recognized under the DC Medicaid program have not kept up with the standard of dental care nationwide. The DC Medicaid Fee Schedule includes codes that are outdated and has not incorporated newer codes that reflect current dental care practices.

For example, the DC Medicaid fee schedule has not yet incorporated a more recent therapeutic scaling treatment that can prevent bone and tooth loss in patients with moderate to severe gingivitis (D4346).

[4] Tracking dental practice overhead and what the results mean, DentalEconomics.com, April 1, 2021

Surprisingly, the current DC Medicaid fee schedule does not provide coverage until the patient's condition advances to a more serious state that features irreversible bone loss, increased potential for pain and discomfort, and increased risk of tooth loss.

Medicaid Fee Schedule Bundles Multiple Procedures

Dental billing codes are designed to reflect the actual procedures performed and care provided. For straightforward procedures, a base fee may be appropriate. When complications arise during treatment, additional codes may be needed to reflect the full scope of care provided for a complex case. DHCF should unbundle certain dental procedure codes to enable dentists to submit claims that accurately reflect the scope of care provided, particularly for complex cases. As a result of bundled codes:

- The code billed does not necessarily reflect the level and complexity of care provided.
- Dentists are not appropriately compensated when treating a patient with a complex case that may require more distinct procedures, longer procedures, additional medical supplies or medical devices.

Closing

These comments are intended to highlight the most pressing challenge faced by DC dentists who participate in Medicaid – outdated and below cost compensation for care provided. The issues described within this testimony can be resolved with the attention and support of this committee and DHCF. We will engage with DHCF on these issues as well as other important matters related to administration of the Medicaid program in the District.

Thank you again for the opportunity to testify today. I am happy to answer any questions you might have.

Table 1: Comparison of Medicaid Dental Fees (2007-2024) and Usual Fee-for-Service Charges in DC

Code	Procedure	2007 Proposed Fee (21+)	2024 Fee Under 21	2024 Fee 21+	AmeriHealth Under 21/21+	AmeriGroup and MedStar Under 21/21+	Usual Fee-for-Service Charge in DC*	Notes
D0150	Comprehensive Oral Exam	$77.50	$77.50	$69.00	$64.48/$57.41	$62.00/$55.20	$135.00	
D0210	Full Mouth X-ray	$91.00	$91.00	$70.00	$75.71/$72.80	$72.80/$70.00	$185.00	
D1110	Cleaning (Prophylaxis, Adult)	$77.50	$77.50	$69.00	$64.48/$57.41	$62.00/$55.20	$140.00	
D1204/ D1208	Topical Fluoride (excl. varnish)	$26.00	$25.00	$25.00	$24.86/$20.80	$23.20/$23.20	$60.00	
D2391	Filling (Resin-Based Composite)	$120.00	$120.00	$96.00	$99.84/$79.87	$96.00/$76.80	$302.00	
D2750	Porcelain Crown (Fused to Metal)	Not included	$500.00	$500.00	$520.00/$469.56	$500.00/$451.50	$1650.00	
D3320	Root Canal (Premolar)	$591.00	$591.00	$472.00	$582.64/$491.92	$560.28/$473.00	$1350.00	
D4341	Periodontal/Deep Scaling	$181.00	$181.00	$140.00	$150.59/$116.48	$144.80/$112.00	$375.00	
Dentures								
D5110	Complete Upper Denture	$1120.00	$1120.00	$1000.00	$931.84/$832.00	$896.00/$800.00	$2850.00	Requires 4-5 visits for complete process.
D5213	Partial Denture – Upper	$1200.00	$1200.00	$1050.00	$998.40/$873.60	$896.00/$800.00	$2600.00	Requires 4-5 visits for complete process.
Extraction Related Procedures								
D7140	Extraction (Routine)	$110.00	$110.00	$88.00	$92.79/$73.22	$89.22/$70.40	$314.00	
D7210	Extraction (Surgical, Portion of Bone Removed)	$192.00	$192.00	$150.00	$159.74/124.80	$153.60/$120.00	$410.00	
D7953	Bone Graft (Time of Extraction)	Not covered	$581.25	$465.00	$483.60/$386.88	$465.00/$372.00	$662.63	
Implant Related Procedures								
D6010	Implants (Surgical Implant Placement)	Not covered	$750.00	$615.00	$561.60/$561.60	$600.00/$492.00	$2999.00	Typically requires 7 visits to complete implant process.

*Source: Dental Fees: Results of the 2022 Survey of Dental Fees, American Dental Association. Due to higher operating costs in Washington, DC (e.g., higher staff salaries, higher rents and other operating costs) many dentistry generally charge fees for service around the 95th percentile among those in the South Atlantic Region, which also includes urban, suburban and rural areas throughout Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia.

D6056	Prefabricated Abutment	Not covered	$375.00	$307.50	$312.00/$312.00	$300.00/$240.00	$1800.00	Recent lab fee to produce: $385.95
D6058	Porcelain/Metal Crown (Abutment Supported)	Not covered	$375.00	$307.50	$312.00/$312.00	$300.00/$246.00	$2150.00 (D6059)	
D6190	Surgical Stent (Radiographic/Surgical Implant Index by Report)	Not covered	$300.00	$300.00	Not covered	$240.00/$240.00	Data not available	Recent cost paid by member: $310+$41 per implant
D6104	Bone Graft (Time of Implant)	Not covered	$575.00	$575.00	Not covered	$304.00/$304.00	Data not available	

Table 2: Priority Categories of Dental Procedures for an Increase in Medicaid Fees

Categories of Care	**Procedures and Services in Category**	**Included Codes**	**Comments**
Oral diagnosis and prevention	Exams, X-rays, and preventive procedures	0120, 0150, 0180, 0210, 0220, 0230, 0270, 0274, 0330, 0350, 0364, 0366, 0470, 0703, 1206, 1208, 1330, 1351	0150 - comprehensive exam; coverage limited to once per lifetime per provider. Should be performed annually. 0703 - the once in a lifetime limit per provider should be lifted; photos are often required for preauthorization. 1330 – should be reinstated in recognition of the time required and value of oral care instructions. 1351 - expand coverage of sealants to cover premolars; allow more than one application in a lifetime
Restorative	Fillings	2140-2160, 2330, 2331, 2332, 2335, 2391, 2392, 2393, 2394, 2920, 2940, 2950, 2954	2940 – the maximum number of temporary fillings per visit should be increased 2950 - Amerihealth does not cover, but other MCOs do
Endodontics	Original root canal, retreatment	0460, 3110, 3220, 3310, 3320, 3330, 3332, 3346, 3347, 3348	
Periodontics	Cleaning/deep cleaning, scaling and root planing, periodontal maintenance, crown lengthening	1110, 1120, 4249, 4342, 4341, 4346, 4355, 4910	

Prosthodontics	Removable (i.e., dentures, full or partial)	5110, 5120, 5211, 5212, 5213, 5214, 5225, 5226, 5421, 5422, 5511, 5512, 5520, 5611, 5612, 5630, 5640, 5650, 5660, 5730, 5731, 5740, 5741, 5750, 5751, 5760, 5761	

Table 2: Priority Categories of Dental Procedures for an Increase in Medicaid Fees (Continued)

Categories of Care	Procedures and Services in Category	Included Codes	Comments
Oral Surgery	Extractions, sinus augmentation/lift, incision and drainage	7140, 7210, 7250, 7311, 7520, 7922, 7951, 7952	7311 – this procedure should be covered without preauthorization. This code is used for a procedure that may be necessary only after an extraction. Requiring preauthorization would prevent a dentist from performing the procedure during the same visit when an extraction is performed. Delay of care due to waiting for preauthorization would extend the period during which that patient experiences pain, increase the risk of infection and necessitate a second appointment to perform this follow-up surgical procedure.
Implants & Crowns	Crown (ceramic and PFM), Abutment (all metal, ceramic and PFM), Bridge (ceramic and PFM)	2740, 2750, 6010, 6053, 6054, 6056, 6057, 6058, 6064, 6065, 6066, 6067, 6080, 6111, 6242, 6245, 6740, 6752	
Adjunct	Night guard, sleep apnea oral appliance, anesthesia	9110, 9222, 9223, 9230, 9941, 9944, 9945, 9946	
Bone grafts	Preservation, periodontal, oral surgery, implant	4263, 4264, 6103, 6104, 7950, 7953	
Orthodontics	Orthodontics (braces), space maintainers. For minors, coverage should be expanded to include aligners	1510, 1516, 1517, 8080, 8090, 8692, 8693	According to current practice under DC Medicaid, payments for orthodontics are made over three years, which may exceed the course of treatment. An alternative approach, which we endorse, is to pay out over the course of treatment.

February 22, 2024

Dear Honorable Members of the DC City Council,

I am Dr. Cheryle Baptiste, a lifelong resident of Washington, DC. I was born in Freedman's Hospital, I live in Ward 5 and I practice dentistry in Ward 3. I have worked in a dental practice since I was 12 years old. I worked on the weekends and during summer break. I graduated from Howard University College of Dentistry in 1984.
My father, the late Dr. Roy L. Baptiste Sr., graduated from the same dental school in 1958.

Guided by a legacy deeply rooted in providing access to dental care I have composed this statement to advocate for a crucial cause: an increase in the DC Medicaid fee schedule for dentists.

In the 1970's and early 1980s, there was no commitment to dental care of D.C. Government employees. There were no health care providers interested in advocating or extending dental care coverage to these employees. Armed with vision and determination, in 1982 my father founded the Greater Washington Dental Service, Inc. and assisted the District Government in creating the first comprehensive dental plan in its history. He negotiated dental benefit contracts for AFSCME, AFGE, TEAMSTERS, UDC & DC General Hospital. Under his leadership, the Greater Washington Dental Service, Inc. evolved into a network of 50 facilities throughout the Washington metropolitan area, serving more than 16,000 employees and offering prepaid services for over 35,000 eligible participants.

When my father was ready to retire in 1996 I left his practice so that he could sell it. I started a separate practice at my current address. I have been a dental provider for the DC Medicaid population since 2008. 80% of my patient population is covered by DC Medicaid.

Sadly, due to escalating costs and inadequate DC Medicaid reimbursements I have drained all of my resources and will be closing my dental practice this year. Regrettably, I am not alone in this predicament. The DC Medicaid program has very high utilization and our contracts require us to schedule patients within 2 weeks of their requests. We have been providing comprehensive dental care and we also screen A1C and Blood Pressure. Often my practice is the reason that patients find out that they have issues that need to be addressed by a physician.

Unfortunately, the public is not educated on the link between oral health and the health of the body. The importance of oral health cannot be overstated, as it is intricately linked to overall well being. The consequences of untreated dental conditions are profound and far-reaching.

- Malnutrition from inadequate dentition to eat or oral pain preventing patients from eating,
- infant mortality due to low birth weight caused by the mother's periodontal disease,
- this population often needs more attentive listening by the practitioner to diagnose their needs,
- head and neck cancers are quite debilitating and we perform those screenings,
- the prevalence of HPV virus which can lead to oral cancer,
- Sjogren's syndrome leads to very dry mouth and rampant caries,
- TMD Joint Deterioration, acid reflux can cause rampant caries and tooth erosion,
- reports show that there is higher mortality when there is higher tooth loss,
- endocarditis from oral infections,
- brain abscess from oral infection,
- infection of joints and bone from oral infection,
- septic arthritis,
- aspiration pneumonia from oral infection,
- diabetes and periodontal disease,
- the inability to seek employment interviews due to missing teeth.

The patients we serve are those with the highest risk of contracting COVID-19 and other ailments, because they have underlying health conditions. These conditions are also linked to dental disease, and are complicated by poor

oral health: coronary heart disease, peripheral artery disease, diabetes, pregnancy complications, respiratory infections, osteoporosis, rheumatoid arthritis, joint and organ health, H pylori from the mouth can cause ulcers, chronic kidney disease, and so on. Many patients have not seen a dentist since before the pandemic and are just returning for care. The fact that we have been unable to provide regular care, including prophylactic preventive care (Teeth and gum cleanings), has made our most vulnerable patients even more susceptible to COVID-19 and other issues. There are many patients who are required to have a prophylaxis prior to having Dialysis, organ transplants and joint replacement and they have been unable to get their dental clearance. Due to stress many patients are clenching so bad that they are fracturing their teeth and crowns.

Because of the nature of our work, and the fact that we 1) work only inches away from our patient's oral cavity and 2) perform aerosol-generating procedures- dentists are at the highest risk for transmission. In the March 15, 2020 article "The Workers Who Face the Greatest Coronavirus Risk," The *New York Times* reported that dentists were among the professions at highest risk. We are also, due to nearly four decades of mandates and OSHA fines (the result of HIV/AIDS), 100% compliant with the universal safety precautions. We have been mandated to add additional layers of safety precautions, and we understand the importance of doing so.

Exploding staffing salaries and shortages add to our overhead. Without adequate staff we treat fewer patients. This adds to a financial strain on our overhead.

All dental providers were required to maintain Electronic Health Records starting in 2012 and no consideration or financial assistance was given to Medicaid providers who have tighter cash flows. Since COVID we were required to update our server and computers to remain HIPAA compliant. This was very expensive. Unfortunately, dental providers were excluded from a federal grant program to assist with this costly, mandated upgrade.

As a leader in organized dentistry and an advocate for equitable healthcare I listen to a significant number of complaints and critical questions from Dental Providers who treat the DC Medicaid population. I urge you to consider the pressing needs of DC Medicaid dental providers and the communities we serve.

Are we reaching all of the population who need care? What are the city's goals for healthy outcomes? What is the allocation for the MCOs? How many DC Medicaid dental providers are there now compared to five years ago? What is being done to address the oral health infrastructure? When was the last state of oral health for DC reported?

For all of the above reasons we are requesting a significant increase in the DC Medicaid fee schedule to ensure the sustainability of dental practices and to improve access to care for our patient population. Your support in this matter is paramount and we hope that we can have our voices heard at the decision-making table.

Thank you for your time and consideration.

Sincerely,
Cheryle Baptiste, DDS, FICD, FIAMDI
Immediate Past President of the Robert T. Freeman Dental Society, Inc (DC Chapter of the NDA),
Current President of the DC Dental Society (DC Chapter of the ADA),
Current President Elect of the National Dental Association
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Testimony before the City Council of the District of Columbia
Committee on Health – FY25 Budget Oversight Hearing on
Department of Health Care Finance
April 29, 2024
Cheryle Baptiste, DDS, FICD, FIAMDI

Good afternoon Honorable Chair Henderson, Members of the DC City Council, Deputy Turnage, Community and Staff,

I am Dr. Cheryle Baptiste, a lifelong resident of Washington, DC, and a dedicated advocate for equitable healthcare access. I live in Ward 5 and work in Wards 3 and 7. Today, I come before you to address a critical issue facing our community: the urgent need to increase the DC Medicaid fee schedule for dental services, which have not been increased since 2007. Our costs and staff salaries have skyrocketed, especially since the pandemic. This testimonial is in addition to the testimony that I submitted in February 2024.

As a dentist with deep roots in our city, I have witnessed firsthand, over my 40 years in practice, the vital role that dental care plays in our residents' overall health and well-being. In the late 1970's my late father, Dr. Roy L Baptiste, DDS established dental benefits for DC employees and their families. We currently have very high DC Medicaid dental utilization of both children and adults.

With 80% of my patient population covered by DC Medicaid, I have dedicated my career to serving our most vulnerable communities. However, despite our best efforts, escalating costs and inadequate reimbursements have pushed my practice to the brink of closure.

Data recently published by the Department of Health Care Finance show that as of January 2024, 49% of DC residents rely on health care funded by DHCF and 43% of DC residents rely on Medicaid. Those statistics underscore the significant reliance on Medicaid for healthcare access among our population. In addition, DC Medicaid does not impose an annual limit for dental care, unlike our neighboring states. Despite this high utilization, our current Medicaid fee schedule for dental services remains woefully inadequate.

I am not alone in facing these challenges. Many dental providers who serve the DC Medicaid population are struggling to maintain financial viability while upholding the highest standards of care. That is why I am urging the DC Council to take action to address this urgent issue.

In addition to increasing the Medicaid fee schedule, I also urge you to consider providing special consideration or grants for providers whose DC Medicaid patient population exceeds 30%. These providers shoulder a disproportionate burden of care for our most vulnerable residents and deserve support to continue their vital work. Daily we hear from patients who need care because their dentists have dropped their Medicaid plans.

Furthermore, I ask for consideration regarding property tax relief for dental practices serving the Medicaid population. These practices often operate on tight margins and face significant financial pressures. Providing relief on property taxes would help alleviate some of the financial strain they face. Additionally, I urge the Council to provide financial assistance for electronic records upgrades, including new servers, for Medicaid providers. Compliance with electronic health records mandates is essential

for patient care and confidentiality, yet the costs associated with these upgrades can be prohibitive for many practices, especially those serving Medicaid patients.

Dentists need to be on the CHCF panels that determine our future. Procedures and costs need to be explained to those who control our income. Our malpractice insurance premiums are higher because we accept DC Medicaid. We are instructed by DC Medicaid that we have to schedule Medicaid patients within 2 weeks of calling. DC Medicaid should cover bridges so that we can provide alternative treatment for patients with a severe gag reflex who are not candidates for dentures.
With dental providers and specialists dropping DC Medicaid, undue strain is put on remaining participating dentists.

As was stated accurately before, we do have to file using our personal social security numbers instead of our long existing tax ID or NPI numbers.

As a leader in organized dentistry and an advocate for equitable healthcare, I echo the concerns of my colleagues and the communities we serve. I currently hold and have held numerous leadership positions within organizations representing dentists; I am the current President of the DC Dental Society, the local ADA society; the immediate Past President of the Robert T. Freeman Dental Society, the local NDA society; and am President Elect of the National Dental Association. While I offer these comments as my own, not on behalf of those organizations, I would like you to understand the deep connection that I have to the DC community and dentistry.

The DC Dental Society has submitted testimony detailing the facts of our plight.

We must ensure that all residents have access to the quality dental care they need and deserve. Increasing the DC Medicaid fee schedule is a critical step toward achieving this goal.

Thank you for your time and consideration of this important matter. Your support in addressing these pressing issues is paramount, and I am hopeful that together, we can work towards a healthier, more equitable future for all residents of Washington, DC.

Respectfully submitted,

Cheryle Baptiste, DDS, FICD, FIAMDI

Immediate Past President of the Robert T. Freeman Dental Society, Inc. (DC Chapter of the NDA)
Current President of the DC Dental Society (DC Chapter of the ADA)
Current President Elect of the National Dental Association
Member of the ADA Task Force to Eliminate Barriers for Underrepresented Minorities into the Dental Profession
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2025 Budget Hearing

Testimony of
Wayne Turnage
Deputy Mayor for Health and Human Services
and
Director, Department of Health Care Finance

Before the Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson

Monday, April 29, 2024
9 a.m.
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

Good morning, Chairperson Henderson, and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services (DMHHS) and Director of the Department of Health Care Finance (DHCF). It is my pleasure to report on Mayor Muriel Bowser's proposed Fiscal Year 2025 (FY2025) Budget and Financial Plan for DHCF. Despite the significant financial challenges faced in the formulation of her proposed budget, the Mayor's commitment to sustaining the District's critical health care insurance safety net is clearly established in this budget, evincing a significant investment of local dollars.

As a prelude to the discussion of the referenced financial challenges and the Mayor's proposal for DHCF, allow me to introduce members of my senior management team. These are staff who played a vital role in helping shape the agency's proposals in response to the budget guidance of the Executive Office of the Mayor, and the explicit instructions of Mayor Bowser. Notably, I am joined today by members of my Executive Management Team (EMT) which includes both my Senior Deputy Director and Medicaid Director, Melisa Byrd, and our Senior Deputy Director of Finance, Angelique Martin. Melisa brings her Medicaid and Alliance policy expertise to this process, while Angelique, and the gifted team that she has assembled, performs the sophisticated data analysis needed by the agency's fiscal officer, Darrin Shaffer, to support his efforts to identify the cost of each proposal.

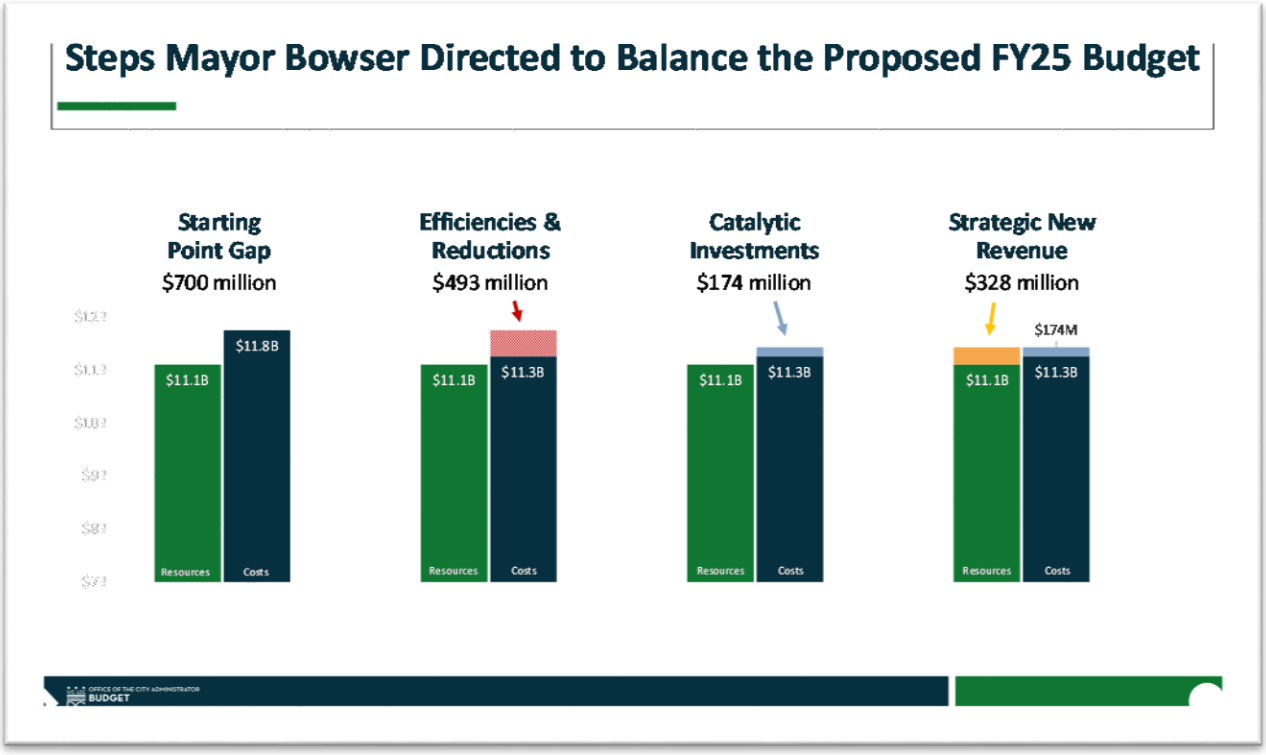
Along with the Administrators of each DHCF division, which includes our program administrators and the director of our Data Analytics division, April Grady, I have asked that two additional DHCF staff from Angelique's finance team attend today's hearing - James Simms, Associate Director of Medicaid Finance, and Joseph Brennan, our actuary. Their discerning and penetrating insight into our budget is the foundation of the proposals that have been advanced to

the Committee on Health as a central component of the Mayor's FY2025 budget proposal. As I have stated in the past, without the collective efforts of this group, DHCF's very complex budget could not have been rationally formulated.

The Financial Environment Impacting Budget Formulation For DHCF

It has been well-documented that Mayor Bowser formulated her FY2025 budget proposal in the headwinds of the most difficult economic forecast witnessed by the District of Columbia in 15 years. While projected revenue growth for the financial plan remains positive, when considered over the span of the plan, these projections fall considerably short of the annual growth rates enjoyed over the preceding 10 years. Further, due to the pernicious interplay of the persistency of remote work, a deteriorating commercial real estate market, and the erosion of sales tax growth rates, the District's Chief Financial Officer has predicted that future revenue growth will remain below the rate of inflation through FY2028.

When these downward adjustments were simultaneously considered with the District's pre-forecast expenditure patterns, the projected financial plan was $4 billion out of balance. The graph shown on page 4 outlines the major steps executed by the Mayor to bring the financial plan into balance, fund the critical functions of government, and make the strategic investments required to move the District forward. Notably, in the initial phases of budget formulation for FY2025 – the first year of the current financial plan – the budget gap was $700 million. However, subsequent developments during the budget formulation process exacerbated this problem, especially the requirement by the Chief Financial Officer that the Executive replenish the reserve fund by no later than FY2028 at a cost of $217 million. Despite the Mayor's concerns about the CFO's authority to mandate this requirement, her budget replenishes the reserve fund in the requested amount.



Addressing The Spending Gap. Through expert stewardship, the Mayor addressed more than half of the FY2025 budget gap with agency spending reductions and efficiencies. Whenever agency retrenchment is required to balance the Mayor's budget proposal to the Council, there are serious questions about whether and how the social safety net can be preserved. This is a necessary consideration because of the substantial amount of government spending on human services programs. Historically, these programs account for more than a third of total District spending – the majority of which is attributable to DHCF programs. So, in working with the Mayor's budget team, the following principles were established to guide the budget development process for our agency:

1. Protect the robust eligibility levels for the Medicaid and Alliance programs.

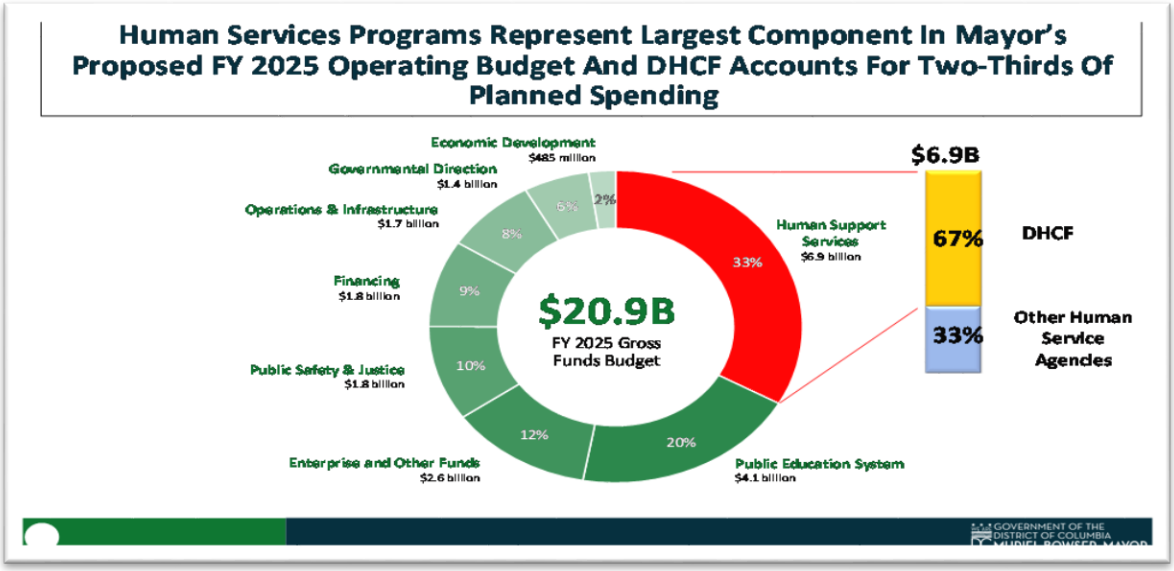
2. Preserve the current scope of expansive benefits in both programs.

3. Where possible, make targeted investments in provider rates, especially for industry groups facing surging costs.

4. Comply with new CMS requirements mandating continuous coverage for children, notwithstanding the assessed cost impact.

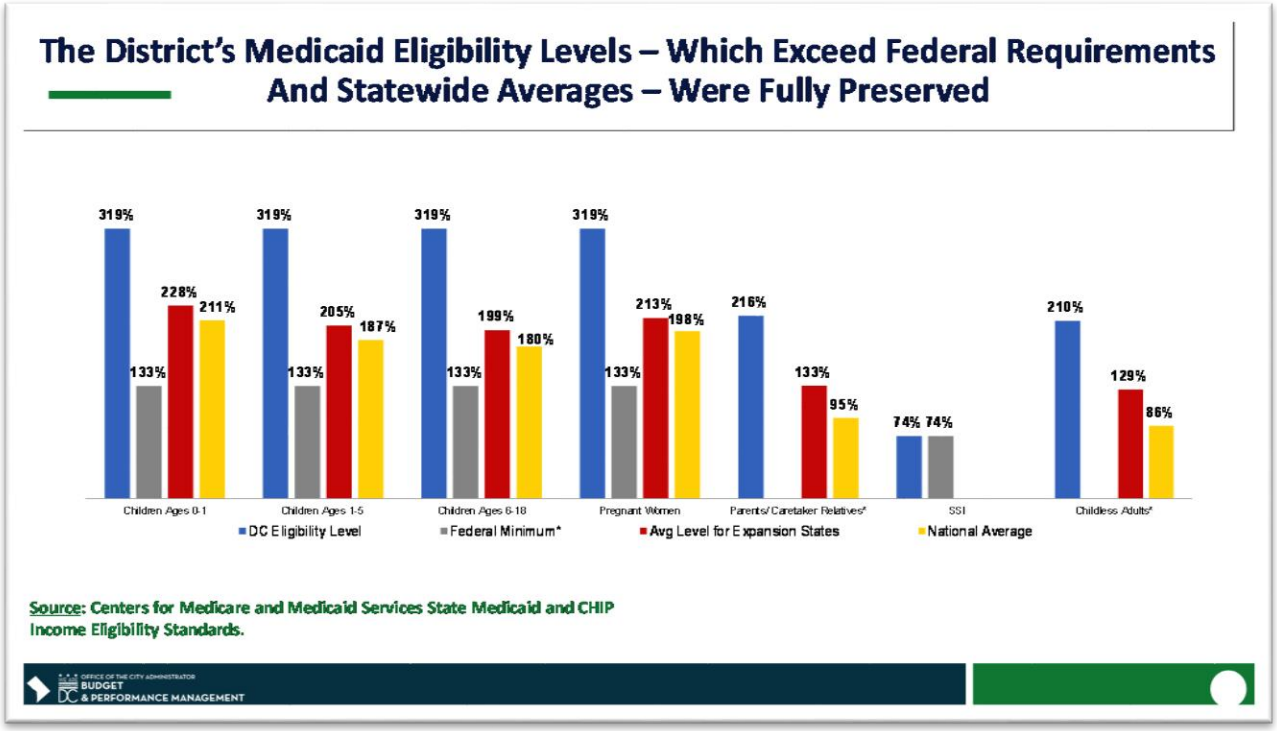
Since major savings in the Medicaid and Alliance program can only be achieved by either lowering eligibility levels, reducing optional program benefits, or slashing provider reimbursement rates, the Mayor needed to pursue more creative options to control spending in DHCF's programs. In addition to pursuing efficiency reductions, the financial challenges also required the Executive to forego opportunities to add new and potentially high-cost benefits, while instructing DHCF to mine our budget for cost-shifting proposals that would relieve local fund pressures across the four-year plan. Finally, in situations where rate increases could not be responsibly held in abeyance, we were challenged to find ways to make such adjustments cost neutral.

Using the established guiding principles listed above, the Mayor's proposal for the Council retains the prominence of DHCF programming in the human services budget (see graph below). Specifically, human service programs are responsible for 33 percent of the Mayor's

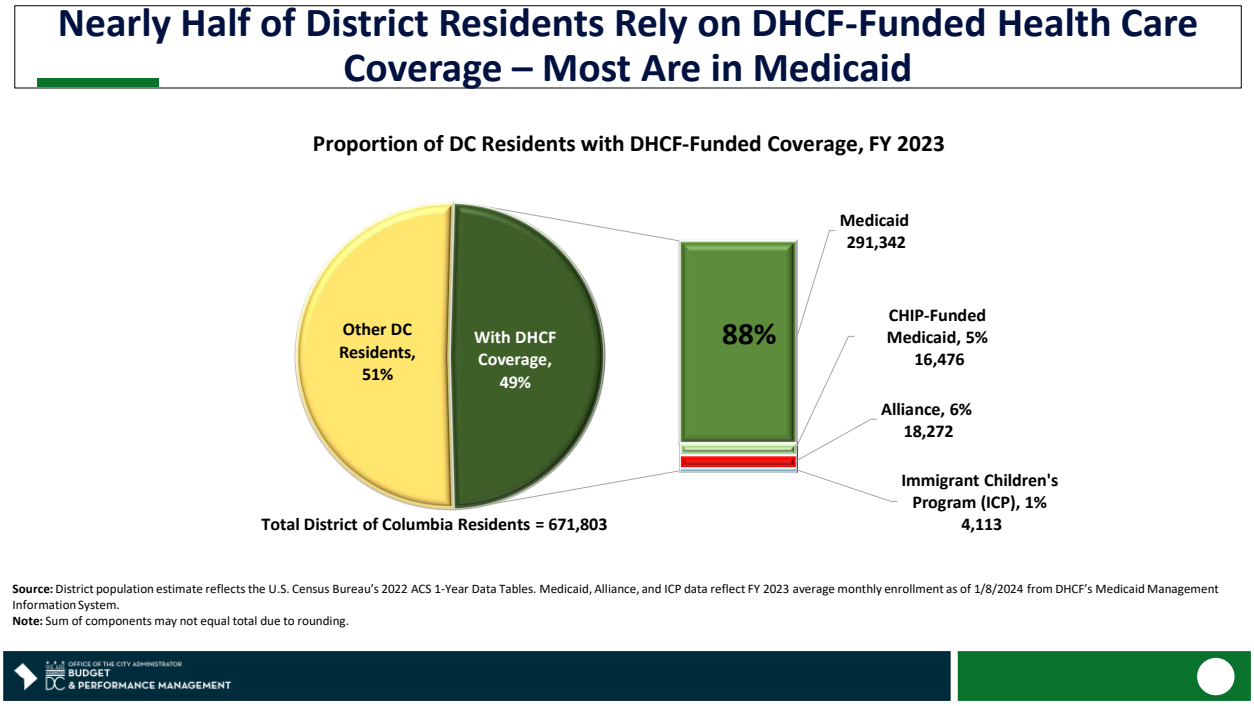


planned spending for FY2025. More than two-thirds of the human services budget is allocated for DHCF programming.

To appreciate the Mayor's commitment to the human services safety net, consider DHCF's eligibility policy. As the graph below reveals, across Medicaid beneficiary groups, the District's eligibility levels are substantially higher than the average levels witnessed for other states, and the federally prescribed minimum levels. Not surprisingly, these aggressive levels have substantially expanded access to fully financed public health care in the District of Columbia.



As the graph on the next page illustrates, when combined with persons who receive Alliance benefits, nearly half of the residents in the District of Columbia (330,203) received health care insurance that is provided free of premium cost, cost-sharing, and co-payments. Among these residents, more than 307,000 are either receiving Medicaid (88 percent) or enrolled in the Medicaid Children's Insurance Program (5 percent). Another 22,000 residents receive full



health care through the Alliance as adults (6 percent), or children (1 percent), through the Immigrant Children's Program.

On the benefit side of the Medicaid program, some services are mandated as a condition of participating in the program, while others are provided as State plan options. Alliance is not subject to federal law and its benefits are largely defined through local agency policy. Notwithstanding these flexibilities, the District has established a history of comprehensive benefits for these programs as a foundational component of the human service safety net, and the Mayor offered no significant changes to these benefits. This means that the Mayor closed a $4 billion budget gap over the financial plan, without changing the framework of the program with the largest amount of total funding in the District – publicly funded health insurance.

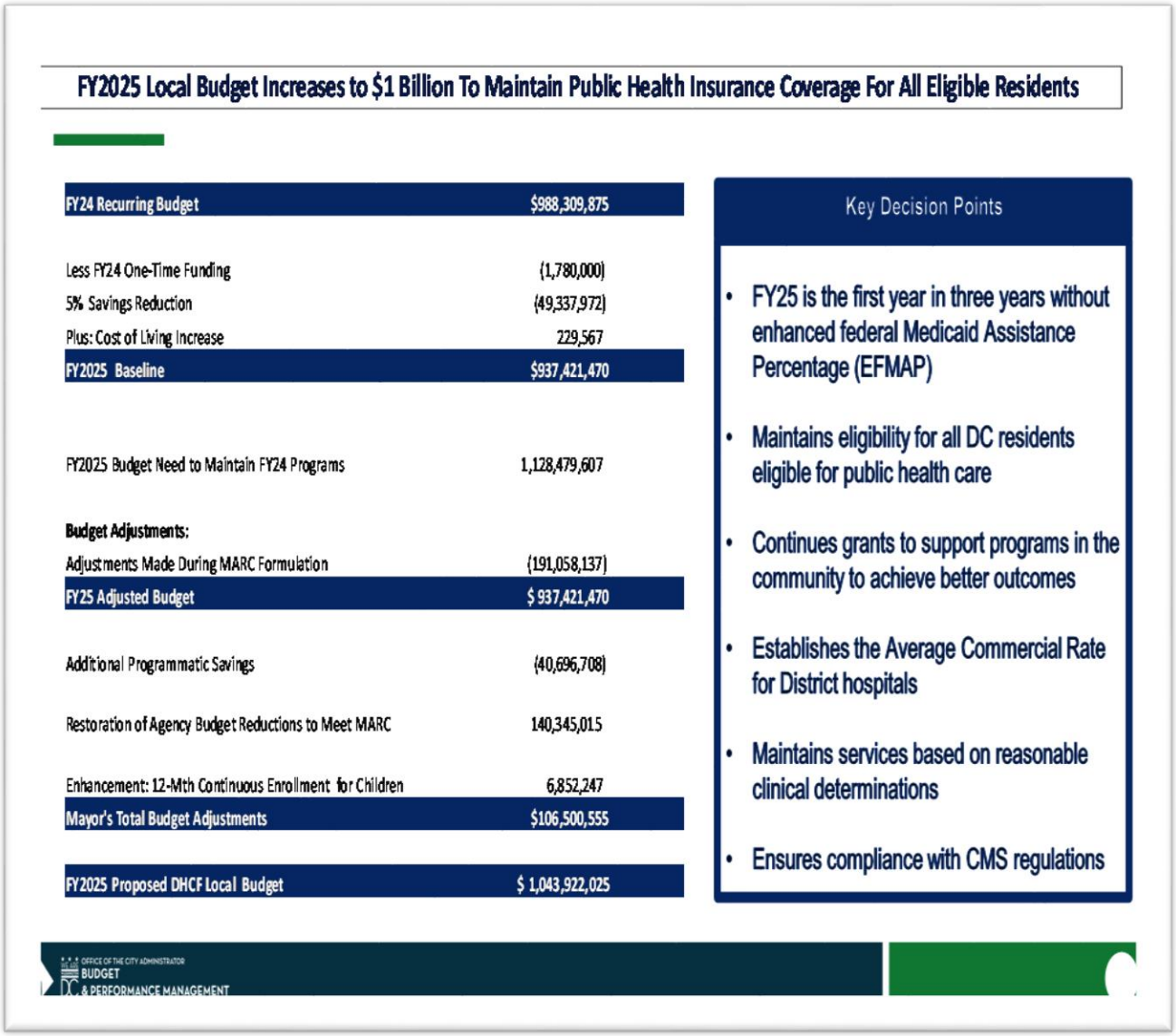
The Building Blocks Of DHCF's Proposed Local Budget

The process used by the budget team to build the agency's FY2025 proposal is iterative, with the FY2024 recurring budget as the starting point for the formulation. Then, through a

series of debits and credits, governed by broad mayoral policy goals and specific programming decisions, the Mayor's budget team builds a bottom-line local funding amount to represent the agency's proposed budget, subject to final approval by the Mayor.

The table on page 9 illustrates this process for DHCF's FY2025 budget. As shown, the baseline funding amount determined by the previous year's approved budget was $988.3 million. Next, DHCF's one-time funding amounts from FY2024 of nearly $1.8 million were removed from the baseline. Additionally, the budget team imposed a 5 percent savings requirement before adding a cost-of-living increase that resulted in DHCF's Maximum Allowable Request Ceiling (MARC) for FY2025 of $937.4 million. Once the FY2025 baseline was established, the DHCF budget team determined the local fund cost that would be associated with maintaining the existing programs based on projected demand, without any additional downward adjustments. This created a local fund cost of more than $1.1 billion. In other words, this reflected the true cost of operating DHCF before the Mayor considered any additional policy options. Comparing this projected cost to the $937.4 million MARC necessitated a reduction of $191 million, a savings DHCF could only achieve with deep reductions in eligibility levels for both Medicaid and the Alliance members and/or restructuring some program benefits. After assuming an additional $40 million savings requirement for DHCF, the Mayor restored $140.3 million of previously assumed reductions, allowing DHCF to avoid further reductions. All budget adjustments concluded with an enhancement of $6.8 million to fund the federal requirement for 12-month continuous enrollment for children in Medicaid. Together, these series of decisions resulted in a local fund budget for DHCF of $1,043,922,025.

DHCF Budget Adjustment Details – Coverage Cost. The aggregate changes summarized in the previous section obscure the detailed policy changes which comprise DHCF's budget



FY2025 Local Budget Increases to $1 Billion To Maintain Public Health Insurance Coverage For All Eligible Residents

FY24 Recurring Budget	**$988,309,875**
Less FY24 One-Time Funding	(1,780,000)
5% Savings Reduction	(49,337,972)
Plus: Cost of Living Increase	229,567
FY2025 Baseline	**$937,421,470**
FY2025 Budget Need to Maintain FY24 Programs	1,128,479,607
Budget Adjustments:	
Adjustments Made During MARC Formulation	(191,058,137)
FY25 Adjusted Budget	**$ 937,421,470**
Additional Programmatic Savings	(40,696,708)
Restoration of Agency Budget Reductions to Meet MARC	140,345,015
Enhancement: 12-Mth Continuous Enrollment for Children	6,852,247
Mayor's Total Budget Adjustments	**$106,500,555**
FY2025 Proposed DHCF Local Budget	**$ 1,043,922,025**

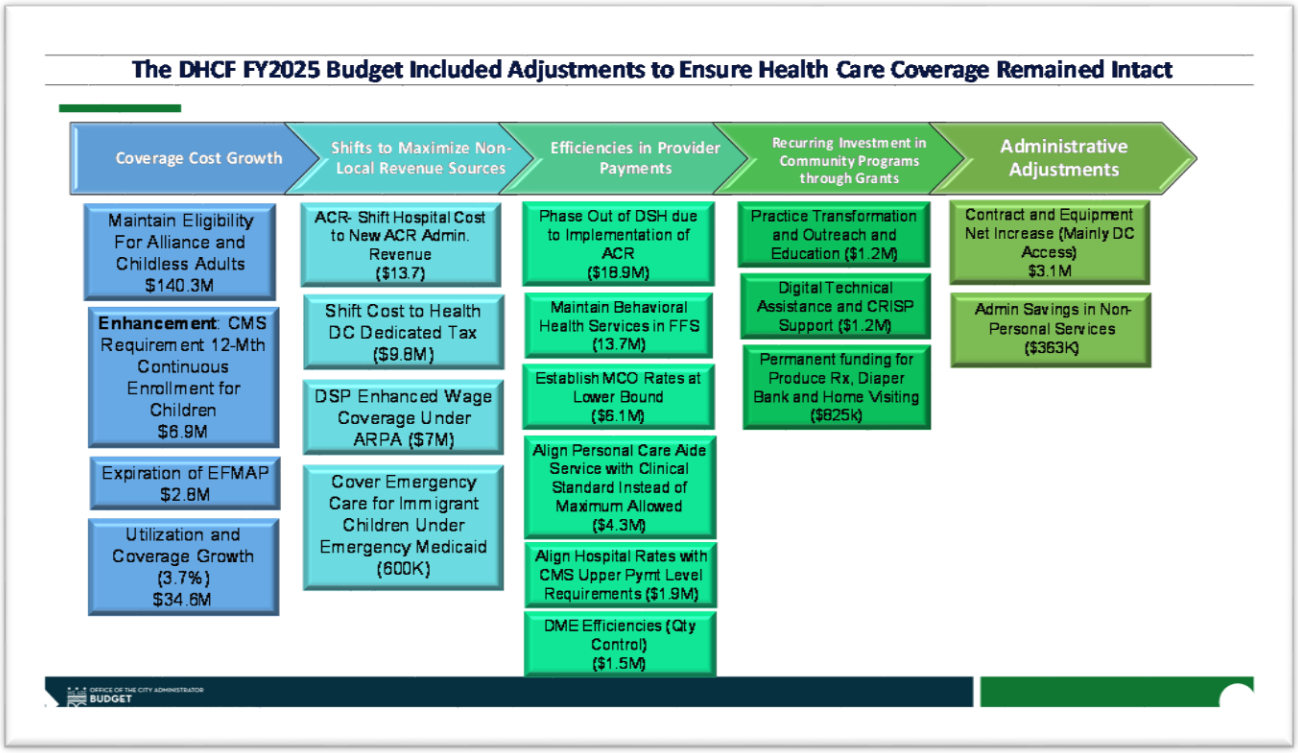
Key Decision Points

- FY25 is the first year in three years without enhanced federal Medicaid Assistance Percentage (EFMAP)
- Maintains eligibility for all DC residents eligible for public health care
- Continues grants to support programs in the community to achieve better outcomes
- Establishes the Average Commercial Rate for District hospitals
- Maintains services based on reasonable clinical determinations
- Ensures compliance with CMS regulations

OFFICE OF THE CITY ADMINISTRATOR BUDGET & PERFORMANCE MANAGEMENT

adjustments. This detail is captured in the graph on page 10. Notably, almost $185 million was allocated by the budget team to maintain eligibility for Medicaid and Alliance members, pay for the federal requirement to provide continuous coverage, and fund the expected growth in enrollment and utilization of services. This projected growth was 3.7 percent, which is higher than the predicted growth rate for District revenues.

Local Fund Cost Shifts. By substituting revenue from other sources, DHCF is reducing the use of local funds by more than $31 million. The largest shift of $13.7 million is made



possible using revenue from new hospital provider taxes. Almost $10 million in local fund Medicaid cost was moved off the books and paid for by the Healthy DC Dedicated Tax fund. Another $7 million in local wage cost for Direct Care Professionals will be paid for by special federal funding provided through the American Rescue Plan for Medicaid Home and Community Based Services (HCBS).

Program Reductions and Efficiencies. Through several efficiencies and program changes, DHCF's FY2025 budget was reduced by $46 million. The largest savings of $18.9 million was produced by phasing out the Disproportionate Share Hospital ("DSH") program. Funding for this program – which reimburses hospitals for uninsured costs – will not be necessary in FY2025 because hospitals will be reimbursed at a rate that reduces their uninsured costs to insignificantly small levels. Another $13.7 million is achieved by keeping behavioral health services in the Medicaid Fee-for-Service program, thereby avoiding the administrative

cost that would have been incurred by carving these services into the Medicaid managed care program and paying the associated administrative fee and taxes, as was previously planned. With the administrative costs, though savings were expected over time, the immediate increases would have occurred, in part, due to the maintenance of FFS rates and other thresholds required for 18 months to help bridge providers through transition.

Two additional changes produce smaller, but significant, savings. First, DHCF will reimburse health plans at the lower bound of the capitated rate range established to pay health plans. This change will save $6.1 million, and it is a federally permissible reduction as the rate that will be paid is within the required range that is determined by our independent actuary. Second, DHCF will tie the provision of personal care services more closely to clinical standards instead of defaulting to the maximum allowable number of hours, producing $4.3 million in program savings.

Establishing An Average Commercial Rate For Hospitals

Following the challenges of the pandemic, hospitals in the District witnessed surging non-contract and contract labor costs, rapidly rising drug expenses, and inflationary costs for equipment and supplies. Almost without exception, these expenses have grown at rates that dwarf increases in Medicaid reimbursements, which are typically significantly lower than commercial insurance rates.

This problem of rising costs and constrained Medicaid reimbursements is exacerbated by the fact that Medicaid patients – with the lower payment rates – are growing as a percentage of hospital visits when compared to their commercial counterparts. This trend, which is partly a function of the decline in daily commuters – many of whom were using commercial insurance to

purchase health care services from District hospitals – adds to the financial pressures with which hospitals now struggle.

Current Medicaid law allows states to tax certain provider groups up to, but no more than six percent of net patient revenue to help with the funding of the Medicaid program, provided the tax meets the three following requirements:

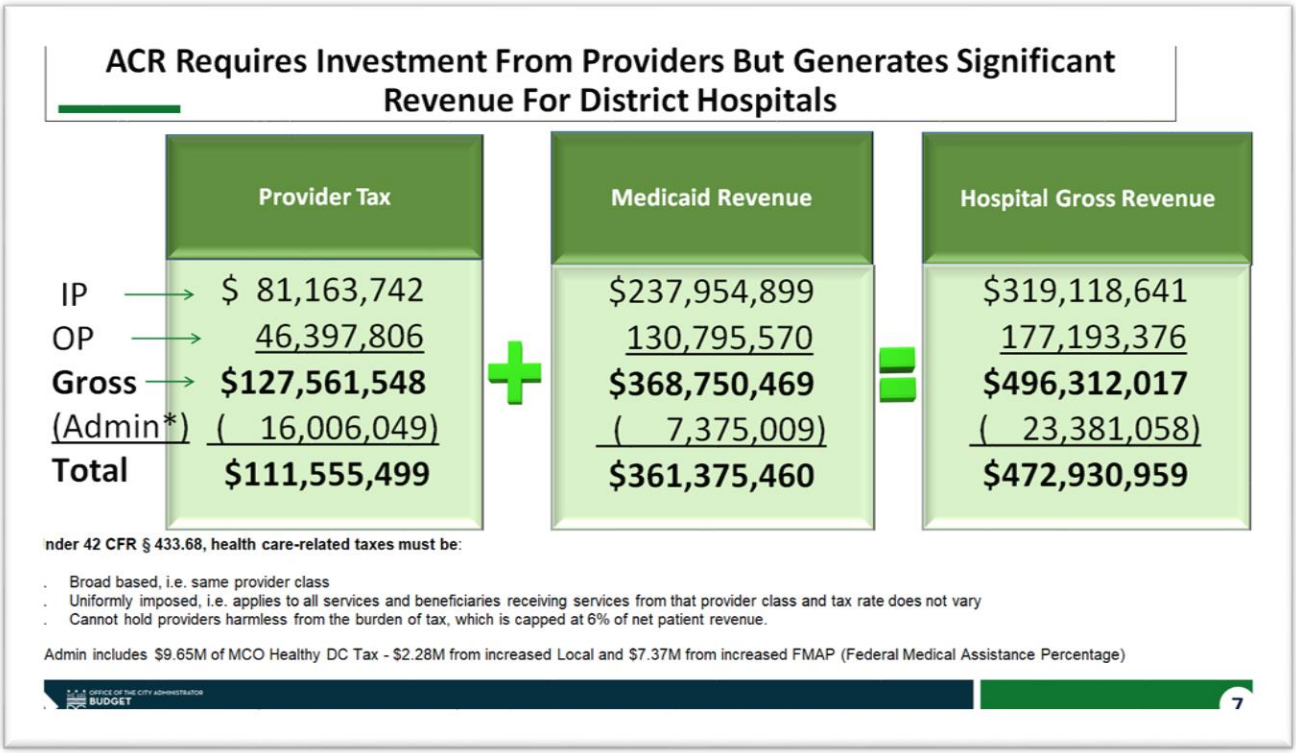
1. The tax must be uniform. This means that all providers must pay the same tax rate.

2. The tax must be broad-based. This means the tax must cover the entire industry – all hospitals must participate equally in the tax unless one or more meets the federal requirements for an exemption.

3. No hospital can be held harmless. Without a federal exemption, no provider in the class can be held harmless from the full burden of the tax through any scheme that increases the tax for some hospitals (those with a larger book of Medicaid business) while reducing the burden for others (those with a smaller book of Medicaid business).

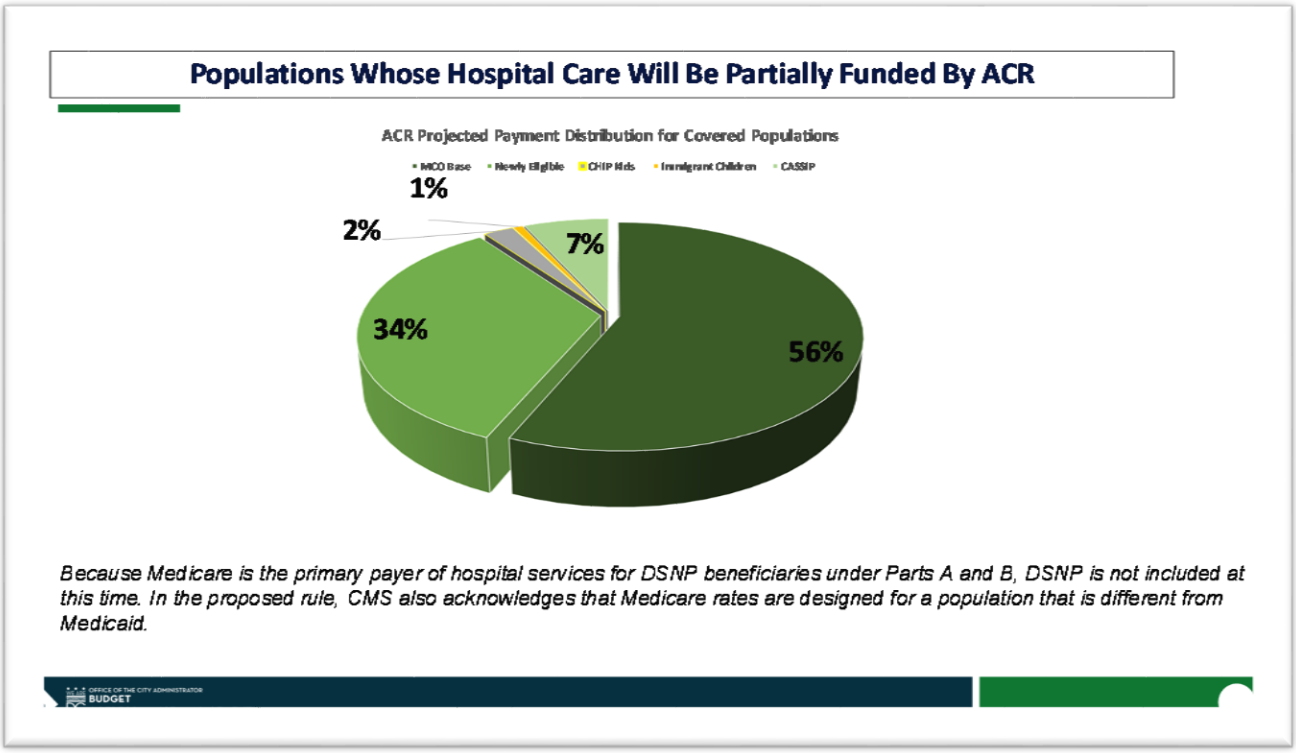
Working collaboratively with the hospital industry, the Mayor is proposing a 2.39% tax on hospital net patient revenue. This policy generates $127.6 million in local funds. As noted earlier, the Mayor proposes to retain $13.7 million of these local funds to defray the ever-rising cost of Medicaid healthcare reflected in DHCF's budget. The balance of the revenue – $113.8 million – will be used by DHCF to draw down $368.8 million in federal funds. This amount will be combined with the remaining local match and used to stabilize and sustain hospital services by paying higher, commercial-like rates for the Medicaid patients they serve (see table on page 13) – this is the so-called Average Commercial Rate ("ACR").

DHCF Implementation Plans For ACR. On an annual basis, ACR will be calculated as a uniform rate increase based on a survey of reimbursement levels for the hospital providers' top 5 commercial payers. Next, we will structure the payment as a tiered percentage increase on top of current reimbursement levels for inpatient and outpatient services.



The responsibility for the payment of ACR to the hospitals will be entrusted to the managed care plans. DHCF will make a retrospective calculation each quarter based on hospital volume. Subsequently, payments will be made to the health plans which are separate from their regular capitation rate. Each health plan will then be directed to filter down payments to each hospital based on actual utilization.

Additionally, ACR will allow hospitals to reinvest in community health care, ensure that District Medicaid beneficiaries will have continued access to a full range of acute care services in all District Hospitals, and give hospitals and DHCF the opportunity to work in partnership on ways to create a nexus between some level of ACR and certain quality strategy and initiatives. The graphic on the next page illustrates the distribution of Medicaid beneficiaries whose care will be supported by the ACR.



Status of the New Hospital

Madam Chairwoman, I close this testimony by providing the latest report on the new hospital. The Mayor's FY25 budget includes **no** new capital funds for this important project and a small amount of operating funds to prepare for opening. As of today, construction remains on schedule for completion at the end of 2024. Presently the exterior is complete, and the major utilities are connected. The work on the interior of the hospital continues.

The precise timing of when the hospital will open for patients is to be determined, but the goal remains early 2025, with a more precise date to be established with UHS at a future time. In the meantime, District agencies and Universal Health Services have begun hospital activation meetings around all local and federal regulatory approvals.

This concludes my testimony and I welcome the opportunity to address any questions therefrom.

Presentation to the Committee On Health

★ ★ ★

FY 2025 BUDGET REQUEST

Budget Overview for FY2025

Department of Health Care Finance

Fair Shot: Strategic Investments and Shared Sacrifice

Presentation Outline

- ☑ **District's Budget Challenge For The Proposed Financial Plan**
- ❑ Key Goals In Building DHCFs Budget In Challenging Environment
- ❑ The Building Blocks To DHCF Proposed FY25 Budget
- ❑ Average Commercial Rate For Medicaid Reimbursement
- ❑ Status of New Hospital

This Year's Budget Reality Is Sobering And Was The Most Challenging In More Than A Decade – Why?

Significantly Increasing Costs

- **WMATA Fiscal Cliff** – $928 million
- **Labor Agreements** – $591 million
- **Retirement Costs** – $200 million
- **Schools Support** – $1.4 billion
- **Medicaid Matching** – $112 million
- **Utilities, Leasing, and Security** - $160 million

Expiring One-Time Federal Funds

More than $3.3 billion in American Rescue Plan Act (ARPA) funding expires at the end of FY 2024:

- **ARPA Recovery Funds** - $2.3 billion
- **ARPA Education Funds** - $618 million
- **ARPA Rental Assistance** - $418 million

Slowing Growth in Revenues

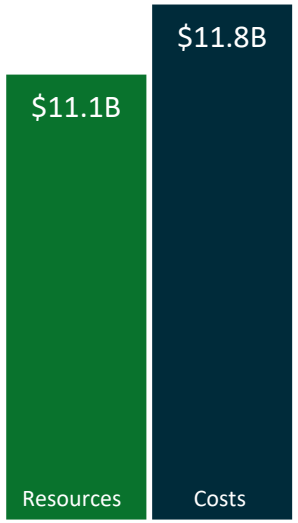
- **Revenue growth has been significant over the last decade**: Since 2010, revenues have grown 6% per year
- **Revenue growth is expected to slow over the next five years:** From FY 2024 through FY 2028, revenues are expected to grow by 2% per year

These factors combined resulted in a $4 billion gap between resources and expenditures through FY 2028

Steps Mayor Bowser Directed to Balance the Proposed FY25 Budget

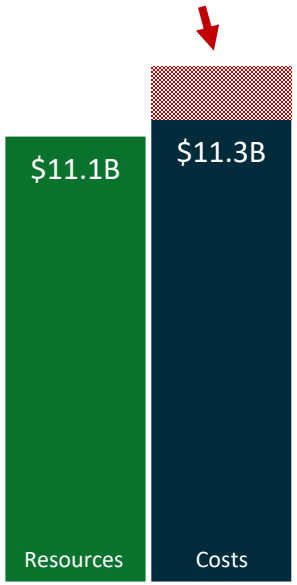
Starting Point Gap

$700 million



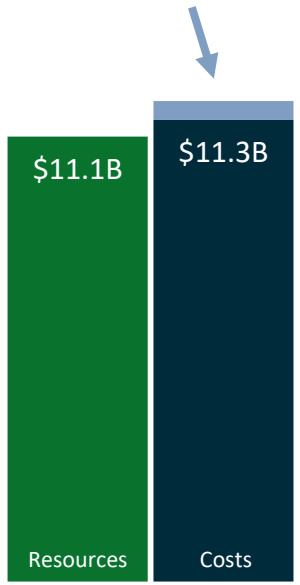
Efficiencies & Reductions

$493 million



Catalytic Investments

$174 million



Strategic New Revenue

$328 million

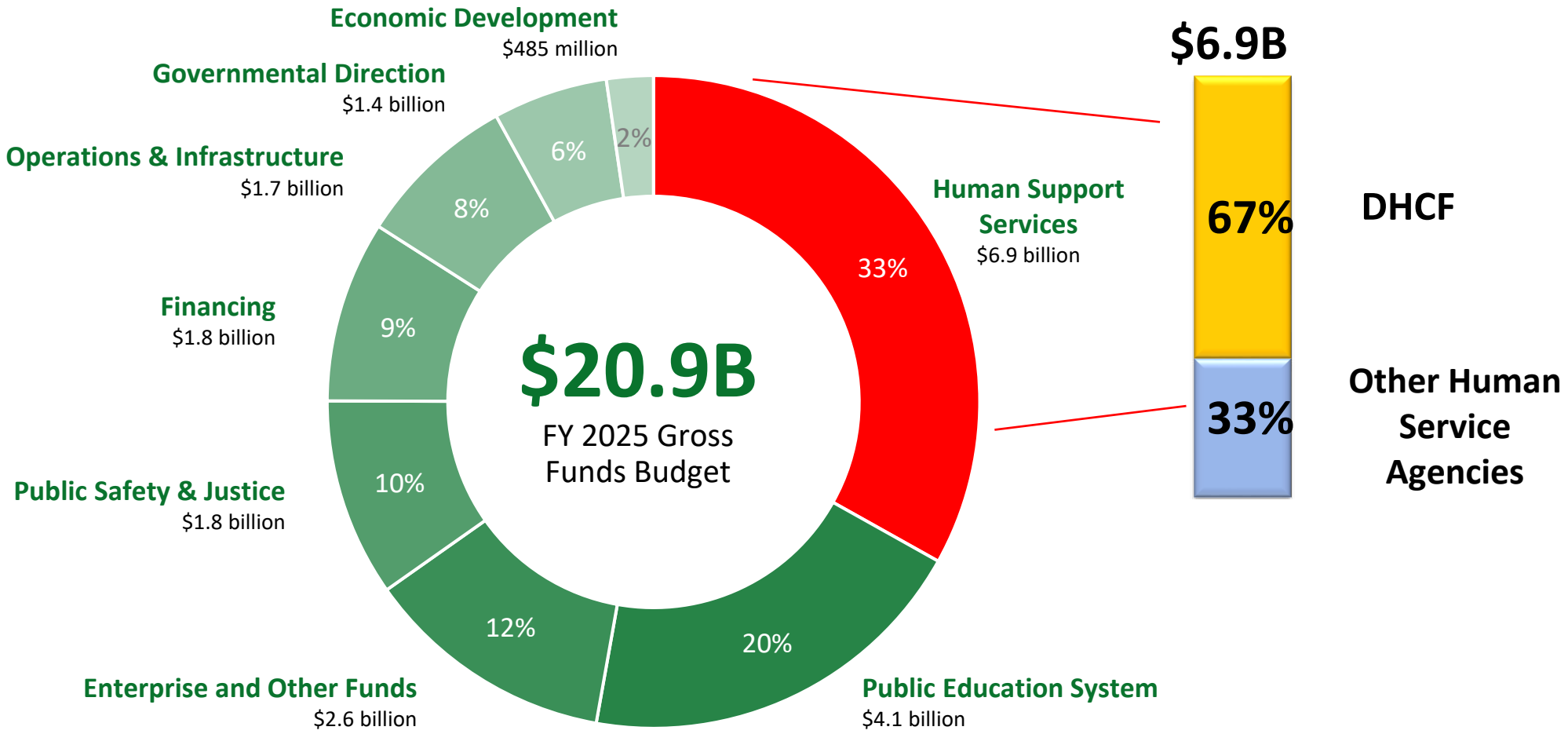
Presentation Outline

- ❑ District's Budget Challenge For The Proposed Financial Plan
- ☑ **Key Goals In Building DHCFs Budget In Challenging Environment**
- ❑ The Building Blocks To DHCF Proposed FY25 Budget
- ❑ Average Commercial Rate For Medicaid Reimbursement
- ❑ Status of New Hospital

Economic and Budget Realities Shifted DHCF Budget Goals To Preservation of Health Insurance Safety Net

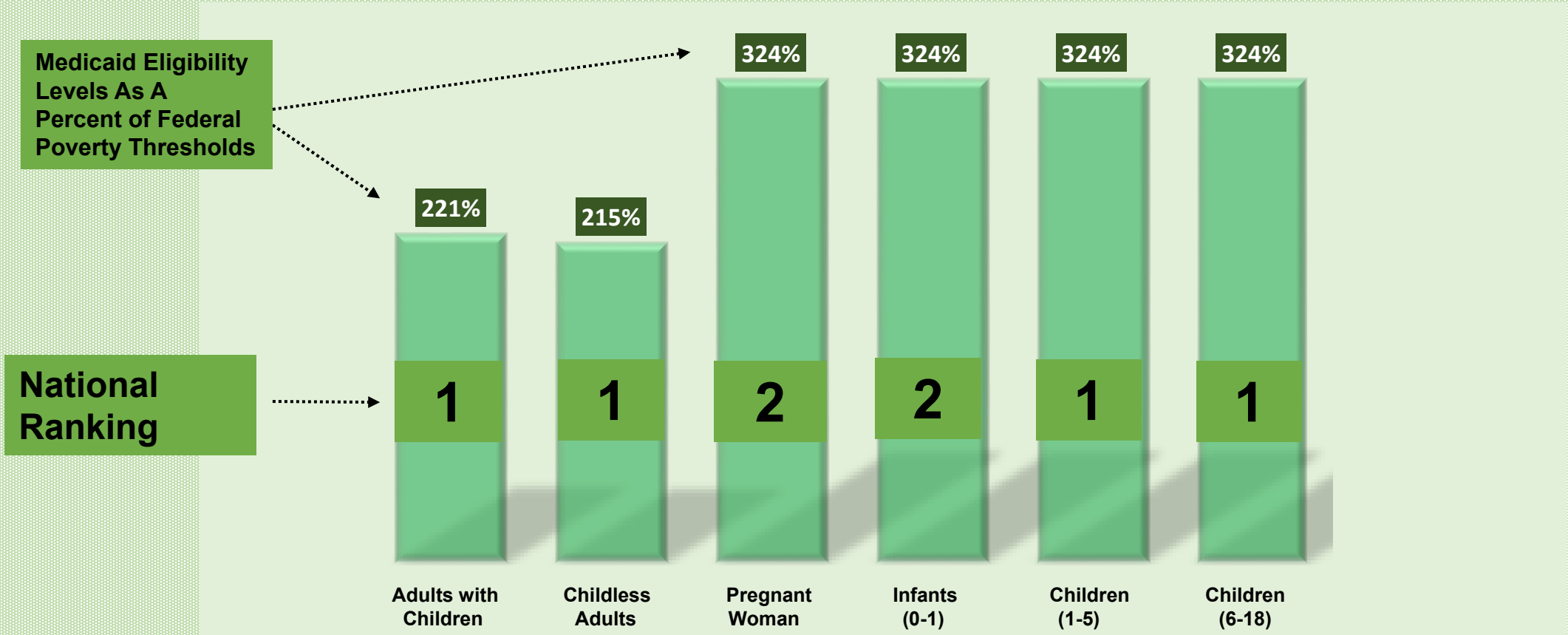
- Protect Eligibility Levels For Medicaid and Alliance Members
- Preserve Current Scope of Medicaid and Alliance Benefits
- Where possible, make targeted investments in provider rates, especially for industry groups facing surging costs
- Comply with CMS Requirements Notwithstanding Cost Impact

Human Services Programs Represent Largest Component In Mayor's Proposed FY 2025 Operating Budget And DHCF Accounts For Two-Thirds Of Planned Spending



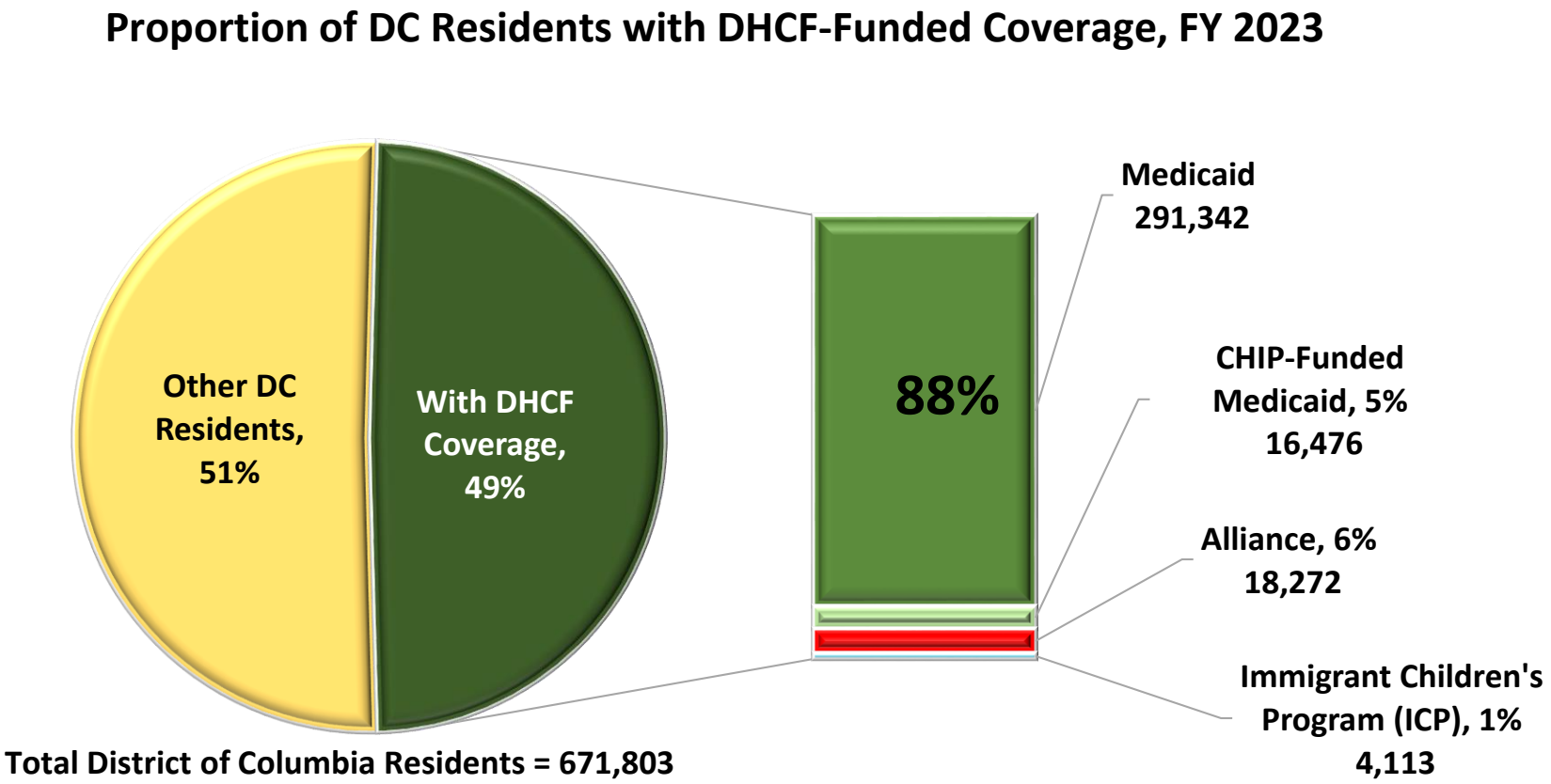
The District's Medicaid Eligibility Levels – Which Are Among The Most Generous In The Nation – Were Fully Preserved In Budget Formulation

National Rankings for District's Medicaid Eligibility Levels, As Of January 2023



Notes: In addition to the District (through Alliance), California, Hawaii, Illinois, Massachusetts, New Mexico, New York, Pennsylvania, and Oregon cover some income-eligible adults and children who are not otherwise eligible due to immigration status. In some cases, the coverage is limited to targeted groups, or the coverage provides more limited benefits than Medicaid.
Source: Kaiser Family Foundation

Thus, Nearly Half of District Residents Rely on DHCF-Funded Health Care Coverage – Most Are in Medicaid



Source: District population estimate reflects the U.S. Census Bureau's 2022 ACS 1-Year Data Tables. Medicaid, Alliance, and ICP data reflect FY 2023 average monthly enrollment as of 1/8/2024 from DHCF's Medicaid Management Information System.
Note: Sum of components may not equal total due to rounding.

No Medicaid Services Were Eliminated As The District Continues With Significant Investments in Provider Services

Provider Payment Category	FY2023 Expenditures	FY2024 Approved Budget	FY2025 Proposed Budget	YoY Variance ($)	YoY Variance (%)	Variance Explanation
Hospital	207,901,088.12	237,426,785.36	169,148,361.66	(68,278,423.70)	-40.4%	With transition to ACR, DSH payments will not be paid in FY25.
ICF/IID	102,962,384.72	93,185,166.24	114,460,654.64	21,275,488.40	18.6%	
Skilled Nursing Facility	324,068,726.60	295,415,801.46	313,224,452.93	17,808,651.47	5.7%	Nursing Facility rate increase
Primary Care (Physicians, Clinics, & FQHC)	82,864,796.79	95,035,667.96	102,155,055.17	7,119,387.21	7.0%	Increase driven primarily by estimated increase in prescribed drugs.
Other (Medicare part A, B, etc)	140,666,202.85	153,502,467.91	168,786,191.17	15,283,723.26	9.1%	
DME	21,179,513.12	21,275,076.49	13,126,390.49	(8,148,686.00)	-62.1%	Savings initiative implemented to address unit limits on excessively billed items.
Behavioral Health (Inc. BH Waiver)	186,532,811.57	178,710,090.42	84,041,594.67	(94,668,495.75)	-112.6%	Complete Federal budget not included in this total. Federal budget will be added via budget adjustment.
Skilled Care	31,342,241.68	26,284,603.53	42,565,380.44	16,280,776.91	38.2%	Increase primarily in private duty nursing. Beneficiaries utilizing significantly more of this service than in past years.
LTCS (incl PCA and PACE)	97,682,872.18	137,954,642.52	121,063,028.04	(16,891,614.48)	-14.0%	PACE enrollment has growth has been lower than anticipated.
DSNP	228,524,460.85	216,382,667.25	305,065,954.86	88,683,287.61	29.1%	Increased capitation rates and enrollment
EPD Waiver	192,147,252.51	147,249,068.86	172,611,918.55	25,362,849.69	14.7%	Increased enrollment driven partially by increased ALF capacity.
DD Waiver	326,958,411.05	241,997,890.60	258,474,146.19	16,476,255.59	6.4%	As the PHE has ended more beneficiaries are beginning to utilizing services more.
IFS Waiver	405,347.71	5,619,813.66	1,568,755.62	(4,051,058.04)	-258.2%	We anticipated higher enrollment in 23 and 24. FY25 reflects observed enrollment .
Emergency Medicaid	31,476,885.17	35,829,676.70	31,511,188.34	(4,318,488.36)	-13.7%	
Medicaid MCO	2,004,949,303.96	1,902,271,177.74	2,426,706,552.99	524,435,375.25	21.6%	
Alliance MCO	111,194,269.82	118,327,853.31	132,493,842.66	14,165,989.35	10.7%	FY25 reflects increased enrollment.
Permanent Supportive Housing	17,254,710.39	57,863,452.64	49,431,530.93	(8,431,921.71)	-17.1%	
Total	**4,108,111,279.09**	**3,964,331,902.65**	**4,506,434,999.35**	**542,103,096.70**		

Presentation Outline

- ❑ District's Budget Challenge For The Proposed Financial Plan
- ❑ Key Goals In Building DHCFs Budget In Challenging Environment
- ☑ **The Building Blocks To DHCF Proposed FY25 Budget**
- ❑ Average Commercial Rate For Medicaid Reimbursement
- ❑ Status of New Hospital

FY2025 Local Budget Increases to $1 Billion To Maintain Public Health Insurance Coverage For All Eligible Residents

FY24 Recurring Budget	**$988,309,875**
Less FY24 One-Time Funding	(1,780,000)
5% Savings Reduction	(49,337,972)
Plus: Cost of Living Increase	229,567
FY2025 Baseline	**$937,421,470**
FY2025 Budget Need to Maintain FY24 Programs	1,128,479,607
Budget Adjustments:	
Adjustments Made During MARC Formulation	(191,058,137)
FY25 Adjusted Budget	**$ 937,421,470**
Additional Programmatic Savings	(40,696,708)
Restoration of Agency Budget Reductions to Meet MARC	140,345,015
Enhancement: 12-Mth Continuous Enrollment for Children	6,852,247
Mayor's Total Budget Adjustments	**$106,500,555**
FY2025 Proposed DHCF Local Budget	**$ 1,043,922,025**

Key Decision Points

- **FY25 is the first year in three years without enhanced federal Medicaid Assistance Percentage (EFMAP)**
- **Maintains eligibility for all DC residents eligible for public health care**
- **Continues grants to support programs in the community to achieve better outcomes**
- **Establishes the Average Commercial Rate for District hospitals**
- **Maintains services based on reasonable clinical determinations**
- **Ensures compliance with CMS regulations**

The DHCF FY2025 Budget Included Adjustments to Ensure Health Care Coverage Remained Intact

Coverage Cost Growth
+ $184.6 million

- Maintain Eligibility For Alliance and Childless Adults $140.3M
- **Enhancement**: CMS Requirement 12-Mth Continuous Enrollment for Children $6.9M
- Expiration of EFMAP $2.8M
- Utilization and Coverage Growth (3.7%) $34.6M

Shifts to Maximize Non-Local Revenue Sources
-$31.1 million

- ACR- Shift Hospital Cost to New ACR Admin. Revenue ($13.7)
- Shift Cost to Health DC Dedicated Tax ($9.8M)
- DSP Enhanced Wage Coverage Under ARPA ($7M)
- Cover Emergency Care for Immigrant Children Under Emergency Medicaid (600K)

Efficiencies in Provider Payments
-$46.4 million

- Phase Out of DSH due to Implementation of ACR ($18.9M)
- Maintain Behavioral Health Services in FFS (13.7M)
- Establish MCO Rates at Lower Bound ($6.1M)
- Align Personal Care Aide Service with Clinical Standard Instead of Maximum Allowed ($4.3M)
- Align Hospital Rates with CMS Upper Pymt Level Requirements ($1.9M)
- DME Efficiencies (Qty Control) ($1.5M)

Recurring Investment in Community Programs through Grants

- Practice Transformation and Outreach and Education ($1.2M)
- Digital Technical Assistance and CRISP Support ($1.2M)
- Permanent funding for Produce Rx, Diaper Bank and Home Visiting ($825k)

Administrative Adjustments

- Contract and Equipment Net Increase (Mainly DC Access) $3.1M
- Admin Savings in Non-Personal Services ($363K)

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Hospital Provider Taxes Are A Critical Component Of The Mayor's Proposed Budget, Supporting The Following Investments Through An Average Commercial Rate For Hospitals

Fund Detail Number and Title		FY25 Proposed Budget	FY24 Approved Budget	FY25 FTE's	FY24 FTE's
Local Fund		**1,043,922,407**	**988,309,875**	**172.42**	**165.00**
1010001	LOCAL FUNDS	1,043,922,407.42	988,309,875	172.42	165.00
Dedicated Taxes		**240,409,641**	**114,535,958**	**7.15**	**8.20**
1011003	NURSING HOMES QUALITY OF CARE FUND	18,633,354	16,659,004	0.55	1.02
1011007	HEALTHY DC FUND	74,690,002	78,475,094	4.95	5.50
1011009	STEVIE SELLOW'S	5,538,639	5,637,568	1.10	1.65
1011010	**HOSPITAL ASSESSMENT TAX**	**8,454,037**	**8,454,037**	**0.00**	**0.00**
1011011	**DC PROVIDER FEE**	**5,532,061**	**5,310,255**	**0.00**	**0.00**
1011018	**INPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND**	**81,163,742**	**0**	**0.55**	**0.00**
1011019	**OUTPATIENT HOSPITAL DIRECTED PAYMENTS PROVIDER FEE FUND**	**46,397,805**	**0**	**0.00**	**0.00**
Special Purpose Revenue		**7,008,261**	**8,805,546**	**15.60**	**15.60**
1060128	MEDICAID COLLECTIONS-3RD PARTY LIABILITY	3,794,846	5,582,557	2.75	2.75
1060132	BILL OF RIGHTS-(GRIEVANCE & APPEALS)	2,613,415	2,622,988	12.85	12.85
1060386	INDIVIDUAL INSUR MKT AFFORD & STABILITY	600,000	600,000	0.00	0.00
District ARPA Funds		**3,572,326,242**	**3,192,412,347**	**182.91**	**177.80**
4020002	FEDERAL GRANTS	5,136,131	4,550,493	5.00	0.00
4025002	FEDERAL MEDICAID PAYMENTS	3,567,190,111	3,187,761,854	177.91	177.80
4040002	PRIVATE GRANT FUND	0	100,000	0.00	0.00
Grand Total		**4,863,666,552**	**4,304,063,725**	**378.08**	**366.60**

Key Points

- $27.6M will fund FFS hospital cost and $113.8M in MCO hospital cost
- $1.4M in Emergency Room Care
- $3.8M in Immigrant Children Hospital Care
- $9.8M in CASSIP Care

What Is The Average Commercial Rate (ACR)?

- ACR is a uniform rate increase based on a survey of reimbursement levels for, in this case, hospital providers' top 5 commercial payers
- The payment is structured as a tiered percentage increase on top of current reimbursement levels for hospital inpatient and OP services
- DHCF, worked in collaboration with the DC Hospital Association (DCHA) to establish ACR
  - ➢ We will direct Managed Care Providers in FY2025 to pay inpatient and outpatient hospitals up to the ACR
  - ➢ Payment will be made through a supplemental payment.
  - ➢ Hospitals would still be reimbursed at Medicaid levels for services to Fee-for-Service (FFS) beneficiaries.

ACR requires investment from providers but generates significant revenue for District Hospitals

	Provider Tax		Medicaid Revenue		Hospital Gross Revenue
IP →	$ 81,163,742	+	$237,954,899	=	$319,118,641
OP →	46,397,806		130,795,570		177,193,376
Gross →	**$127,561,548**		**$368,750,469**		**$496,312,017**
(Admin*)	(16,006,049)		(7,375,009)		(23,381,058)
Total	**$111,555,499**		**$361,375,460**		**$472,930,959**

Under 42 CFR § 433.68, health care-related taxes must be:

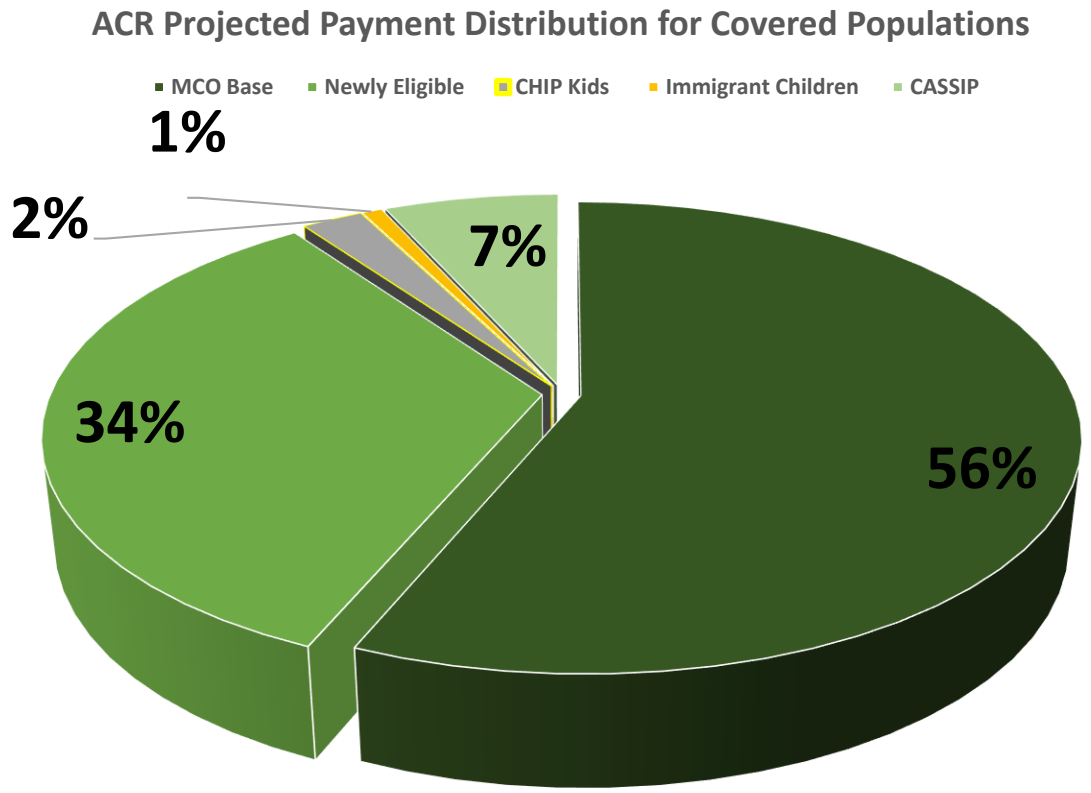
1. Broad based, i.e. same provider class
2. Uniformly imposed, i.e. applies to all services and beneficiaries receiving services from that provider class and tax rate does not vary
3. Cannot hold providers harmless from the burden of tax, which is capped at 6% of net patient revenue.

* Admin includes $9.65M of MCO Healthy DC Tax - $2.28M from increased Local and $7.37M from increased FMAP (Federal Medical Assistance Percentage)

How Will DHCF Implement The ACR?

- ACR is calculated annually as a uniform rate increase based on a survey of reimbursement levels for providers' Top 5 commercial payers
- We will structure payment as tiered percentage increase on top of current reimbursement levels for IP and OP services
- ACR applies equally to all in provider class
- Separate payment term calculated retrospectively and paid to MCPs, who are directed to filter down payments to each hospital based on actual utilization

Populations Whose Hospital Care Will Be Partially Funded By ACR



Because Medicare is the primary payer of hospital services for DSNP beneficiaries under Parts A and B, DSNP is not included at this time. In the proposed rule, CMS also acknowledges that Medicare rates are designed for a population that is different from Medicaid.

ACR Benefits DC Community

Allows reinvestment into community health care efforts

- DHCF will work with Hospitals and DCHA to identify a set of concrete investments designed to improve access to care

ACR Payments are tied to quality strategy and initiatives

- State Directed Payments are an important mechanism for DHCF to achieve policy goals and influence outcomes with respect to managed care quality

Ensures District beneficiaries continued access in all District Hospitals

- Shrinks reimbursement gap between commercial and Medicaid patients and promotes equitable treatment regardless of insurance

The Funding Hospitals Will Earn From The ACR, Must Include A Plan To Increase Quality and Reinvestment in District Health Care Initiatives

Proposed quality investment areas to address health care challenges that impact the health care system as a whole:

- Maternal Health
- Workforce Investment
- Improve emergency room throughput
- Reduce FEMS wait times on patient delivery
- Improve transition of care once a patient is ready for discharge

Timeline:

- FY2024 will be used to define and establish the criteria of each of the above initiatives and corresponding quality measures (led by DCHA)
- FY2025 will be set as the base year for all quality measures and milestones

Two Legislative Vehicles are Proposed in FY 2025 Local Budget Act to Support ACR

Revise existing tax legislation

Medicaid Hospital Outpatient Supplemental Payment & Hospital Inpatient Rate Supplement Adjustments Act of 2024

- Amends prior hospital tax language in The Medicaid Hospital Outpatient Supplemental Payment Act of 2017 and The Medicaid Hospital Inpatient Rate Supplement Act of 2017 to align gross and net patient revenues definitions with new ACR statue.
- Adds language to exempt Howard once tax waiver is approved by CMS.

New law to codify ACR

Medicaid Inpatient Hospital Directed Payment Act of 2024 & Medicaid Outpatient Hospital Directed Payment Act of 2024

- These subtitles establish provider funds for new collected taxes to pay local share of directed payments that bridge the gap between Medicaid reimbursement paid through capitation rates and ACR.
- Outlines mechanisms and logistics for payment to providers through MCOs.
  - Can adjust original tax rate up or down during year as necessary
- In addition to local share of ACR directed payment, increased provider taxes generate 12% additional revenue for the General Fund and salary for DHCF FTE to administer funds.

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Cedar Hill Regional Medical Center GW Health Construction Remains on Time and on Budget ($434.4 million)

- Mayor's FY25 budget includes no new capital funds for project and a small amount of operating funds to prepare for opening.
- Construction to finish at end of 2024. Exterior is complete, major utilities connected. Interior work continues.
- Opening to patients "early 2025. Exact timing TBD.
- District agencies and UHS have begun hospital activation meetings around all local and federal regulatory approvals.
- New CEO, Anthony Coleman, started in late December 2023.
- We have met our CBE and hiring goals. Tour for DCHA Board in May.
- Building a Comprehensive System of Care
- In February, the Mayor and UHS announced a collaboration to build a freestanding emergency department at the Fletcher-Johnson Campus in Ward 7. This is a requirement under the District's agreement to establish a system of care and will be paid for by UHS.

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The End